

Western Sussex Hospitals NHS Foundation Trust

Annual Report and Accounts 2020 / 21

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Western Sussex Hospitals NHS Foundation Trust

Annual Report 2020-21

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1. Performance Report

The purpose of this section of the Annual Report is to provide a summary of the purpose and activities of Western Sussex Hospitals NHS Foundation Trust (WSHFT) the Trust's priorities and objectives for 2020/2021, the key risks to achieving these objectives and how we have performed in relation to these during the year.

1.1 Welcome from the Chairman and Chief Executive

For all of us, 2020/21 has been a year like no other. The far-reaching impacts of the pandemic have spread like the virus itself, affecting almost every aspect of our personal and professional lives.

The coronavirus crisis has been testing, tiring and at times traumatic, particularly for the thousands of people working in our hospitals.

Covid-19 is a vicious illness. Struggling to breathe is an horrific symptom. More than 20% people admitted to hospital with the disease die.

The tragedy of their loss is particularly difficult for families who cannot spend as much time as they would wish with their loved one because the virus is so contagious.

Staff too must contend with the trauma of such high mortality and bear the burden of being the patient's only contact and comfort as their symptoms worsen.

Our teams have cared for the most severely unwell patients from behind an impersonal veil of protective equipment that masks smiles, makes every task more difficult and communication harder.

At the same time, around 10% of our workforce contracted Covid-19. Two colleagues tragically paid the ultimate price and we grieve alongside their loved ones for their loss.

Many of our people continue to experience debilitating symptoms associated with Long Covid and the toll on mental health and wellbeing has proved high.

Despite this, the dedication shown by our staff throughout the year has been truly exceptional.

Their response to the crisis has been incredible and we are extraordinarily proud of everything they have achieved.

We must remember, pandemic pressures at work have not been experienced by staff in isolation.

They are compounded by the many legitimate concerns we have all carried for our family and friends this past year.

The virus separated us from our loved ones, support networks and all the social activities that help boost our wellbeing.

COVID brought us much closer together

While Covid forced us apart as never before, professionally it has also brought us much closer together.

Indeed, as we draw these reflections, we are writing as chief executive and chairman not of Western Sussex Hospitals (WSHFT) but University Hospitals Sussex NHS Foundation Trust, created on 1 April 2021.

It was the Covid crisis, and the closer collaboration and team-working it necessitated, that ultimately convinced us to pursue a merger with Brighton and Sussex University Hospitals (BSUH).

After nearly four years of shared leadership, our joint response to the emergence of a highly infectious novel coronavirus made clear the benefits of drawing on the best of both Trusts.

Colleagues, teams and departments from WSHFT and BSUH rallied together to expand our wealth of expertise and do battle with the virus

The crisis showcased what our staff excel at; an unwavering commitment to patient care, resilience, adaptability, teamwork and, in particular, innovation.

In just a few short weeks, the layout of our hospitals was transformed into Covid red and green areas as we introduced stringent new infection control measures.

Every service reassessed the way patients accessed care and adapted their working practices as we learned more and more about the disease and its transmission.

We rapidly developed new procurement and supply functions, developed workforce hubs to redeploy staff and introduced virtual consultations for thousands of patients.

All this was achieved in a matter of weeks as wave one struck, peaking in mid-April 2020.

A set of fresh challenges

These important measures to keep our patients and staff safe need to stay in place as long as Covid-19 is circulating in our communities.

This, in turn, presents its own set of fresh challenges. In response to a national directive, all non-urgent hospital activity was paused during wave one, causing waiting lists to increase dramatically.

As the summer months returned to us a sense of normality, our greatest concern was for the thousands of people whose care had been disrupted in the preceding months.

The scale of the challenge was, and continues to be, unprecedented.

Long waiting lists are made worse by infection prevention protocols that reduce how many patients we can see at the very time we need to expand capacity.

As the country ate out to help out in August 2020, we continued to draw on the expertise of our people to deliver care in new ways to ensure we could see as many people as safely as possible.

More than 162,000 virtual appointments were held for outpatients, therapies and fracture clinics and 'virtual waiting rooms' were set up to reduce the need for patients to attend hospital in person.

We introduced home testing kits for patients awaiting certain diagnostic endoscopy procedures. This helped us prioritise patients in most urgent need and also spared hundreds of others from unnecessary invasive colonoscopies.

By October, thanks to the incredible resilience and ingenuity of our staff we were back to providing more than 90% of our pre-Covid hospital activity.

The threat of winter loomed large, however, and concerns about a second wave were soon realised as a new variant, first detected in Kent, began to ravage communities in Sussex.

The second wave

Hospital admissions climbed sharply and in January 2021 they peaked at three times worse than we had experienced in the first wave.

As the country locked down for a third time and Covid cases exploded, the teamwork and ingenuity of our staff brought us back from the brink.

We expanded critical care departments and converted dozens of wards into new isolation areas for infectious patients.

Hundreds of staff worked additional shifts or were redeployed into new areas and departments to assist wherever the need was greatest.

For example, colleagues from paediatrics, outpatients and therapies supported staff in critical care, A&E and inpatient wards.

We also saw staff from all over the organisation helping set up and run our vaccination hubs, including even some who returned to practice from retirement to support the Trust's response.

The hubs were incredible, providing a much-needed dose of optimism at an incredibly bleak time.

Tragically, many more patients lost their lives during the second wave - again, in very difficult circumstances for them, their families and our staff.

The cruelty of Covid will be its legacy. But so too will be the disruption and delay the pandemic has caused to the care of hundreds of thousands of people in need of non-Covid hospital services.

While urgent treatment, trauma and cancer care continued, many so called 'less urgent' procedures were postponed – but, for all those waiting, we know their health remains a most urgent concern.

Addressing their needs is now our first priority. The challenge, however, is immense. For every hospital in the country, waiting lists have never been longer and demand continues to rise.

Our staff are exhausted and emotionally drained. But the creation of our new organisation gives us fresh impetus to put our patients first and innovate in order to meet the challenge head on.


We are drawing on the best from both legacy Trusts and bringing together our clinical teams to problem-test and devise fresh solutions.

Their ingenuity was key to our Covid response and it remains pivotal to our recovery. Our 20,000 staff are our greatest asset.

We are confident that their exemplary commitment to clinical excellence showcased throughout 2020/21 will ensure University Hospitals Sussex recovers services for patients as swiftly as possible.

 14 June 2021

Dame Marianne Griffiths,
Chief Executive

 14 June 2021

Alan McCarthy, MBE, DL
Chairman

1.2 UHSussex: Becoming one Trust

In April 2021, after a long period of collaborative working, Western Sussex Hospitals NHS Foundation Trust (WSHFT) merged with Brighton and Sussex University Hospitals NHS Trust (BSUH) to form University Hospitals Sussex NHS Foundation Trust (UHSussex).

The Trust is one of the largest in the country, providing hospital services from five main locations including Brighton, Haywards Heath, Worthing, Shoreham and Chichester. University Hospitals Sussex employs around 20,000 staff, caring for 1.8 million people in Sussex, with a budget of £1.2 billion.

1.3 About the Trust

Western Sussex Hospitals NHS Foundation Trust served a population of around 450,000 people across a catchment area covering most of West Sussex.

Prior to our merger with Brighton and Sussex University Hospitals NHS Trust on 1 April 2021, the Trust ran three hospitals:

- St Richard's Hospital in Chichester
- Southlands Hospital in Shoreham-by-Sea
- Worthing Hospital in the centre of Worthing

St Richard's and Worthing hospitals provide 24-hour A&E, acute medical care, maternity and children's services, while Southlands specialises in day-case procedures and diagnostic and outpatient appointments, and is home to the Trust's eye care unit opened in June 2017.

In addition to our three hospitals, we provide a range of services in other community settings, including:

- Bognor War Memorial Hospital
- Crawley Hospital
- Health centres
- GP surgeries
- Sexual health clinics

Western Sussex Hospitals was created in 2009 by a merger of the Royal West Sussex and Worthing and Southlands Hospitals NHS Trusts, and has been an NHS Foundation Trust since 2013.

Our services are delivered through four clinical divisions – Medicine, Surgery, Women and Children and Core Services – and two enabling ones: Corporate, and Facilities & Estates.

As an NHS Foundation Trust, we also benefit from a membership of more than 14,000 staff, patients and members of our community, who are able to help guide our future plans and priorities through a range of channels including our Council of Governors.

As well as representing the views of local people, our governors act as a “critical friend” to the Trust, holding the organisation to account and monitoring performance.

Our year in numbers

- 10,110 Substantive staff members
- 211 Volunteers
- 508,283 Outpatient appointments
- 104,699 Virtual/telephone appointments
- 66,662 Inpatients treated
- 130,838 A&E attendances
- 14,131 Children’s A&E attendances
- 4,470 Babies delivered

Further information in respect of the Trust’s operational and financial performance can be found at Section 1.4

COVID-19

2020/21 was a year like no other. The latter part of the 2019-20 financial year was spent preparing for the pandemic which required our hospitals to rapidly reconfigure its provision in order to respond to the crisis.

Our preparation for Covid-19 started in January before the first positive case was announced on the 31 January 2020.

In response to growing community cases and increasing numbers of hospitalised patients, WSHFT rapidly:

- stopped all non-emergency elective surgery
- followed national guidance to discharge patients when ready
- increased virtual appointments to keep people at home
- increased critical care capacity after advice to “double and then double again”
- secure 24/7 mental health provision to keep people out of A&E

- divided our hospitals into “red” and “green” areas to treat Covid and non-Covid patients separately
- redeployed staff from halted services to support where needed and created the workforce hub to find and fill gaps.

Elective surgeries were paused on 20 March 2020 as staff redeployed to Covid areas and made room for the surge in Covid patients.

Electives were resumed over the summer period but paused again from 12 January 2021 to prepare for the second wave.

Overall, 39,111 elective and non-urgent operations were carried out over the course of the year compared to 64,805 completed in 2019-20. Despite a much higher surge in Covid patients during the second wave, our teams maintained more elective care during this period.

During December and January 2021 the number of patients we were treating with Covid-19 sharply increased to more than three times that of the wave 1 peak. The wave 1 peak was on the 13 April with 81 Covid patients in our hospitals. The wave 2 peak was on 19 January with 268 Covid patients.

COVID in numbers 2020- 21

- 2,077 Covid patients treated
- 193 Covid patients cared for in intensive and critical care units
- 1,619 Covid patients discharged/recovered (78%)
- 452 Covid patients sadly died (22%)
- 39,111 elective operations performed in 2020-21 despite high Covid numbers
- 104,699 virtual appointments held

Vaccination

The WSHFT vaccination programme commenced at Worthing Hospital on 22 December. Learning from colleagues at the Royal Sussex County Hospital, which was in the first 50 hospital hubs to go live for vaccinations, the team hit the ground running, administering several hundred doses of the Pfizer vaccine from day one.

As with the pandemic response, the set-up of the hospital hub brought together colleagues from many different departments.

Our teams created new clinical spaces, set up new IT systems, established new booking processes and developed new patient pathways. The team

worked at speed to provide a safe, sustainable vaccination service, the model for which was adopted by partner organisations across the region.

Two weeks later, the hub at St Richard's Hospital opened to provide the same service for local health and care workers.

Since we first opened the vaccination hub, we have administered 43,798* doses to healthcare workers and patients across Sussex from vaccination hubs in Worthing and St Richard's.

- First doses administered 26,793*
- Second doses administered 17,005*
- Total vaccinations administered 43,798*

*Figures correct up to 31 March 2021.

Merger – the creation of University Hospitals Sussex NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust (WSHFT) and Brighton and Sussex University Hospitals NHS Trust (BSUH) have been working together for four years under a joint management contract that expired on 31 March 2021.

During this time, BSUH became the fastest improving acute hospital Trust in England, emerging from special measures and earning a Care Quality Commission rating of *Good* overall and *Outstanding* for caring. WSHFT meanwhile maintained its own *Outstanding* status and also became the first non-specialist acute Trust to achieve *Outstanding* ratings in all key inspection areas.

As the end of the joint management contract approached and having worked increasingly closely together to respond to the global Covid-19 pandemic, the Trust board explored options for an ongoing relationship. We looked at developing a group structure, in which the two Trusts would operate independently alongside each other while remaining under a single leadership.

However, as a result of regulatory and financial changes within the NHS and the recent successful joint-working between the Trusts, it became clear the best interests of patients and staff would be better served by pursuing a full merger.

We developed a strategic outline case, which was approved by NHSEI in September 2020. Six months of intense planning ensued as we followed a rigorous process to assess the case for change to enable us to complete the formal merger on 1 April 2021 as the joint management contract expired.

Benefits

The case for the merger was strong. We identified a broad range of benefits that would advantage patients, staff and communities across Sussex, including:

- Building on our Outstanding reputation and delivering excellent care to the communities in Sussex
- Strengthening leadership, governance and structures, enabling us to move forward quickly and keep improving care for patients
- Creating greater 'economies of scale' as a larger and more influential NHS Trust
- Increase our potential to use the same processes and equipment to support the smoother running of services
- Creating more career opportunities across our hospitals for our people
- Continuing our closer collaboration and sharing of resources as we restore services and manage our ongoing response to the Covid pandemic
- Improving continuity of care and better access to services
- Increasing support for services under pressure due to national challenges, such as increasing demand, workforce availability and financial pressures.

The new Trust would employ nearly 20,000 people across five main hospital sites in Sussex, with an operating budget of more than £1 billion. It would run seven hospitals in Chichester, Worthing, Shoreham, Haywards Health and Brighton and Hove, as well as numerous community and satellite services.

It would be responsible for all district general acute services for patients across Brighton and Hove, West Sussex, Mid Sussex and parts of East Sussex. It would also provide specialised and tertiary services across Sussex and parts of the South East, including neuroscience, arterial vascular surgery, neonatology, specialised paediatric, cardiac, cancer, renal, infectious diseases and HIV medicine services.

The driving force behind our plans was our ambition to continually improve the care we provide.

Our clinical boundaries

Against a backdrop of our pandemic response, we undertook to develop the full business case for merger while protecting frontline staff and services. We committed to not making any immediate changes to our clinical services as a result of the merger. We also published a set of clinical boundaries that would guarantee security of services including continuing to invest in:

- Access to emergency medical care and A&E services 24 hours a day, seven days a week on the Princess Royal, Royal Sussex County, St Richards and Worthing Hospital sites
- Maternity services at the Princess Royal, Royal Sussex County, St Richard's and Worthing Hospital sites
- A teaching hospital in conjunction with Brighton and Sussex medical school
- Outpatient, day case and rapid diagnostic services across the Trust including on our non-acute sites
- Tertiary service provision as part of a network of tertiary care providers across the regional and nationally
- Trauma services as part of a Trauma Network that includes a Major Trauma Centre on the Royal Sussex County Hospital site along with all the supporting services this requires
- A wide range of cancer services across Sussex, including the Sussex Cancer Centre on the Royal Sussex County Hospital site
- A specialist centre for paediatric care, combined with a neonatal intensive care service and paediatric cancer services from the Royal Alexandra Children's Hospital
- Hyper Acute Stroke Units and other stroke services as part of a Sussex-wide stroke provision
- Specialist renal care, including dialysis and other services for East and West Sussex
- The system-wide benefits of the 3Ts development in line with Sussex Integrated Care System Long Term Plan.

Engagement and feedback

With NHSEI's approval of our outline business case, we sought to gather the views of staff, patients, public and partners, launching an online survey in October 2020. The survey asked for thoughts on the vision and values of the proposed Trust as well as hopes and fears and opinions on a selection of name options. The survey attracted responses from more than 3,000 employees across WSHFT and BSUH as well as more than 700 responses from patients, partners and public.

The responses were highly consistent and led to the identification of six new Trust values: compassion, communication, teamwork, respect, professionalism and inclusion.

The survey feedback also helped us define a series of vision statements in line with our five strategic themes:

- Sustainability - Living within our means providing high quality services through optimising the use of our resources.
- People - To be the employer of choice and have the most highly engaged staff within the NHS.
- Patient - Providing outstanding, compassionate care for our patients and their families, every time.
- Quality - Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have.
- Systems and partnerships - Delivering timely, appropriate access to acute care as part of a wider integrated care system.

There was also a great deal of consistency amongst the responses to the concerns and benefits questions, with staff identifying key benefits as: improved continuity of care, better career development opportunities and strong, consistent leadership. They raised concerns around job security, terms and conditions and the size of the Trust.

Similarly, the public hoped the merger would lead to better care, better access and reduced travel, but were concerned about the bigger geography, reduction in services and the implications for staffing.

Finally, the survey asked respondents to select their preferred option for the name of the new Trust. Due to the importance of our partnership relationships and based on survey and other feedback, the Trusts agreed that the new, merged Trust would be called University Hospitals Sussex.

Developing our full business case and clinical strategy

Following the survey, our dedicated merger team worked to develop our full business case, while we continued to work with teams to launch our clinical strategy development programme.

Our new five year clinical strategy will identify where we can make the best improvements for our patients and develop new services that ensure fewer people in Sussex have to travel elsewhere for high quality hospital care. We will work closely with the rest of the Sussex Health and Care Partnership to realise the strategy.

This clinical strategy work also cements our commitment to continuing to invest in all the services we currently provide, including emergency, specialist, tertiary and trauma care. We are committed to developing our vibrant local hospitals and maintaining the services we know local people treasure, such as A&E and maternity care. By coming together as one Trust, we will have the experience, expertise, funds and influence to safeguard and improve hospitals services in Sussex.

Approval

On 9 March 2021, NHSEI issued its risk rating for the merger, with an overall rating of Amber/ Green and describing the strategic reasons for the merger as both 'clear' and 'strongly supported'.

On 18 March 2021, the Trust boards of both WSHFT and BSUH and the WSHFT Council of Governors (CoG) met to review the business case and vote on the proposal to submit the official application to merge. Both the boards and the CoG approved the proposal to apply to merge and the application was submitted to NHSEI on 19 March 2021.

On 22 March 2021, we received a letter from the Secretary of State for Health and Social Care providing support for the proposal to merge.

On 24 March 2021 we received approval from NHSEI to proceed with the merger.

On 1 April 2021 our new Trust, University Hospitals Sussex NHS Foundation Trust, was formed.

The headquarters of the Foundation Trust are:

Chief Executive's Office
Worthing Hospital
Lyndhurst Road
Worthing
West Sussex BN11 2DH

1.4 Performance Analysis

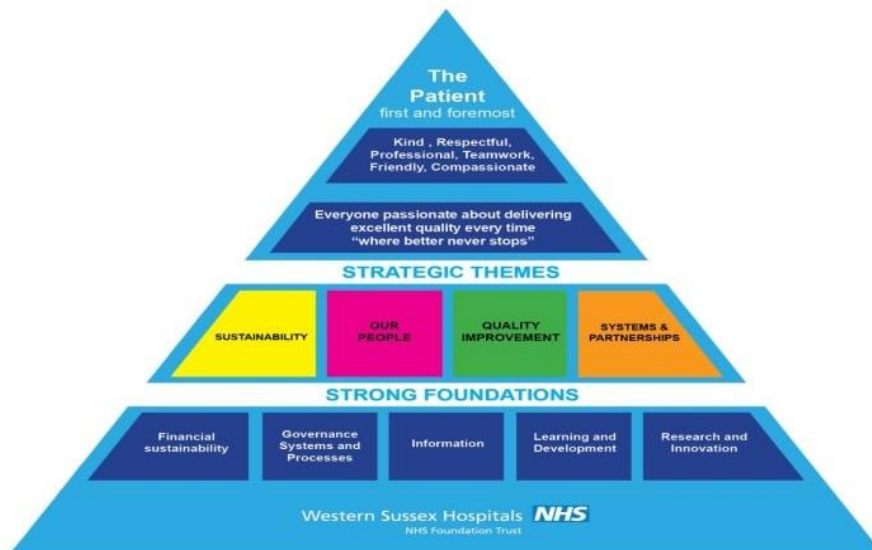
1.4.1 Patient First

The Trust Board recognises that much of the strength of our hospitals lies in the skill, enthusiasm and innovation of our staff and has actively sought to build an organisational culture that empowers these teams and individuals to make lasting changes that benefit our patients and the community.

To do this we have developed Patient First – our leading, long-term approach to transforming the way we deliver services for the better.

Patient First is a programme based on standardisation, system redesign and ongoing development of care pathways, built on a philosophy of incremental and continuous improvement led by frontline staff empowered to initiate and lead positive change.

We describe the structure and focus of Patient First visually in the form of a triangle.



The patient, first and foremost, is at the apex of the triangle, to make explicit the commitment that everything we do, no matter how large or small, should always contribute to improving outcomes and experiences for the people we care for in our hospitals.

This is the ‘True North’ of our organisation – the one constant towards which we must always set our direction of travel in order to achieve our vision.

The middle tier of the triangle identifies our four strategic themes on which we need to focus to create the organisation our patients want us to become:

- Sustainability
- People
- Quality improvement
- Systems and partnerships

How it is delivered

Patient First is supported by five pillars what will support the strategic themes and help us achieve the targets we have set under each:

- Strategy deployment
- Kaizen Office
- Capability building
- Patient First Improvement System (PFIS)
- Improvement Initiatives

The Patient First Improvement Programme uses the methodologies of the Lean and Six Sigma improvement framework, which has been proven throughout the world as a highly successful system for enabling sustained progress towards strategic goals.

This approach has enabled us to identify a True North metric and associated objectives for each of the strategic themes – essentially a point of focus and measurement that will make the strongest direct contribution to moving us forward towards our Patient First goal:

True North Domain	Metric	Objective	Executive Lead
Patient	Friends and Family Test	Family & Friends Recommend Rate >96%	Maggie Davies (Chief Nursing Officer)
Sustainability	Budget Management	Breakeven	Karen Geoghegan (Chief Financial Officer)
People	Staff engagement score	Top Acute Trust in the country	Denise Farmer (Chief Workforce Officer)
Quality	Avoiding harm	99% harm-free care on Patient Safety Thermometer	Maggie Davies (Chief Nursing Officer)
Quality	Preventable mortality	HSMR among best 20% in the country	George Findlay (Chief Medical Officer)

Systems & Partnerships	Patient flow	A&E waits under four hours for 95% of attenders	Pete Landstrom (Chief Delivery Officer)
Systems & Partnerships	Patient flow	Referral-to-treatment time less than 18 weeks for 92% of patients	Pete Landstrom (Chief Delivery Officer)

The culture of change needed to achieve service transformation on this scale requires a significant degree of support, which is what the triangle's five underlying pillars have been created to provide – all working collectively but each with a specific focus of its own.

Strategy deployment identifies and reviews the True North objectives for each strategic theme and is responsible for cascading these throughout the Trust to enable all improvement initiatives to support these common goals.

The Kaizen Office is the Trust's centre of excellence for the Lean techniques underpinning Patient First, home to a dedicated team tasked with enabling a consistent and sustainable Trust-wide approach to improvement over the long term.

Capability building is about equipping our staff with the skills to deliver continuous improvement, with training available for every staff member, beginning at induction and going all the way through to Lean practitioner level.

The Patient First Improvement System (PFIS) is a Trust-wide Lean Management system which will empower front-line staff at all levels to make changes aligned to the True North goals and give back 'time to care' by removing wasteful activities and improving processes.

Improvement initiatives are specific, larger projects aligned to True North metrics and breakthrough goals, managed by Lean-trained staff and supported by the Kaizen Office.

Patient First in 2020/21

Patient First continues to be recognised across the Trust as giving clinical teams fast-track methods of problem solving, creating better leadership, raising standards and helping staff release more time to care for patients.

The Kaizen Office also provides support to improvement projects across the Trust that have enabled us to make major advances in the quality and safety

of patient care, for example tackling excess noise at night, which is detailed further in the Quality Improvement section.

Progress against our Patient First True North objectives is described in detail below and within section two of this Annual Report.

Whilst Covid-19 had an impact on our ability to provide PFIS training we are pleased that wards and divisions applied PFIS tools and techniques as they made rapid changes and tested their efficacy ensuring high quality care and safe practices were implemented. 2021/22 will see the relaunch of our PFIS team training.

1.4.2 Trust True North Objectives

The Patient – True North objective: an overall score of over 97% for patient satisfactions when measured through the Friends and Family Test.

Our Friends and Family Test (FFT) patient feedback has consistently ranked the Trust higher than the national average. For 2020/21 we sought to build on our past achievements and enter the top 20% of NHS Trusts for FFT recommendation score. To do this we have set a 'True North' long-term goal to achieve 97% recommendation for FFT feedback, and reduce 'not recommend' rates.

From March 2020, NHS England and Improvement temporarily suspended the submission of FFT data from all settings due to the Covid-19 pandemic.

Whilst there was the suspension of the national Friends and Family Test we continued with our own, more detailed inpatient surveys completed by patients using hand-held tablets shortly before their discharge (Real Time Patient Experience Surveys: RTPS).

The Trust also supports completion of the national inpatient survey commissioned by the CQC every year for hospital admissions where feedback is taken from a representative sample of patients. This is designed to be a one-off snapshot of experience or views that can be compared with other Trusts and is based on a lengthy structured questionnaire.

Other means of monitoring experience included feedback from complaints and PALS enquiries, comments placed on social media and the NHS Choices website, and those submitted to Healthwatch West Sussex.

These processes enabled us to maintain our focus on delivering high quality, safe and effective care.

Our People – True North objective: to be in the top acute Trust in the country for staff engagement.

Improving staff engagement is the strategic objective for the People domain of Patient First and our long-term objective is to achieve a staff engagement score that places the Trust as the top acute trust in the country. In the medium term, we want to increase the number of staff who would recommend the Trust as a place to work.

2020/21 has required different approaches to staff engagement to be adopted. However, the introduction and extensive use of MS Teams across the organisation provided an opportunity to engage with staff more widely. Weekly Executive-led briefings were held throughout the year to update staff on the impact of the pandemic on the hospitals and how this was being managed. This was supplemented with preparations in readiness for the Trust's planned merger with Western Hospitals Foundation NHS Trust from 1 April 2021. The use of technology has enabled staff to engage on important topics and to post questions of importance to them. 'Live' attendance at the weekly briefings now exceeds circa 1,000 participants and provides a platform for staff unable to attend to catch up on the events at a later date.

A series of workshops and surveys with staff in the autumn informed the development of a set of refreshed organisational values for University Hospitals Sussex NHS Foundation Trust and the People Strategy for 2021/22.

Staff engagement, as measured through the annual staff survey, was 7.2 (out of 10) in 2020. In particular staff advocacy about the trust as a place to work improved by 1% to 76% and as a place to receive care and treatment by 2% to 84%. Given the context within which the staff survey was conducted (Sep-Dec 2020), this is very encouraging.

The Trust has a comprehensive plan to further improve scores by identifying key focus areas gathered as part of the annual survey, internal merger survey and focus group workshops and by using a targeted approach to drive correlated low scoring questions at Divisional level.

Quality Improvement – True North objective: to be in the top [best] 20% of trusts for preventable mortality and provide 99% harm free care.

Reducing preventable mortality and improving outcomes

The primary indicator for our 'reducing preventable mortality and improving outcomes' goal is hospital mortality. The Trust uses Dr Foster's HSMR risk-adjusted mortality tool to monitor this.

Our measure for 2020/21 achievement: to remain in the top 20% of NHS organisations for HSMR.

Our HSMR score improved from 107.48 in 2011/12 (ranked 112 of 141 acute trusts; 79th centile) to 94.9 in 2018/19 (ranked 51 of 133 acute trusts; 38th centile). Following a deterioration in 2019/20 (104.7 for the 12 months up to and including December 2019) over 2020/21 our HSMR has improved to 92.4 (for the 12 months up to and including December 2020, ranked 23rd of 124 acute trusts) putting the Trust in the 19th centile nationally and achieving our target for the year.

Avoiding harm

The Trust used the national NHS Patient Safety Thermometer to monitor overall harm-free care until the end of 2019/20 when national data collection stopped. Local data was monitored in 2020/21 for falls, venous thromboembolism and pressure damage; nationally produced NHS Patient Safety Thermometer replacement data will be used for oversight as soon as it is available.

Our measures were

- 2020/21 achievement: 30% reduction in in-hospital falls (from a baseline of 2016/17) – target of 30% achieved.
- 2020/21 achievement: 81% reduction of hospital-acquired category 3 and above pressure damage (from baseline of 2018/19) – target of 30% exceeded.
- 2020/21 achievement: 65% reduction in avoidable hospital-associated VTE (from 2018/19 baseline) (data to November 2020 only) – target of 50% exceeded.

Sustainability – True North objective: to deliver high quality healthcare in a sustainable way.

Our long-term sustainability objective is to live within our budget. The Trust has a proven track record in delivery of a surplus financial performance position. In 2021/21 the Trust has faced multiple risks to meeting our financial targets, the traditional delivery of healthcare has been challenged by Covid-19, requiring the Trust to redesign the way it runs its hospitals and delivers healthcare to the population it serves. The Trust has also operated under 3 different financial frameworks during 2020/21 each one requiring the Trusts' to amend their financial plans, their contracting approach and refine how Covid-19 costs are recorded. The requirement of each financial framework has been the delivery of a break-even position. The Trust delivered a financial year end position of

£5k surplus from a performance perspective, surpassing this target of breakeven. The plan for 2021/22 is to continue to meet the target of breakeven for the year, and support recovery of elective services; as intended by the new interim financial framework.

Systems and Partnerships – True North objective: to have 95% of A&E patients waiting less than four hours to be admitted or discharge and to reduce referral to treatment below 18 weeks for 92% of patients.

Our long-term systems and partnerships objectives are to have 95% of A&E patients waiting less than four hours and to achieve a referral to treatment (RTT) time below 18 weeks for 92% of patients. In the medium term, we are concentrating our improvement efforts on reducing the numbers of patients who visit A&E and wait over four hours and then aren't eventually admitted to hospital, and are committed to ensuring no patients wait more than 52 weeks for elective treatments.

As with all NHS Trusts these aims were materially impacted by the Coronavirus in 20/21.

The Trust reduced its routine elective capacity in accordance with National clinical guidelines, but maintained care for patients with the most urgent clinical needs, and responded to significant numbers of Covid patients. As a result of the reduction in elective capacity the Trust performance for RTT reduced to 56.6% by March 2021.

In A&E the Trust saw, treated, admitted or discharged 91.8% of patients within 4 hours across the year (including Bognor MIU). The Trust has worked collaboratively with partners, continued to develop our estate to support A&E and continued to enhance our internal process improvements which will continue to mature and deliver improvements into 2021/22.

Risk Management

The Trust has an established risk management framework, which has been judged by the Trust's internal auditors as effective. This framework incorporates a Board Assurance Framework (BAF) which is used to record and track the management of the Trust's strategic risks against each of the Trust's true north objectives. Each strategic risk has an executive lead and is overseen by a specific Committee of the Board. Throughout the year regular reporting of these risks has been provided through the Board Committees to the Board and at each Board meeting the Board confirmed the Board Assurance Framework fairly represented the Trust's strategic risks. The Board also confirmed the Trust's risk appetite statements which are used to drive the respective risk's target scores. During the year the BAF records that

the Trust has been managing 13 significant risks, and at the year end the Trust had three highly scored key risks remaining, these related to

- Being unable to deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services;
- Being unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with Covid-19 restrictions; and
- Being unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation and the reputation of the Trust.

For each of these risks there is a detailed series of actions which will continue through 2021/22. The delivery of these actions and the impact on these risks is monitored through the appropriate oversight Committee of the Board.

The Trust took action during the year which saw its BAF financially related risk reduce but the risk relating to the Trust's ability flex its resources did not reduce to the same level reflecting the level of uncertainty over the demands on the Trust to deal with the Covid-19 pandemic and the changing financial framework the NHS is subject too.

The Trust has taken a number of actions to enhance its processes to support the wellbeing of its staff. However, given the relentless pressure the pandemic has placed on the Trust's services and the prolonged period of the national incident the Trust has assessed the long term risk to staff wellbeing as increasing. The Board has established a dedicated People Committee will track the effectiveness of its plans to mitigate this risk alongside receiving direct information from staff feedback / surveys on the efficacy of the wellbeing programmes developed to support the Trust's staff.

During the year in respect of the compliance with regard to the key constitutional targets the Trust took action and has prioritised the treatment of patients according to their clinical needs. Like the majority of NHS providers, the Trust has taken action to support the NHS and the Country with their measures to deal with Covid-19 which has impacted on the Trust's ability to reduce further this risk.

During 2020/21 the Trust has responded positively to the national requirements placed on it with regards to countering Covid-19. The Trust has been supported through the established bronze, silver and gold incident control processes which included a robust capturing of issues and risks and the follow through on actions to mitigate these. These processes were considered by Internal Audit to be robust and effective and have placed the Trust in a strong position to adapt its control environment to respond to the changing nature of the county's and national health service response to Covid-19.

Further detail in respect of the Trust's risk management framework can be found in the Trust's annual governance statement which is at section 2.7 of this report.

1.4.3 Regulatory standards

Western Sussex Hospitals NHS Foundation Trust utilises an extensive Performance Framework to ensure sustained delivery of key measures based on the principles of the Balanced Scorecard. This framework ensures scrutiny, assurance, and where necessary, remedial actions and follow through to compliance recovery. The layering of this framework ensures oversight occurs through

- Directorate review of departmental/ward delivery
- Divisional Management Board review of associated Directorates
- Divisional Strategy Deployment Reviews (SDRs) undertaken by the Trust Executive
- Monthly performance review by Finance and Performance Committee and Trust Board

Each layer of review and action considers both the key targets and outcomes/objectives used to assess operational performance under the Single Oversight Framework, and a wider set of balanced scorecard indicators that have been selected to provide a more complete view of operational risks and interdependencies. The review process is underpinned by an extensive suite of business intelligence tools designed to show outcomes, but also the drivers of potential compliance risks such as changing demand profiles.

This governance framework was adjusted as part of covid prioritisation process as the Trust adopted its Gold command framework to respond to the national Covid-19 pandemic as instructed to do so by NHS England. However, through this period the Trust maintained its scrutiny of performance via its established Gold command, and continued to submit performance reporting in

accordance with National mandated standards. The routine governance framework is being restored 2021/22.

The operational performance of WSHFT is measured against key access targets and outcomes objectives set out in the Single Oversight Framework drawn up by NHS Improvement, the regulator of health care organisations. These are:

- A&E maximum waiting time of 4 hours from arrival to admission/transfer/ discharge
- Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway
- All cancers – maximum 62-day wait for first treatment from:
 - urgent GP referral for suspected cancer
 - NHS cancer screening service referral
- Maximum 6-week wait for diagnostic procedures

Operational Performance Metrics		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	MAR	YTD
OP1	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	97.0%	96.5%	96.7%	95.0%	91.5%	89.9%	91.4%	92.0%	89.9%	82.9%	90.4%	91.0%	91.8%
OP2	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	70.6%	60.6%	49.0%	42.3%	47.5%	54.9%	60.4%	64.6%	64.3%	60.0%	57.6%	56.6%	57.6%
OP3A	All cancers : 62-day wait for first treatment following urgent GP Referral	85%	75.4%	67.9%	75.4%	82.9%	75.5%	65.2%	72.9%	69.0%	61.1%	66.7%	58.3%	66.7%	69.3%
OP4	Maximum 6-week wait for diagnostic procedures	1%	65.7%	68.6%	62.7%	54.6%	54.5%	49.4%	39.4%	34.4%	39.0%	41.0%	45.3%	39.8%	48.9%

Performance summary:

A&E

Nationally it has been a challenging environment throughout 2021/20 with emergency demand affected by Covid-19. Trust performance for the year was 91.8%, below the National target of 95%, but still amongst the best performers Nationally, and an improvement of 2% compared to 2019/20. As the Trust has come out of the respective waves of the pandemic, the Trust has recommenced its programme of work to improve performance through recognised improvement methodologies and clinical pathway improvements throughout the patient emergency pathway

Additionally, the Trust has continued to engage and co-ordinate aligned resilience plans in the wider Local Health Economy, through the Sussex ICS chaired Local A&E Delivery Board, and wider regional acute partners for escalation to target reduced delayed transfers of care, to free up bed capacity and enhance patient flow.

Referral To Treatment (RTT)

The Trust's RTT performance has been variable across the year with a reported performance of 56.6% March-21. The impact of Covid-19 National guidance regarding the suspension of routine elective cases impacted on RTT throughout most of the year, with restoration and recovery undertaken between waves, and has continued in 2021/22.

Cancer 62-day Performance

The impact of coronavirus in March 2020 and into 2020/21 impacted materially on cancer performance. Cancer 62 day performance was 69.3% compared to 80.9% the preceding year. The Trust experienced an increase in 62 day waits as a result of the initial wave of covid to September-20, but has plans to restore to pre-covid levels in the first 6 months of 2021/22

A focus on improving the waiting times for diagnostics, in a safe environment will also contribute to the improvement in this standard.

Diagnostic 6-week waiters

In line with all Trusts, the Trust's performance fell to an average of 48.9% 2020/21 against the 1% national target. The Trust observed significant capacity pressures in imaging modalities and endoscopy due to the reductions and impacts of the covid-19 response. This has improved to 39.8% in March-21 with recovery plans in place for endoscopy and imaging the largest areas within the diagnostic modalities.

1.4.4 Financial Performance

The key highlights for the Trust's financial performance during the period from 1 April 2020 to 31 March 2021 were:

- Against an extremely challenging operating environment the Trust delivered a retained surplus of £5k. The Trust delivered a financial risk rating of 1 at year end, this being the top possible rating.
- Cost improvement programme savings of £5m (1% of turnover)
- Expenditure on capital schemes of £35m, including medical equipment, increasing ward capacity and patient flow, estates backlog maintenance and the centralisation of the patient meal service. The capital programme was supported by the Trust's dedicated hospital Charity, Love Your Hospital, and the League of Friends.

The Trust saved £5m by streamlining processes, improving productivity, smarter procurement and reducing waste.

As commented elsewhere in the annual report the impact of Covid-19 affected the Trust's activity and saw an increase in costs as the Trust adapted to the changing needs placed on our Hospitals. Rigorous cost control was maintained and the Trust was fully reimbursed for these extra costs.

As at the end of March 2021, the Trust is reporting a surplus of £5k after adjustment for impairments and donated assets as summarised in the table below.

Financial Performance for 2020/21	£m
Net Surplus/(Deficit)	(£9.083)
Add back:	
Impact of Donated Assets	£0.312
Impairment of Fixed Assets	£9.116
Impact of Centrally Procured Inventories	(£0.340)
Retained Surplus/(Deficit)	£0.005

The impairments of £9.116m relate to net changes in the asset value following the annual revaluation.

Long-term liabilities

The affordability of long-term loans is considered by the Trust Board prior to approval. Further information on the Trust's long-term borrowings is available within Note 30.1 to the accounts.

Financial outlook

On 1 April 2021, Western Sussex Hospitals NHS Foundation Trust acquired the assets, liabilities and operations of Brighton and Sussex University Hospitals NHS Trust, forming University Hospitals Sussex NHS Foundation Trust through merger by acquisition under section 56A of the NHS Act 2006.

The new Trust, University Hospitals Sussex NHS Foundation Trust, has developed and submitted a revised financial plan for 2021/22 reflecting these new arrangements and a target position of break-even. Prior to 25th March 2021, both Trusts' had prepared a preliminary financial plan for 2021/22 to deliver a break-even position. It should be noted that in the Full Business Case for the merger, the forecast for 2021/22 was a break-even position and maintaining a Use of Resource Rating of 1.

Summary

From a financial perspective 2020/21 was a positive year with the Trust achieving its True North objective of 'delivering high quality healthcare in a sustainable way' by delivering a surplus position for the year. This performance was achieved whilst also responding to the fast changing challenge of the Covid-19 pandemic, which saw operational priorities reviewed and adjusted throughout the year in response to the changing healthcare needs of the population that the Trust serves.

Going concern

International Accounting Standards (IAS1) require the Trust Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern.

In carrying out its assessment, the directors have taken account of the requirements in the NHS Foundation Trust Annual Reporting Manual. In particular, that the accounts should be prepared on a going concern basis unless the Trust Board either intend to apply to the Secretary of State for the dissolution of the trust without the transfer of the services to another entity, or have no realistic alternative but to do so. The directors have also taken into account revised guidance from The Public Audit Forum to auditors, and subsequent guidance published by NHS England and NHS Improvement on 1st April 2021 which states that for NHS bodies the assessment of going concern "should solely be based on the anticipated future provision of services in the public sector."

There has been no application to the Secretary of State for the dissolution of the trust. Moreover on 19th March 2021, the Trust Boards of Western Sussex Hospitals and Brighton and Sussex Hospitals made a joint application to NHS Improvement for their merger by way of the acquisition of Brighton and Sussex University Hospitals NHS Trust by Western Sussex Hospitals NHS Foundation Trust under section 56A of the NHS Act 2006. The Grant of Application for the Acquisition took effect on 1 April 2021. On this date, Western Sussex Hospitals NHS Foundation Trust acquired the assets and business of Brighton and Sussex University Hospitals NHS Trust. The newly merged trust is known, from 1st April 2021, as University Sussex Hospitals NHS Foundation Trust.

In preparation for the merger, the trust undertook long-term financial modelling covering the five-year period April 2021 to March 2026. This financial modelling demonstrated that there is no adverse impact on either organisation from merging and that University Hospitals Sussex is able to deliver a

sustainable financial position and maintain a positive cash position from the point of merger. The modelling also considered a range of sensitivities and demonstrates that University Hospitals Sussex is able to respond to emerging financial and operational pressures and can continue to maintain a positive cash position.

or 2021/22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding available to support Elective Recovery / Mental Health Services / transformation of Community Services post Covid-19. Additional funding has also been received for the continuing costs of Covid-19.

For the second half of the year the Trust has assumed that income will continue at a value equal to the income blocks, which were integral to the financial frameworks in place in 2020/21 and underpin the financial framework which has been rolled forward in April 2021 to September 2021. Assumptions have been made regarding increased activity trajectories to support restoration and recovery, taking into account resource availability and close working with System partners. Additional funding is available from the Elective Recovery Fund and the Trust has been prudent in assuming a cost neutral basis for activity delivery, with no contribution from this activity being included to deliver the full year plan.

The Trust has produced its financial plans based on these assumptions which have been approved by the Trust Board. The Trust, in conjunction with the Sussex ICS, has submitted a breakeven plan, both individually and collectively for the first half of the year. The assumptions include an operational efficiency target of £6m for the first half of the year, which forms part of the Trust's annual efficiency plan of £24.4m for the full year, c. 2% of the Trust's cost base. This compares to efficiency targets of c.4% delivered by both legacy Trusts in years pre-Covid. In 2020/21, the Trust delivered efficiency savings of 1.1%. The Trust is therefore reasonably assured of the achievability of this financial target.

The Trust has prepared its financial plans and cash flow forecasts for the coming year on the assumption that funding will be received from the Department of Health and Social Care consistent with the revised funding arrangements in response to the Covid-19 pandemic. Discussions to date indicate that this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due and will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health and Social Care. Interim support is part of the framework and can be accessed if it were required, but there is currently no such identified requirement

Taking into account the financial forecast for University Hospitals Sussex NHS Foundation Trust, the directors have a reasonable expectation that the trust will have access to adequate resources to continue in operational existence for at least 12 months from the date of approval of the accounts. For this reason they continue to adopt the going concern basis in preparing the accounts.

Governance ratings

The Trust is assessed under the Use of Resource Rating, which is driven by assessments on liquidity, capital service cover, income and expenditure margin, variance to plan and agency expenditure. The highest rating that can be achieved is a score of 1. A score of 2 indicates no significant financial concerns and a score of 3 requires an increased level of monitoring. The Trust scored a 1 in all four quarters of 2020/21.

There were no formal interventions by the regulator during the year 2020/21.

Other financial information

Accounting policies for pensions and other retirement benefits are set out in Note 1.3 Employee Benefits.

Details of senior employees' remuneration can be found within the Remuneration Report.

Post balance sheet events. On 1 April 2021, Western Sussex Hospitals NHS Foundation Trust acquired the assets, liabilities and operations of Brighton and Sussex University Hospitals NHS Trust, forming University Hospitals Sussex NHS Foundation Trust through merger by acquisition under section 56A of the NHS Act 2006.

The Trust spent £1.24m on external consultancy services in 2020/21.

Note 37 to the accounts sets out, in relation to the financial instruments, an indication of the financial risk management objectives and policies of the Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, where material for the assessment of the assets, liabilities, financial position and results of the Trust.

Income disclosure

The income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes. Income from goods and services not for the purposes of the health service in England is required to at a

minimum cover the full cost of delivery of the goods and services. Any surplus from these activities is reinvested and supports the provision of goods and services for the purposes of the health service in England.

1.4.5 Efficiency programme delivery

Quality-led improvement remained a key priority for Western Sussex, supporting the NHS Long Term Plan to develop workforce, technology and innovation-led efficiencies. Improvements to patient experience – including safety and effectiveness – means we can deliver consistent high-quality care in more cost-effective ways; improving the flow of patients through our hospitals.

The impact of Covid-19 from early 2020 onwards limited the Trust's capacity to develop and deliver new efficiency schemes, which meant that the overall size and scope of the programme in 2020/21 was smaller than in previous years. However, WSHFT alongside BSUH were part of the few Trusts nationally that were able to deliver Efficiency Programmes in such challenging circumstances, and delivered the 1.1% cost saving against budget that was set prior to the pandemic response. Overall, £5m savings were delivered against the opening plan of £4.8m

All schemes were subject to rigorous quality and safety checks to ensure quality standards were maintained or improved, and that they did not negatively affect the Trust's response to Covid-19 or its capacity to recover and restore non-Covid services. Quality impact assessments for each scheme are developed by staff working in the relevant areas, and signed off at executive level before implementation.

The Procurement team worked with Divisions to deliver non-pay savings of £1.2m through cost avoidance. In addition, the Medicine Division delivered significant pay saving contributions of £1.3m through recruitment resulting in medical agency being exited within A&E SRH, A&E Worthing, Respiratory and Rheumatology areas. The introduction of Microsoft Teams during the financial year provided an additional £156k non-pay mileage saving, and work is taking place to embed and extend this benefit into the 2021/22 financial year.

The Trust's response to the covid surges has also enabled significant changes in how patients have been cared for, encouraging the adoption of new ways of working and patient pathway improvements. Whilst initiated through pandemic conditions, a number of these changes will be evaluated

and embedded into clinical and operational practice moving forward, sustaining the positive impact on our patients where possible.

Whilst operational teams remained focussed on managing the covid response in early 2021, efficiency planning for the coming year took place where possible to minimise impact to front-line staff. Building on the small number of tactical schemes that will deliver from April 2021 onwards, a focus on restoration and recovery forms a significant part of the 2021/22 programme.

A key opportunity for 2021/22 will also be the realisation of benefits following the merger of BSUH and WSHFT, where the increased scale of University Hospitals Sussex will enable us to go further and faster on improvements to the quality of patient care whilst at the same time enabling productivity and efficiency benefits.

1.4.6 Our Capital Plan

Development of the Trusts capital plan followed an extensive prioritisation process and Board approval in March 2020. During the year the Trust successfully delivered 187 separate investments totalling £35,812k. These covered a wide range of investments linked to clinical divisional priorities (including service developments), medical devices, backlog maintenance in the estate and IM&T infrastructure and systems. This represents a significant programme of work, funded from:

- £15,189k of internally generated capital resources (net of loan repayments);
- £7,597k cash from historic reserves;
- £7,472k Public Dividend Capital (PDC), ring-fenced for specific investments;
- £2,481k PDC for medical equipment required for the Covid-19 pandemic;
- £2,337k of PDC to support IM&T developments, including digital Histopathology and patient facing systems;
- £375k transfer from Sussex Partnership Trust; and
- £361k of charitable funding.

Highlights include investments in:

- A new 20-bed respiratory ward, Worthing hospital (£3,545k);
- A new Urology Investigation Unit, Worthing hospital (£2,150k);
- A new multi-faith centre, Worthing hospital (£686k);
- A joint investment with Sussex Partnership Trust in a dedicated mental health assessment and treatment facility, Worthing hospital (£375k);

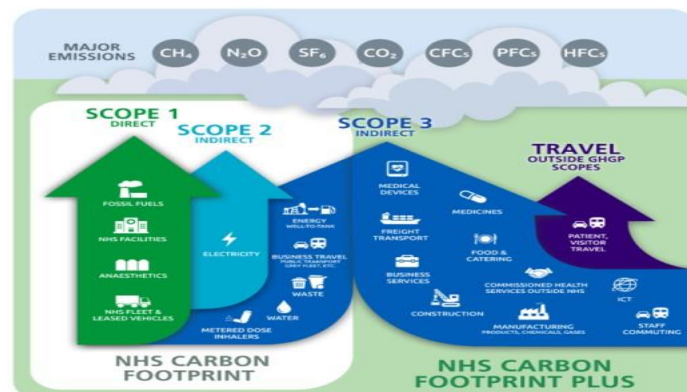
- Further investment in ‘Changing Places Toilet’ facilities, Worthing hospital (£190k);
- Investments in our Emergency Departments, Worthing and St Richards hospitals (£3,700k);
- Investments in diagnostics (£1,630k);
- A new MRI scanner, St Richards hospital (£1,700k);
- Continued investment in productive ward storage systems that is benefiting wards and departments across the Trust (£117k);
- Replacement of more than 104 items of aging and new medical equipment (£5,271k);
- Investment in our estates backlog maintenance (£4,235k); and
- Supporting the modernisation of the Trusts IM&T infrastructure, hardware and software systems including, a significant investment in cyber security and a many clinical systems that will improve efficiency and how we do things (£8,849k).

1.4.7 Environmental Sustainability

Environmental sustainability, our Green Plan and Net Zero has been highlighted as a key priority for the Trust. Looking ahead to 2021/22 we will be tracking progress against our Environmental Strategy as a corporate strategic initiative. During 2020/2021 we have continued to work in partnership with colleagues from neighbouring Trusts and placed significant effort formalising our structures within our Environmental Strategy Steering Group (ESSG).

The Trust recognises and is signed up to the NHS campaign ‘For a greener NHS’ and its two key targets;

1. The NHS Carbon Footprint (the carbon emissions the NHS has direct control over) aims to be Net Zero by 2040. To achieve this an ambitious 80% reduction of carbon emissions by 2028 to 2032 has been defined.
2. The NHS Carbon Footprint Plus (the carbon emissions the NHS can influence) aims to be Net Zero by 2045. With an 80% reduction target of the carbon emissions by 2036 to 2039.



The ESSG will oversee the direction and delivery of the Environmental Strategy against these two targets. Membership is broad from across all divisions and the action work-streams have been shaped around the NHS Carbon Footprint Plus. Work-streams set clear actionable objectives which ensure continual improvement, effective ongoing management and adaptation in developing a culture with green sustainability at the core and the commitment to meet net zero carbon emissions.

Our aim to increase carbon awareness and literacy amongst our staff, empowering and equipping them with the knowledge and tools to implement effective change to achieve net zero within their work remits.

Our approach to deliver will follow key principles

- Measure
- Avoid
- Re-use
- Alternatives
- Communicate

During 2020/21 The Green Group continued to develop and implement the Trust's environmental strategy, adapting to the challenges that Covid-19 placed on operational demands and resources. Some highlights include;

1. Utilities usage reductions:
 - a. 3% reduction in utility usage across during 2020/2021
 - b. The borehole provided SRH Laundry with over 4,500m³ of water.
 - c. New windows have been installed across 3 sites improving the thermal efficiency of the building, improving the aesthetic and making the area more comfortable for its occupants.
 - d. We have continued to rollout LED lighting across the estate
2. Green Travel Plan
 - a. Conducted a staff wide survey on commuting habits in order to review the car parking permit strategy.
 - b. Continued to promote the usage of offsite parking and minibus service to staff. Reviewing offsite permit flexibility allowing more options for staff holding an out of hours permit.
 - c. Introduced a new timetable and app giving minibus users live access to vehicle locations and expected arrival times.
 - d. Commissioned the production of an Umbrella Travel Plan by an external consultant to undertake a parking review for WSHFT and BSUH.

3. Waste
 - a. Successfully managed and adapted to meet the exponential growth of waste management requirements generated through Covid 19 crisis.
 - b. Introduced waste segregation training as part of mandatory training, adapting to an online delivery method.
 - c. Engaged with our contractors to challenge recycling/recovery rates requesting a video of the journey of our waste.
 - d. Developing a strategy for a project to fully evaluate our waste processes including the trial introduction of a chilled compactor for offensive waste streams.
 - e. Utilised the team of Porters to conduct waste audits to assess and improve clinical waste segregation compliance at ward/department level.
 - f. Designed new stickers informing users of how the waste is recycled for bins and produced an education leaflet for staff.

4. Green Plan 2021 and Net Zero
 - a. Aligning our strategy to meet the requirements set out in “Delivering a Net Zero NHS” published in October 2020.
 - b. Engaging with clinical leads for inclusion in strategy and formation of clinical work stream to capture existing good practice and projects and formalise approach going into 2021/22.
 - c. Producing Carbon Footprint process document for full reporting of our NHS Carbon Footprint Plus from 2021.

5. Business Services
 - a. Completed P4CR assessment of 2018/19, 2019/20 purchasing data and utilising to highlight hotspots and present local level trends.
 - b. Included an environmental impact assessment stage as part of the PID process.
 - c. Conducting a review into the uptake of online meeting software and its impact on cross site travel.

6. Trust Green Ambassadors
 - a. Nearly 100 staff have signed up to be Green Ambassadors for the trust,
 - b. The GAs have been submitting project ideas to be delivered in 2021/2022
 - c. The ambassadors challenged the GSG on our electricity tariff and from April 2021 we will purchase 100% REGO certificated electricity.
 - d. Supported the Energy work-stream by completing Demand Surveys of their work environment



- e. Assisted with delivering the Green Group message via the Patient First, People First Newsletter.
- f. Many have established local action groups within their teams.

1.4.8 Statement on equality and equity of access

WSHFT is committed to offering services that are equitable and provide equality of access. As part of this commitment the Trust within its service change and business case process undertakes a review on the equality and equity of access as part of the needs assessment and associated service configuration processes. The Trust as lead for the Sussex Acute Collaborative Network within the Sussex ICS plays an active role with Sussex ICS who, in accordance with Operating Framework 2021/22 are embarking on a programme of work to review equity of access by geographic and demographic profile of the Trust catchment populations, with the aim to build stronger and more collaborative strategies to address health inequalities.

The Trust has built the voice of the patient into each of its transformation programmes to check that any changes improve equality and equity of access. Also the Trust monitors patient and carer feedback as described in the section 1.4.9 below and uses this to assist in monitoring the equality and equity of access to our services and takes steps where feedback highlights deficiencies.

1.4.9 Patient Care

Care Quality Commission standards

Western Sussex Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered without conditions”.

In 2019/20, the Trust was inspected by the Care Quality Commission (CQC) and was rated ‘Outstanding’ for the second time and the Trust became the first non-specialist acute trust in the country to be rated ‘Outstanding’ in all the key inspection areas assessed, as well as the first-ever acute trust to be rated ‘Outstanding’ for the safety of its services.

Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆
Are resources used productively?	Outstanding ☆



Inspected and rated
Outstanding ☆
Care Quality Commission


Western Sussex Hospitals
 NHS Foundation Trust

The CQC Chief Inspector of Hospitals, Professor Ted Baker, endorsed our Patient First approach to improvement as being a key differentiator that secured the outstanding ratings in each assessed domain. Prof Baker commended the positive attitude of staff and their innovative solutions to continually enhance the care they provide and to improve the patient's experience of the Trust's services. The CQC was also impressed by our willingness to identify our weaknesses and empower frontline staff to make the changes that will enable us to overcome them.

The Care Quality Commission has not taken enforcement action against Western Sussex Hospitals NHS Foundation Trust during 2020/21.

Western Sussex Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Due to the limitations of the pandemic regular monthly meetings have continued with CQC but predominantly virtually. These meetings have provided a valuable arena for providing quality assurance during both the first and second waves of Covid-19 to the CQC. In addition, led by the division of medicine, a detailed CQC engagement visit assessing the key lines of enquiry in relation to emergency medicine was held in October 2020. A further engagement visit in relation to outpatients and ophthalmology is planned for May 2021.

We also continue to monitor performance against CQC standards through monthly internal reporting across a wide range of important measures. Patient experience concerns and complaints are monitored by the Trust's PALS and patient experience teams, and patient safety incident data is recorded, monitored and actioned by the electronic incident and reporting systems. Thematic reviews are completed following the reporting and investigation of any serious incident.

The Trust's Triangulation Committee identifies any new and or emerging patient safety or staff concerns within the organisation. The aim of the group focuses on the triangulation of complaints, incidents, safeguarding reviews, inquests and litigation and the themes correlated from the Trust's Freedom to Speak Up Guardians, with the primary objective of the group being to evidence shared learning within the organisation. At each committee a number of 'deep dive' presentations are discussed, focusing on case reviews where significant learning has been identified for the organisation. The ensuing action log details how the learning will be cascaded and shared within the divisions and to further close the learning loop, at the end of each quarter, the divisions demonstrate how this shared learning had been achieved.

How we learn

We have robust systems in place for reviewing incidents, complaints, mortality reviews and inquests within our clinical divisions. Each clinical division has a clinical governance lead to coordinate this activity and help the Divisions to track and complete the actions arising out of each of these areas. The divisions also use safety huddles, the “Theme of The Week”, Patient Story newsletters and staff meetings to help communicate changes made in response to learning.

When harm occurs, talking to the person affected or their family/carer provides crucial context to any investigation. We continue to develop and encourage an open and honest approach to supporting patients who have been harmed, or their families, as candour and transparency are core values for Western Sussex Hospitals NHS Foundation Trust. In 2020/21 the Trust remains 100% compliant in the Health & Social Care Act – Regulation 20 – Duty of Candour.

Learning from incidents

The Trust Patient Safety Team is currently undertaking an improvement project regarding the Datix incident reporting system. The improvement programme has taken two years to plan, and has involved a variety of stakeholder feedback methods and engagement / training days. The revised system will enable the Trust to analyse safety themes and data more effectively, developing safety dashboards enabling robust reporting and a shared learning and solution focused model of care.

Due to the pandemic, our two day Serious Incident (SI) Investigator training programme accredited by the Royal College of Physicians and sponsored by the Kent Surrey and Sussex Quality and Patient Safety Collaborative (KSS AHSN) continued as virtual ‘modular training’ in 2020/21. The programme was facilitated by the head of patient safety and provided training on how to investigate SIs using a Human Factors approach, the Duty of Candour and involving the patient, their family and carers. The programme was extremely well received with a recommendation that all staff investigating serious incidents should attend the training in the future.

With the publication of the NHS Patient Safety Strategy 2019, a further revised training programme is planned for 2021/22 with an annual training programme under development. Trends and themes from incidents, complaints, inquests and deaths (mortality) are also shared at the monthly Trust Triangulation Committee, with the learning translated into the Patient

Safety and Learning Newsletter, for use by the teams in safety and improvement huddles.

Further regional learning events were held in and December 2020 and February 2021. Hosted by the WSHFT Patient Safety Team, all Sussex healthcare providers and commissioners were invited to attend. Focusing on the shared learning from SI investigation, infection prevention and control and the learning from inquest, the events were extremely well attended with positive feedback received. In addition, a family member also attended the learning event in February to give powerful insight into their experience of inquest.

In 2019, following the Care Quality Commission's inspection, the domain of Safe was rated as "Outstanding". WSHFT are the first acute non-specialist hospital to receive this rating. Feedback in the published CQC report particularly focused on the SI training provided, the quality of SI investigations and immediate actions taken, the sharing of the lessons learned and opportunities for improvement, and the involvement of patients, families and carers within the Duty of Candour process. In line with the recommendations detailed in the new NHSE Patient Safety Strategy; WSHFT has now identified a Patient Safety Specialist for the organisation.

Responding to Complaints

Our Patient Advice and Liaison Service (PALS) is usually the first port of call for anyone who has a problem they need the Trust to look into or resolve. PALS responders are able to offer advice on how and where to complain, investigate concerns and help bring resolution if things have gone wrong. Our complaints team investigates more complex concerns that require a formal investigation about past events.

Full details of PALS and complaints activity are included in the Quality Report section of this Annual Report, but some key figures are as follows:

- 3,642 concerns have been dealt with via our PALS service at the time of reporting (22/3/21) and this rate of activity is a reduction of 1,726 cases compared to the previous year
- 360 formal complaints have been received during 2020/21 at the time of reporting (22/3/21). This is a decrease of 175 compared to 2019/20.
- This reduction in number of contacts has largely been due to the visiting restrictions in place and reduced activity as a result of the Covid-19 pandemic.

The number of formal complaints referred to the Parliamentary Health Service Ombudsman (PHSO) for independent review by the complainant (*these may relate to complaints made to the Trust in earlier years even though received in the reporting financial year*) was 7, the same as the previous year. Of these 7, 5 remain under review and 2 were not upheld (at 31 March 2021).

Quality improvement

Our continuing focus on quality improvement was a major factor in the Care Quality Commission's assessment of the Trust as an *Outstanding* healthcare organisation.

Continuous improvement is a key strand of the philosophy behind our Patient First programme and is guided by the Trust's Quality Strategy.

The Quality Strategy sets out the four broad areas in which our improvement efforts can have the strongest positive effect on outcomes and experiences for patients.

Within the period covered by the Quality Strategy, the Trust sets out annual priorities under each of the four key areas of focus.

Below is a summary of the work undertaken in respect of the Trust's key quality priorities for 2020/21 and the work planned for 2021/22. Progress against the 2020/21 objectives is described in more detail in the Quality Report.

Avoiding harm: Falls prevention

Falls are a significant cause of patient harm in our hospitals and in 2020/21 we undertook work to ensure that the success of previous years falls reduction programme was maintained, aiming specifically to see no increase in falls compared to the previous year. We have successfully delivered this goal during this period.

Over 2021/22 we will specifically aim to ensure that current position is maintained with no increase in falls and also will try to reduce our falls causing harm by a further 5% in order to contribute to the overall breakthrough objective for reducing patient harm.

Avoiding harm: Elimination of severe pressure damage

Whilst a high proportion of our patients with pressure ulcers are admitted to hospital with existing skin damage, we had seen a significant rise in hospital acquired pressure damage since 2015/16. We have worked to understand and deliver improvements with ward teams over recent years. During 2020/21,

we worked to deliver an improvement in this area with a goal to reduce category 3 and above by 30%. We successfully delivered this goal with a 79% reduction compared to the 2018/19 baseline.

During 2021/22, we will work to maintain this achievement with a specific goal of 5% reduction in all reported pressure ulcers in order to contribute to the overall breakthrough objective for reducing patient harm.

Avoiding harm: Reduction in hospital-associated venous thromboembolism (VTE)

The development of VTE [which includes deep vein thrombosis (DVT) and pulmonary embolism (PE)] is often an unavoidable consequence of a patient's illness. However, we have seen a significant rise in the reporting of VTE since 2015/16. Whilst the number of cases that have been deemed avoidable had remained static, there was a need to fully understand the nature of our challenge and to ensure we have reliable processes in place in order to eliminate avoidable harm. During 2019/20 the reduction in avoidable VTE was a key breakthrough improvement objective which successfully delivered a reduction in avoidable VTE of 58.8%

During 2020/21 we aimed to maintain the reduction in avoidable hospital-associated VTE cases delivered in 2019/20 and are pleased that we have delivered this goal with a 65% reduction year to date, with the March data being validated at the time of drafting this report. During 2021/22 we aim to build on this success with a further 5% reduction in order to contribute to the overall breakthrough objective for reducing patient harm.

Improving patient experience: Patient experience of discharge

We want all our patients to have a safe and positive experience of being discharged from our hospitals; we know this issue has a substantial impact on our patient experience of care and it is therefore one of the key pillars of our Patient Experience Strategy.

The Trust has now progressed its work further on discharge with an aim to significantly improve the discharge experience for all patients. Our patient feedback survey data shows that patients are dissatisfied with the discharge planning process and how this is communicated to them. Patient discharge has therefore now become a breakthrough objective in 2021/22. Real-time patient experience survey data, complaints and PALS data is being triangulated to analyse themes. Inpatient dissatisfaction was 53% for 2020/21 in the inpatient survey. An improvement programme has been designed and led by the Kaizen team with executive leads and being facilitated by the Patient Experience team, to work collaboratively with

multidisciplinary teams to promote early discharge work and identify driver wards to understand opportunities for improvement. A team of volunteers is also carrying out weekly virtual surveys on discharge with patients who have recently left hospital to understand issues and provide support where required which will also feed into the improvement programme going forward.

Improving patient experience: Reducing noise at night

Sleep is important for healing; sleep deprivation is recognised as a major concern for patients in hospital and has been shown to lead to induced stress, increased pain sensitivity, high blood pressure and poor mental health. The two most recent National Inpatient Surveys carried out in 2017 and 2018 (published in 2018 and 2019 respectively) confirmed that noise at night, particularly from other patients, was a major area requiring improvement. National trends are similar, with the CQC reporting around 40% of patients are affected by noise from other patients at night time, a figure which has been static for some time.

For 2019/20 we set ourselves a goal to improve noise at night satisfaction from 54% to 65% as measured by our inpatient real time patient experience surveys. We narrowly missed this target and therefore continued this programme of work in 2020/21, building on our positive successes and aiming to embed approaches put in place as business as usual. We aimed to deliver and maintain patient satisfaction scores at 65% through 2020/21 however the volume of data was very limited due to the Covid-19 impact on patient experience volunteers not being able to conduct the surveys with patients and they were paused for most of the year. For those surveys carried out, satisfaction in 2020/21 was 57%.

Monitoring of Quality Priority Improvements

The Trust has a robust Quality Governance Structure which was overseen at Board level by the Quality Assurance Committee and at Executive Level through the Quality Board chaired by the Medical Director. The Trust's annual quality improvement objectives are set out in the Quality Report and progress against these key metrics was presented to both the Quality Board, Quality Assurance Committee and Trust Board.

1.4.10 Research as a driver for improving the quality of care and patient experience

Clinical research is considered a core part of NHS services with the huge contribution of clinical research to improving outcomes emphasised as a key feature of the national response to the Covid-19 pandemic. While prior to the pandemic there was already significant evidence that organisations which

support high quality clinical research and innovation improve clinical outcomes for *all* their patients, not just those taking part in specific research trials, NHS clinical research has been at the forefront of learning about the spread of Covid-19 and developing and testing medications, new treatments and vaccines. At Western Sussex, our ambition continues to be delivery of high quality patient care through innovation and continuous quality improvement, education and research. The Trust's 2019 CQC report demonstrated how research, embedded in everyday clinical practice across the organisation, is making a significant contribution to improving quality and experience for our patients and clinical research has been a key part of the Trust's response to the current global pandemic in 2020/21.

The numbers of new participants taking part in clinical research at Western Sussex has continued to grow with 2558 patients and staff members taking part in 2020/21 predominantly in trials for Covid-19. Western was amongst the very first organisations in the country and the first in Kent, Surrey and Sussex to open and enrol participants to the RECOVERY trial, a globally important study testing medicines for those most severely affected by Covid-19. In the early days of the pandemic little was known about how to treat or care for people with Covid-19 and the RECOVERY trial has already been able to recommend two medicines effective in improving outcomes and reducing mortality whilst also demonstrating several medicines that are not of benefit to patients with Covid-19. Clinical, support service and research teams have worked collaboratively across the breadth of the organisation to support participation in 7 nationally prioritised Urgent Public Health Covid-19 trials and alongside also delivered a broad portfolio of other COVID and non-COVID related clinical trials, providing opportunities for patients and staff to participate in important research across a range of clinical services.

The Trust has also had ongoing support from the local patient Research Champions group who continued to meet virtually and have been able to contribute their expertise to the rapid design of several new Covid-19 specific research studies developed within the organisation. These studies are vital to understanding more about the impact of the virus, for example the long term recovery of people severely affected by Covid-19 and its impact on local healthcare provision.

The Trust has continued to support the growth of their innovative clinical academic programme, developed in 2017/18 for nurses, midwives and allied health professionals (NMAHPs) across the Trust. The programme has increased opportunities to bring the latest research evidence into everyday practice to enhance patient care. The Trust has developed a number of new roles, including nurse, midwife, AHP and medical doctoral research

fellowships and is supporting research education through the NIHR Integrated Clinical Academic Fellowship programme and with the support of a number of local Higher Education Institutes. The Trust has also partnered to support research development and clinical academic roles with colleagues at BSUH and St Barnabas Hospices and through the local NIHR Clinical Research Network and NIHR Applied Research Collaborative (ARC) Kent, Surrey and Sussex.

The Trust's award winning Clinical Improvement Scholarship programme, developed in 2017 in collaboration with Health Education England and cited by the CQC as an example of best practice, empowers NMAHPs to use research evidence to challenge and improve patient care. The programme, which is closely linked to Patient First, focuses on leading change and using and developing research evidence to improve the quality of everyday care. The programme has already supported 24 nurses, midwives and allied health professionals in developing their research, leadership and quality improvement experience to directly influence improvements in care alongside their everyday clinical roles. During the Covid-19 pandemic the programme has also been adapted to provide four new clinical research fellow roles to support locally developed Covid-19 research studies.

The Trust is one of only four organisations in Kent, Surrey and Sussex to be hosting a prestigious NIHR 70@70 Senior Nurse and Midwife Research Leader. This post has been appointed for a period of three years to work locally and nationally on engaging and involving more nurses and midwives in healthcare research.

1.4.11 The Best of Western Sussex Hospitals

April 2020

As staff responded to the beginning of the pandemic they were supported and cheered on by members of the community and public sector. Local schools, charities and organisations rallied around to provide care packages, parking, groceries and scrubs for health and care staff in the area.

Love Your Hospital, our dedicated charity, launched *The Hospital Heroes Covid-19 Appeal* at the end of March 2020, which has now raised more than £127,000.

May 2020

Chichester's former deputy mayor received rousing applause from dozens of staff as he left St Richard's following his recovery from Covid-19 and following two months as an inpatient. Trevor Tupper OBE, who spent two weeks in an

induced coma in ITU before being transferred to Ashling ward, said: “Thanks to this amazing team, I will be able to celebrate my 80th birthday in a few months’ time!”

June 2020

Artists paint WSHFT staff for a national Covid-19 project called ‘Portraits for NHS heroes’. The campaign became an Instagram hit after artist Tom Croft painted an A&E nurse in full PPE as his way of giving something back to the health service. As the project grew, the public was encouraged to put people forward for portraiture and the Trust’s head of clinical governance and patient safety enthusiastically embraced the opportunity and began spending her evening nominating her colleagues for pictures. The Western Sussex gallery grew to include more than 50 members of staff.

July 2020

Pilots and cabin crew have come together to give a boost to staff at WSHFT by opening Project Wingman lounges at Worthing Hospital and St Richard’s Hospital. Project Wingman started at the height of the Covid-19 pandemic to enable furloughed, grounded or redundant UK airline personnel a chance to support NHS staff. The airline volunteers are all trained to communicate in stressful situations and their lounges provide a space for NHS staff to unwind and de-compress while at work.

August 2020

An innovative and collaborative way of working, implemented following government guidance, has significantly reduced waiting times for patients being discharged and helped restoration by freeing up beds for patients who need them. This ‘discharge to assess’ model requires team-working across many organisations, including the community and social care teams, to ensure patients leave hospital when it is safe and appropriate to do so, to continue their care and assessments in the right place. The benefits of this new discharge model have been significant in terms of improving both patient flow and safety and WSHFT is keen to continue developing this way of working.

September 2020

A £2.1 million investment was approved to develop a new specialist urology area in Worthing Hospital to improve patient experience, quality and safety. The Urology Investigation Unit (UIU) is the first phase of implementing a new strategy for the delivery of urology services, with a second UIU planned for St Richard’s Hospital, subject to business case, following completion of the

Worthing project. The UIU will bring together a multidisciplinary team of doctors and specialist nurses in a purpose-built facility where they can investigate, diagnose and treat patients.

October 2020

In October 2020, we announced our plans to merge with Brighton and Sussex University Hospitals and invited our staff, members and people living locally to share their thoughts about the new Trust's vision and values, as well its aspirations for the future, by completing a short survey. Nearly 4,000 people shared their views on the new organisation's vision and values, their hopes and concerns, and gave their feedback on a selection of naming options.

A £3 million investment is approved develop a new respiratory ward in 774m² of former administrative space at Worthing Hospital. The new 20-bed specialist ward would provide modern purpose-designed facilities to improve care for patients with respiratory illnesses. Lead respiratory consultant, Dr Katrine Steele, said: "The new ward will improve patient care and enable us to provide specialist treatment in a purpose-built modern environment with better facilities."

November 2020

The Duchess of Cambridge chooses a photo of loving couple Pat and Ron Wood married for 70 years holding hands in Worthing Hospital before their death from COVID for National Portrait Gallery exhibition. The loving couple stayed together and held hands until the end thanks to the compassion and consideration of staff on Beacon ward. The couple's daughter, Nikki, said: "Worthing Hospital was brilliant, wonderful and caring. I would like to thank all the team, doctors, nurses and the ward clerk on Beacon."

December 2020

The Covid-19 vaccination programme launches across the country and colleagues and patients at WSHFT receive their jab at the Trust's two vaccination hubs at Worthing Hospital and St Richard's Hospital. By early January 2021, the vaccine hubs had delivered more than 2,000 first doses and within a month, 85% of WSHFT staff had received their first dose.

January 2021

A £1.79 million investment is approved to replace the 16 year old MRI scanner at St Richard's with a new state-of-the-art model from Siemens called the Magnetom Sola. Superintendent radiographer Bill Hallett said: "The new machine is absolutely brilliant news for patients. We're jumping from a second generation MRI to fourth generation model that provides much better patient

experience. It is virtually silent, more comfortable, less claustrophobic and a lot quicker.”

We also announce a £5.9 million refresh of the laundry and linen department over three years at St Richard’s Hospital. This will replace all the equipment, improve efficiency and provide new capacity for the laundry to serve greater demand and potentially more hospitals or other local businesses.

February 2021

Works begin to improve patient flow and increase capacity in the A&E departments at Worthing and St Richard’s, following a £3.7 million award from Public Dividend Capital funding. Interim chief operating officer Gethin Hughes said: “This significant investment in both our A&E departments will ensure we can provide our patients and staff with an improved environment for their care. It will increase our capacity to care for more patients and it also will improve the experience for our patients with areas purposely designed to support our pathways of care.”

March 2021

The merger of Brighton and Sussex University Hospitals and Western Sussex Hospitals NHS Foundation Trust was given the green light, heralding the dawn of a new future for healthcare in Sussex. The merger will see the best of both Trusts brought together to create a new, larger organisation called University Hospitals Sussex NHS Foundation Trust (UHSussex) which will further improve hospital services for patients in Sussex.

1.4.11 Stakeholder Relations

Collaborative working is key to achieving the ambitions of our *Patient First* programme and its *Systems and Partnerships* strategic theme, which puts a strong focus on the way we work with our external partners as well as on a multidisciplinary basis within the Trust.

Our approach is, and always has been, based on openness, honesty and a genuine desire to listen to and act on feedback to improve our services and our patients’ experience. The Governors’ Patient Experience and Engagement Committee exists to seek the views of Foundation Trust members through the governors, and those of the statutory bodies to inform priority work programmes to improve patient experience and influence the strategic direction of patient and public involvement by ensuring a wide range of stakeholder views are gathered and taken into account.

Our partners in our local health economy include GPs, community healthcare provider, the Coastal West Sussex Clinical Commissioning Group, Sussex Health and Care Partnership, Healthwatch West Sussex, social care providers, charities, the ambulance service and mental health Trust.

1.4.12 Directors' statement

The directors are required under the NHS Health Service Act 2006 to prepare accounts for each financial year.

The directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators, and stakeholders to assess the Trust's performance, business model and strategy.

Each director of the Trust Board, at the time of approval of the Annual Report and Financial Statements, declares that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.


..... 14 June 2021

Dame Marianne Griffiths, Chief Executive

2. Accountability Report

2.1 Directors' Report

Our Board of Directors is responsible for the management and performance of the Trust, and for setting its future strategy.

This section of the Annual Report provides an overview of 2020/21 from an operational and strategic standpoint, outlines the in-year development of the Trust's relationships and partnerships with stakeholders, and details its governance and management arrangements from a Board perspective.

2.1.1 Managing the Trust

How the Trust is run

The Trust's Constitution sets out the way in which the Council of Governors and the Board of Directors will operate and work together including their key areas of responsibilities.

The Trust's Scheme of Delegation sets out the responsibilities of the Trust's Board and key Committees.

In the event of dispute between the Council and the Board then the dispute resolution procedure set out in the Constitution shall be followed in order to resolve the matters concerned. This has again not been required during the period 1 April 2020 to 31 March 2021.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the Trust and consults on its future strategy with its members through the Council of Governors (CoG).

The Board revised its governance arrangements across 2020/21 to ensure they remained appropriate when dealing with the national pandemic. This saw in wave one of the pandemic a refocusing of the Quality Assurance Committee to focus on assurance on the Trust's processes for dealing with covid patients. As the Trust moved from wave one to restoration the Committee revised its focus again to encompass its wider assurance role. During the second wave rather than repurpose the Quality Assurance Committee complementary GOLD executive briefings were provided to the Non Executives supplemented by weekly Chief Executive information exchanges.

As part of the merger with Western Sussex Hospitals NHS Foundation Trust the Boards of both Trust's reviewed their current Board Committee governance arrangements. The review resulted in a revised Committee

structure seeing five Committees being established aligned to the Trusts' five patient first pillars. The Committees retain their oversight of allocated BAF risks but will also have capacity within their respective work programmes to provide enhanced assurance to the Board over the Trust's delivery of their stated True Norths, Breakthrough Objectives, Corporate Projects and Strategic Initiatives.

Our Board of Directors 01 April 2020 to 31 March 2021

NON-EXECUTIVE DIRECTORS

Alan McCarthy, Chairman from 01-10-18 (Term of Office to 30-09-21)

Chair of the Executive Appointments and Remuneration Committee

Mike Rymer Deputy Chair from 01-01-19 (Term of Office to 31-05-2021)

Non-Executive Director

Joanna Crane, Senior Independent Director (Term of Office to 30-06-2022)

Chair of the Quality Assurance Committee

Chair of Charitable Funds Committee

Jon Furmston (Term of Office to 30-06-2022)

Chair of the Audit Committee

Lizzie Peers (Term of Office to 11-05-2023)

Chair of the Finance and Performance Committee

Patrick Boyle (Term of Office to 19-01-2024)

Non-Executive Director

ASSOCIATE NON-EXECUTIVE DIRECTORS (non-voting members of the Board)

Lillian Philip (Term of Office to 29 April 2023)

Kirstin Baker (Term of Office as an associate NED was linked to the management contract to 31 March 2021, Kirstin then became a voting NED of UHSussex from 1 April 2021)

EXECUTIVE DIRECTORS

Marianne Griffiths, Chief Executive

Dr George Findlay, Chief Medical Officer and Deputy Chief Executive

Karen Geoghegan, Chief Financial Officer

Pete Landstrom, Chief Delivery and Strategy Officer

Denise Farmer, Chief Culture and Organisation Development Officer

Maggie Davies, Chief Nurse

Fiona Ashworth, Chief Operating Officer (To 30 September 2020)

Gethin Hughes, Chief Operating Officer (From 01 October 2020)

Board of Directors

The Chair and Non-Executive Director Directors are appointed by the Council of Governors.

The Directors of the Trust for the period of this report are shown in the table below together with their attendance at Board meetings for the same period. All of the Non-Executive Directors are considered to be independent.

The Chair of the Board is also the Chair of the Council of Governors.

Deputy Chair

Good practice suggests that the Trust should have a Deputy Chair to stand in during any period of absence of the Chair. The Trust Constitution makes provision for the appointment of a Deputy Chair and NHS Improvement's guidance states that this should be a Council of Governors appointment, although it would be expected that the Chair would make a recommendation to Governors.

Mike Rymer, Non-Executive Director, is the Deputy Chair.

Senior Independent Director

The Senior Independent Director is a Non-Executive Director appointed by the Board as a whole in consultation with the Council of Governors. The Senior Independent Director has a key role in supporting the Chair in leading the Board and acting as a sounding board and source of advice for the Chair.

Joanna Crane, Non-Executive Director, is the Senior Independent Director.

Operation of the Board

The Board has agreed a scheme of reservation and delegation which sets out those decisions which must be taken by the Board and those which may be delegated to the Executive or to Board sub-committees.

The Board sets the Trust's strategic aims and provides active leadership of the Trust. It is collectively responsible for the exercise of its powers and the performance of the Trust, for ensuring compliance with the Trust's Provider Licence, relevant statutory requirements and contractual obligations, and for ensuring the quality and safety of services. It does this through the approval of key policies and procedures, the annual plan and budget for the year, and schemes for investment or disinvestment above the level of delegation.

The Non-Executive Directors play a key role in taking a broad, strategic view, ensuring constructive challenge is made and supporting and scrutinising the performance of the Executive Directors, whilst helping to develop proposals on strategy.

Board meetings follow a formal agenda which includes an update from the Chief Executive, a structured integrated performance report that reflects the Trust's performance against its True North priorities, and where appropriate information on its breakthrough objectives, strategic initiatives and corporate projects and reports from each Board Committee Chair. Complementing these items are specific reports covering Strategic and Operational items including; patient safety and experience, infection prevention and control, safer staffing information along with wider workforce matters. Through the robust reporting through the Board Committee Chair the Board is updated on a range of clinical governance, financial and non-financial performance, together with performance against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by the Executive. These performance measures include metrics covering infection control targets, patient access to the Trust, waiting times, length of stay, complaints data and the results of the Friends and Family Test. The Board also receives information in respect of compliance with its provider licence.

During the year the Trust held five Public Board Meetings, and 14 Private Board Meetings. There were also 3 Public Council of Governors Meetings and the Annual General Meeting and, in addition, there was a joint review day between the Board and Council of Governors.

In addition, subject specific seminars were held with the Board and Governors, covering topics such as the Trust's clinical strategy, the Management Contract between WSHFT and BSUH and the development of a

sustainable group structure for WSHFT and BSUH and the Trust's sustainability strategy.

Attendance at Public Board meetings 1 April 2020 to 31 March 2021

Name	6 Aug 20	1 Oct 20	3 Dec 20	4 Feb 21	^19 Mar 21
Alan McCarthy (Chair)	✓	✓	✓	✓	✓
Patrick Boyle	✓	✓	✓	✓	✓
Joanna Crane	✓	✓	✓	✓	✓
Jon Furmston	✓	x	✓	✓	✓
Lizzie Peers	✓	✓	✓	✓	✓
Mike Rymer	✓	✓	✓	✓	✓
Kirstin Baker*	x	x	✓	x	x
Lillian Philip*\$	✓	✓	✓	x	x
Marianne Griffiths	✓	✓	✓	✓	✓
George Findlay	x	✓	x	✓	✓
Karen Geoghegan	x	✓	✓	✓	✓
Maggie Davies	✓	✓	✓	✓	✓
Pete Landstrom*	✓	✓	✓	✓	✓
Fiona Ashworth	✓	Fiona left the Trust on 30 September 2020			
Gethin Hughes	Gethin started as Interim COO from 01 October 2020	✓	✓	✓	✓

* non-voting members of the Board

\$ on maternity leave from the end of February

^Extraordinary Public Board Meeting

Due to the national guidance on public gatherings and social distancing the Public Board in June 2020 was cancelled and then subsequent meetings were undertaken by MS Teams.

Attendance at Private Board meetings 1 April 2020 to 31 March 2021

Name	Apr	Jun	Aug	Oct	Dec [^]	Dec	Feb
Alan McCarthy (Chair)	✓	✓	✓	✓	✓	✓	✓
Patrick Boyle	✓	✓	✓	✓	✓	✓	✓
Joanna Crane	✓	✓	✓	✓	✓	✓	✓
Jon Furnston	✓	✓	✓	x	✓	✓	✓
Lizzie Peers	✓	✓	✓	✓	✓	✓	✓
Kirstin Baker*	✓	✓	✓	✓	✓	✓	x
Mike Rymer	✓	✓	✓	✓	✓	✓	✓
Lillian Philip*\$	✓	✓	✓	✓	✓	x	x
Marianne Griffiths	✓	✓	✓	✓	✓	x	✓
Pete Landstrom*	✓	✓	✓	✓	✓	✓	✓
George Findlay	✓	✓	x	✓	✓	✓	✓
Karen Geoghegan	✓	✓	x	✓	✓	✓	✓
Denise Farmer*	✓	✓	✓	✓	✓	x	✓
Maggie Davies	✓	✓	✓	✓	✓	✓	✓
Fiona Ashworth	✓	✓	✓	Fiona left on 30 September 2020			
Gethin Hughes	Gethin started as Interim COO from 01 October 2020			✓	✓	✓	✓
Jennie Shore*	x	✓	✓	x	x	✓	✓
Tim Taylor*	✓	✓	✓	x	x	✓	✓

* non-voting members of the Board
 \$on maternity leave from the end of February
 ^ Extraordinary Private Board

Attendance at EXTRAORDINARY Joint Private Board Meetings in Common between WSHFT and BSUH between 1 April 2020 to 31 March 2021. (Meetings taken place to enable transactional items relating to the Merger to be progressed.)

Note only WSHFT Board members are recorded in the table below

Name	Jun	Jun	Jul	Oct	Oct	Nov	Nov	Nov	Dec	Jan	Jan	Feb	Feb
Alan McCarthy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patrick Boyle	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x
Joanna Crane	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x
Lizzie Peers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kirstin Baker	✓	✓	✓	x	x	x	✓	✓	x	✓	x	x	x
Mike Rymer	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Marianne Griffiths	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	x	✓
Pete Landstrom	✓	✓	✓	x	x	x	✓	✓	x	x	✓	x	x
George Findlay	✓	✓	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓
Karen Geoghegan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Denise Farmer	✓	✓	✓	x	x	✓	x	✓	x	✓	✓	✓	x
Jon Furmston	✓	✓	✓	x	x	✓	x	✓	x	✓	✓	x	x
Lillian Philip*\$	✓	✓	x	x	x	✓	x	x	x	✓	✓	x	x
Maggie Davies	✓	✓	✓	✓	✓	✓	x	✓	x	x	✓	x	x
Fiona Ashworth	✓	✓	✓	Fiona left on 30 September 2020									
Gethin Hughes	Gethin started as Interim COO from 01 October 2020			✓	✓	✓	x	✓	✓	✓	✓	x	✓

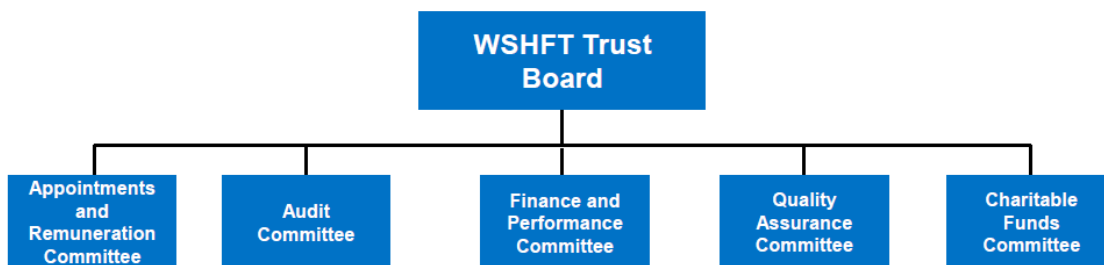
* non-voting members of the Board
 \$on maternity leave from the end of February

Complementing both the Public and Private Board meetings were a number of Board Workshops again held with BSUH to review and provide input into the transactional merger processes.

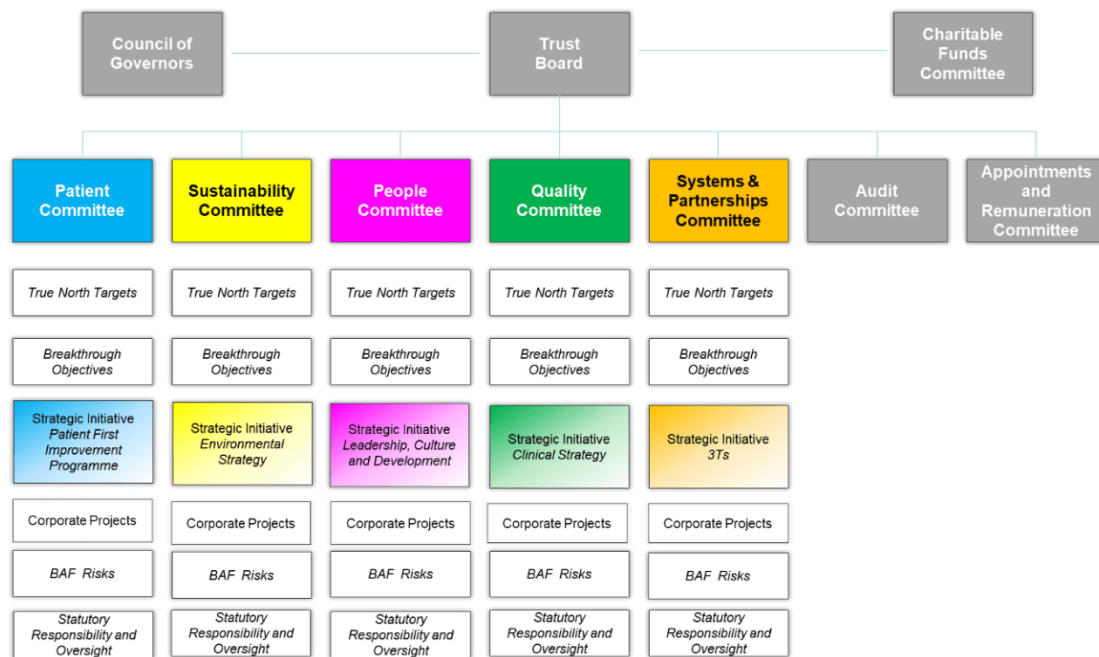
Board Committees

The Board has established a number of formal sub-committees that support the discharging of the Board’s responsibilities. Each Committee is chaired by a Non-Executive Director.

These committees do not operate independently of each other but where appropriate operate together (and indeed report to one another) to ensure full coverage and clarity on all areas of Trust activity. The diagram below shows the inter-relationships of the Committees and the Board



During the merger planning the Boards of Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust the Boards reviewed their current Board Committee governance arrangements. Both Boards had adopted a similar structure to that shown above, with a Finance and Performance and Quality Assurance committee providing key assurance oversight on behalf of the Board. The merger review resulted in a revised Committee structure being established for 2021/22 seeing five key assurance Committees, outside that provided by the Audit Committee, being established. Each Committee is aligned to the Trusts’ five patient first pillars. Whilst each Committee retains their oversight of allocated BAF risks they will also have capacity within their respective work programmes to provide enhanced assurance to the Board over the Trust’s delivery of their stated True Norths, Breakthrough Objectives, Corporate Projects and Strategic Initiatives. The revised governance structure is shown overleaf



Audit Committee

The existence of an independent Audit Committee is the central means by which the Trust Board ensures effective control arrangements are in place. The Committee membership is solely made of Non-Executive Directors in line with the Code of Governance for Foundation Trusts.

The Audit Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes.

Register of Members' attendance at Audit Committee meeting for the period 01 April 2020 to 31 March 2021

Name	Apr	Jun	Jul	Oct	Jan	Total
Jon Furmston (Non-Executive Director and Committee Chair)	✓	✓	✓	✓	✓	5 of 5
Lizzie Peers (Non-Executive Director)	✓	✓	✓	✓	✓	5 of 5
Joanna Crane (Non-Executive Director)	✓	✓	✓	✓	✓	5 of 5
Patrick Boyle * (Non-Executive Director)	x	x	x	x	✓	1 of 5

*Patrick is not a regular member but as all NEDs are invited to be members he attended this meeting to ensure quoracy was remained as two NEDs had other commitments during the meeting with NHSE/I

The Chief Financial Officer, Chief Workforce and Organisational Development Director, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. The Committee requests other senior Trust officers to attend for specific items. The Committee is supported by the Company Secretary.

The Trust retained its External Auditors, Ernst and Young for the year.

The Trust does not have its own internal audit or counter fraud functions. The Trust's Internal Auditor is BDO LLP. The Trust's Local Counter Fraud Service is provided by RSM UK.

The Audit Committee agenda is based upon an agreed annual work-plan. In order to maintain independent channels of communication, the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud ahead of each Audit Committee. This provides all parties the opportunity to raise any issues without the presence of management.

The Audit Committee is responsible to the Board for reviewing the adequacy of the governance, board assurance and risk management and internal control processes within the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.

The Audit Committee review the financial year-end Annual Report, Annual Accounts and Annual Governance Statement with the External Auditor prior to Board approval and sign off.

The Audit Committee agrees the schedule of Internal Audit reviews at the start of the year and receives the reports of those audits and tracks the implementation of recommendations at each of its meetings.

Quality Assurance Committee

The Quality Assurance Committee supports the Board in ensuring that the Trust's management of clinical and non-clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services provided by the Trust.

Register of Members' attendance at Quality Assurance Committee meeting for the period 01 April 2020 to 31 March 2021

Name	^May	Jun	^Jul	Sep	Dec	Mar	Total
Joanna Crane (Non-Executive Director and Committee Chair)	✓	✓	✓	✓	✓	✓	6 of 6
Mike Rymer (Non-Executive Director)	✓	✓	✓	✓	✓	✓	6 of 6
Patrick Boyle (Non-Executive Director)	x	✓	✓	x	✓	✓	4 of 6
Lizzie Peers** (Non-Executive Director)	✓	✓	✓	x	x	x	3 of 6
Jon Furmston** (Non-Executive Director)	✓	x	x	x	x	x	1 of 6
Alan McCarthy** (Non-Executive Director and Trust Chair)	✓	✓	✓	x	✓	✓	1 of 6
George Findlay# (Chief Medical Officer and Deputy Chief Executive)	x	x	x	x	✓	x	1 of 6
Maggie Davies (Chief Nurse)	✓	✓	✓	✓	✓	✓	6 of 6
Fiona Ashworth (Chief Operating Officer)	x	✓	✓	x	Fiona left on 30 September 2020		2 of 6
Gethin Hughes (Interim Chief Operating Officer)	Gethin started as Interim COO from 01 October 2020			✓	x	✓	2 of 6

^May and July were Extraordinary QAC meetings

George was MD of BUSH until the summer of 2020 so his attendance at WSHFT Committees was reduced to allow him to fulfil that role.

**In attendance not formally a member of the Committee

Finance and Performance Committee

The Finance and Performance Committee supports the Board to ensure that all appropriate action is taken to achieve the financial objectives of the Trust through regular review of financial strategies and performance, investments, and capital and estates plans and performance.

The Committee is chaired by a designated Non-Executive however all Non-Executive and Executive Directors are invited to attend.

**Register of Members' attendance at the Finance and Performance
Committee meeting for the period 01 April 2020 to 31 March 2021**

Name	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec [^]	Jan	Feb	Feb*	Mar	Total
Alan McCarthy (Chairman)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✓	✓	11 of 13
Lizzie Peers (Non- Executive Director & Committee Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13 of 13
Mike Rymer (Non- Executive Director)	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	11 of 13
Marianne Griffiths (Chief Executive)	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12 of 13
Karen Geoghegan (Chief Financial Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13 of 13
George Findlay # (Chief Medical Officer and Deputy Chief Executive)	✗	✗	✗	✗	✗	✗	✓	✗	✓	✗	✓	✓	✓	5 of 13
Maggie Davies (Chief Nurse)	✓	✓	✓	✓	✗	✗	✗	✓	✗	✓	✓	✓	✗	8 of 13
Jon Furmston ** (Non- Executive Director)	✓	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓	✗	✓	6 of 13
Joanna Crane** (Non- Executive Director)	✓	✓	✓	✓	✗	✗	✗	✗	✗	✓	✗	✗	✗	5 of 13
Patrick Boyle** (Non- Executive Director)	✓	✗	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	4 of 13
Fiona Ashworth	✓	✓	✓	✓	✗	✗	Fiona left on 30 September 2020						4 of 13	

Name	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec [^]	Jan	Feb	Feb*	Mar	Total
(Chief Operating Officer)														
Gethin Hughes (Interim Chief Operating Officer)	Gethin started as Interim COO from 01 October 2020						✓	✓	✓	✓	✓	✓	✓	7 of 13

** Non-members, in attendance

George was MD of BUSH until the summer of 2020 so his attendance at WSHFT Committees was reduced to allow him to fulfil that role.

Charitable Funds Committee

The purpose of the Charitable Funds Committee is to monitor progress and performance against the strategic direction of the Trust's charity fundraising activity as determined by the Board as corporate Trustee; to approve and monitor expenditure of charitable funds in line with specified priority requirements; and to monitor the management of the Trust's investment portfolio ensuring that the Trust at all times adheres to Charity Law and to best practice in governance and fundraising.

Register of Members' attendance at the Charitable Funds Committee for the period 01 April 2020 to 31 March 2021

Name	Jul	Oct	Jan	Total
Joanna Crane (Non-Executive Director and Committee Chair)	✓	✓	✓	3 of 3
Lizzie Peers (Non-Executive Director)	✓	✓	✓	3 of 3
Patrick Boyle (Non-Executive Director)	✓	✓	✓	3 of 3
Karen Seabridge (Acting Finance Director)	✓	x	✓	2 of 3
Maggie Davies* (Chief Nurse)	x	✓	✓	2 of 3
Mike Rymer** (Non-Executive Director)	✓	x	x	1 of 3
Lillian Philip** (Associate Non-Executive Director)	✓	x	x	1 of 3

*Committee member from October 2020

** Non-members, in attendance

Appointment and Remuneration Committee

The Committee sets the terms and conditions of the Executive Directors. This committee's membership is the Trust Chair and Non-Executive Directors only.

In attendance at meetings are the Chief Executive, Chief Workforce and Organisational Development Director and the Group Company Secretary.

During the period the Committee did not procure any external advice relating to pay.

2.1.2 Appointments and appraisal

The Chief Executive undertakes an appraisal on the performance of the Executive Directors, which are formally reported to the Appointment and Remuneration Committee.

The Chair conducts the Chief Executive's appraisal which is reported in the same way.

The Chair undertakes the appraisal of the Non-Executive Directors, having sought feedback from other Directors. The Senior Independent Director conducted the appraisal of the Chair which included feedback from Directors Governors and members of the Integrated Care System.

The Chair and Non-Executive Directors appraisals were formally reported to the Council of Governors.

The Chairman, other Non-Executive Directors, and the Chief Executive are responsible for deciding the appointment of Executive Directors.

Non-Executive Directors are appointed by the Council of Governors with the process being led by the Governors Nomination and Remuneration Committee. Non-Executive Directors are appointed for a three-year term in office. A Non-Executive can be re-appointed for up to two further three-year terms in office on an uncontested basis, subject to the recommendation of the Chairman and approval by the Council of Governors.

During the year the Council of Governors approved the re-appointment of Non-Executive Directors; Mike Rymer for a shorter term to 31 May 2021 to allow for the recruitment of his successor to conclude and Patrick Boyle for a second term of three years to 19 January 2024. The Council of Governors also appointed Kirstin Baker to be a full voting NED from the 1 April 2021 upon completion of the merger.

2.1.3 Statement of compliance with the NHS Foundation Trust Code of Governance 2020-21

Western Sussex NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July

2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

2.1.4 Statement of compliance with the NHS Constitution

The Board of Directors takes account of the NHS Constitution in its decisions and actions, as they relate to patients, the public and staff. The Board of Directors is compliant with the principles, rights and pledges set out in the Constitution. However, the Trust has recognised that it has not met all the NHS Constitutional Targets during 2020/21 due mainly to the impact of the challenges in dealing with the Covid-19 pandemic and activity being reduced in line with National guidance and to allow staff and resources to be directed to the treatment of Covid-19 patients.

2.1.5 Statement on directors' disclosures

The Annual Report is required to include a statement that for each individual, who is a director at the time the report is approved, as follows:

- So far as each director is aware, there is no relevant audit information of the which the (external) auditor is unaware; and
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

The Directors have confirmed the above statement.

2.1.6 Declarations of interest

All Board members have declared their relationship, under the terms of a management contract, with Brighton and Sussex University Hospital NHS Trust as an 'Interest' in order to provide transparency on Board decision making.

No Board Member has declared any significant commitments that require disclosure, other than that highlighted above relating to Brighton and Sussex University Hospital NHS Trust.

The Trust holds a register of company directorships and other significant interests, held by both directors and governors, which may conflict with their management responsibilities. The Audit Committee receives an Annual Report on Board Declarations and the process to mitigate any potential conflicts. The Council of Governors receives an Annual report on Governors Declarations in the public part of its meeting.

The register of these interests is made publicly available on the Trust’s public website. The register can be found at

<https://www.westernsussexhospitals.nhs.uk/your-trust/board/declarations-of-interest/>

In line with a revision to the standard contract for NHS Services Provider Trusts are required to report the level of staff required to make an annual declaration who have made such a declaration. Whilst the majority of staff make a nil return, we secured returns from 482 of the 483 staff required to make a return.

2.1.7 NHS Oversight Framework

The Trust is subject to the NHS England and Improvement’s Oversight Framework which 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.

2.1.8 Finance and use of resources

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

Area	Metric	2020/21 Scores				2019/20 Scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	1	2	2	2	1	1
	Liquidity	1	1	1	1	1	1

		2020/21 Scores				2019/20 Scores	
Area	Metric	Q4	Q3	Q2	Q1	Q4	Q3
Financial Efficiency	I& E margin*	2	2	2	2	1	1
Financial Controls	Distance from financial plan	1	1	1	1	2	2
	Agency spend	1	1	1	1	1	1
Overall scoring		1	1	1	1	1	1

* The interim financial framework in place during 2020/21 and the requirement to breakeven capped the I&E margin metric at '2'

2.1.9 NHSI Well led framework

In line with the FT code of governance, the Board commissioned an external review of its Board effectiveness, such reviews should be undertaken at periodic intervals. The review was undertaken in 2018/19 by Deloitte who provided initial feedback to the Board at the end of the year with the formal report provided in May. The Board was delighted to receive the feedback from Deloitte who concluded “Overall we are of the view that the governance arrangements in place at WSHFT are highly effective, with a clear sense of purpose and values, enabling a culture of continuous improvement and innovation focusing on the patient. Many of the attributes of a high performing organisation as defined within the well led framework were evident throughout our review.”

The CQC inspection undertaken during 2019/20 re confirmed the 2018/19 assessment as the Trust was awarded the rating of “outstanding” for Well Led.

Whilst not a formal assessment as part of the merger approval process NHSE/I concluded that there were no reasons not to progress with the merger. An element of the merger involved the engagement with the Board which offered an opportunity to raise any issues with the capacity and capability of the Board. No such observations were made.

2.1.10 Emergency Planning and Business Continuity

The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the NHS England core standards for Emergency Preparedness, Resilience and Response (EPRR) Assurance. The

accountable emergency officer in each organisation is responsible for ensuring these standards are met.

Due to the impact of the Coronavirus Pandemic, the 2020 Emergency Preparedness, Resilience and Response (EPRR) Assurance process was reviewed by the national director of EPRR, NHS England and NHS Improvement, the revised process was determined to require:

- an updated assurance position of any organisation rated partially compliant or non-compliant in the 2019/20 assurance process;
- assurance that a thorough and systematic review of the response to the first wave of the Covid-19 pandemic has been undertaken and the learning embedded; and
- confirmation that any key learning identified as part of this process is actively informing wider winter preparedness activities for your system.

A full statement of assurance stating that the trust remained **fully compliant** with all core standards, as detailed in the previous 2019 assurance return with additional details covering the above areas, was initially submitted to the Sussex NHS Commissioners in October 2020. This was then, post review by the Commissioners, subsequently submitted to the Trust Executive Committee and Board as part of the Emergency Preparedness, Resilience and Response (EPRR) Assurance Annual Report in January 2021.

The Western Sussex Hospitals Emergency Planning and Business Continuity Department formulates a detailed work stream identifying key risks and appropriate mitigating actions for the identified core standards and any assessed shortfalls which is then expanded further as necessary with specific Emergency Planning and Business Continuity work flow for each calendar year with specific key dates identified for completion. This work is monitored through the Emergency Planning and Business Continuity Integrated Performance Group quarterly and reported to the Trust Executive Committee on an annual basis or as required.

In November 2020, EU exit planning was 'stood up' again and work continued with health and multi-agency partners to ensure appropriate preparedness for the potential impacts of the end of the EU Exit transition period. This built on work completed previously and took into account the implications of the Covid-19 pandemic, including the impact on staff well-being of managing

these events concurrently. The Board was provided with an update on EU Exit – End of Transition period.

The past year has seen unprecedented pressure on all areas of the Trust due to the Coronavirus Pandemic, but despite this, the Emergency Planning and Business Continuity team have continued to ensure that the Trust's Emergency Planning and Business Continuity arrangements are compliant with the Emergency Preparedness, Resilience and Response (EPRR) Assurance Process all EPRR Core Standards for a fourth year in a row.

2.1.11 Membership engagement

We have continued to refine and improve the way we communicate with members and how we enable them to share their views.

Our e-newsletter, @WesternSussex, is a popular channel for communicating with members. It contains news, event information, feedback methods and articles explaining how the Trust responds to suggestions from patients, carers and members.

In September 2020, we hosted our first virtual Annual General Meeting of the Council of Governors and Annual Members Meeting. Chief Executive, Dame Marianne Griffiths reflected on the previous year before Dr James Nicholson, clinical director for anaesthesia, critical care, theatres and pain, spoke about how the critical care team responded and adapted during Covid-19.

In October 2020, we announced our plans to merge with Brighton and Sussex University Hospitals and invited our members and people living locally to share their thoughts about the new Trust's vision and values, as well its aspirations for the future, by completing a short survey.

More than 700 members of public shared their views on the new organisation's vision and values, their hopes and concerns, and gave their feedback on a selection of naming options.

Following announcement of our plans to merge with Brighton & Sussex University Hospitals, we introduced a campaign in December 2020 to welcome new members across West Sussex, Brighton and Hove, Mid Sussex and East Sussex. By 31 March 2021, we had recruited some 914 new members.

2.1.12 Disclosures to Auditors

The directors are required under the NHS Health Service Act 2006 to prepare accounts for each financial year.

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

Each director of the Trust Board, at the time of approval of the Annual Report and Financial Statements, declares that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

2.1.13 Income Disclosures

The income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes. Income from goods and services not for the purposes of the health service in England is required to at a minimum cover the full cost of delivery of the goods and services. Any surplus from these activities is reinvested and supports the provision of goods and services for the purposes of the health service in England.

2.1.14 Political Donations

The Trust did not make any donations to political parties during the year.

2.1.15 Better Payments Practice Code

The Trust's measure of performance in paying suppliers is the Better Payment Practice Code (BPPC). The Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. In 2020/21 possible interest liabilities on invoices was £428,000. The total amount of interest actually paid was nil (see note 12.2 in the Notes to the Accounts)

Measure of Compliance	2020/21		2020/21
	Number		£000
Non-NHS Payables			
Total Non-NHS Trade Invoices Paid in the Year	88,910		236,435
Total Non-NHS Trade Invoices Paid Within Target	82,686		221,401

Percentage of Non NHS Trade Invoices Paid Within Target	93.0%		93.6%
NHS Payables			
Total NHS Trade Invoices Paid in the Year	2,850		12,018
Total NHS Trade Invoices Paid Within Target	2,187		7,990
Percentage of NHS Trade Invoices Paid Within Target	76.7%		66.5%

2.2 Governors' Report

2.2.1 Council of Governors

As a Foundation Trust Western Sussex NHS Hospitals has a Council of Governors (COG). The Board of the Trust is directly responsible for the performance and success of the Trust and satisfying the COG that the Board is achieving its aims and fulfilling its statutory obligations. Governors act as a vital link to the local community and report matters of concern raised with them to the Board, via Governor Patient Experience and Engagement Committee. Governors also participate in other activities in support of the Trust's work.

2.2.2 Role of Governors

The COG has a number of statutory roles and responsibilities as follows;

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances and other terms and conditions of office of the chair and other Non-Executive Directors
- Approve (or not) any new appointment of a Chief Executive
- Approve and, if appropriate, remove the Trust's auditor
- Receive the Trust's Annual Accounts and Annual report at a general meeting of the COG
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust
- Approve Significant Transactions as defined by NHS Improvement guidance
- Approve an application by the Trust to enter into a merger or acquisition

- Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose; and
- Approve amendments to the Trust’s Constitution

2.2.3 Composition of the COG

The COG comprises the following Constituencies;

Elected public and patient governors

The COG has 15 Governors elected from its membership that represent the public and patients (14) and one Governor who represents patients who live out of the catchment area of the Trust. Public Governors are elected from within Local Authority areas. The number of elected Governors for each constituency is in proportion to the population within the area using the Trust’s services.

Area	Number
Adur	2
Arun	5
Chichester	3
Horsham	1
Worthing	3
Patient	1
Total Elected Public and Patient Governors	15

Staff Governors

There are six staff Governors drawn from different areas of the workforce and elected by staff members from those particular professional areas.

Professional Area	Number
Medical and Dental	1
Nursing and Midwifery	1
Scientific, Technical and Professional (including Allied Health Professionals)	1
Additional Clinical Services	1

Estates and Ancillary	1
Administrative and Clerical	1
Total Elected Staff Governors	6

Stakeholder (Appointed) Governors

The Trust has a further seven Governors who are appointed by partnership or stakeholder organisations.

Partner/Stakeholder Organisation	Number
West Sussex County Council	1
Brighton and Sussex Medical School	1
Friends of WSHFT Hospitals	1
University of Brighton School of Nursing and Midwifery	1
Worthing Borough Council	1
Chichester District Council	1
Arun District Council	1
Total Partner/Stakeholder Governors	7

As part of the merger the Trust was required to amend its constitution to reflect the extended geography of the new Trust. At the Council meeting held on 16 October 2020 approval was given to add three new public constituencies for Brighton & Hove, East Sussex and Mid Sussex.

The Trust commenced a recruitment campaign with an online membership form to allow prospective members to register to become member of the enlarged Trust at the time of the transaction. Initially information on how to become a member was circulated by our neighbouring Foundation Trusts to their members and placed on our website. In the latter quarter of 2020/21 the Trust utilised a number of avenues to engage with our communities to secure members, including utilising patient letters and staff communications to encourage them or friends and family to become members. It should be noted that BSUH staff automatically became members of the Trust on the 1 April 2021 subject to the ability to opt out.

At its meeting on the 18 March 2021 the Council agreed the relevant minimum numbers of members within each of its new constituencies and these are detailed within the constitution for University Hospitals Sussex NHS Foundation Trust.

During the year 1 April 2020 to 31 March 2021 attendance at Council of Governor meetings was as follows:

Constituency	Full Name	End of Term of Office ¹	Number of COG meetings attended ²
Elected Governors			
Public – Adur	VACANCY	-	
Public – Adur	John Todd	30 June 2022	5 of 5
Public – Arun	Lyn Camps	30 June 2022	5 of 5
Public – Arun	Anita Mackenzie	31 March 2021	1 of 5
Public – Arun	Jill Long	31 March 2021	5 of 5
Public – Arun	John Thompson	31 March 2021	5 of 5
Public – Arun	Andrew Ratcliffe	31 March 2021	5 of 5
Public – Chichester	Linda Tomsett	30 September 2021	4 of 5
Public – Chichester	Alan Sutton	31 March 2021	3 of 5
Public – Chichester	Les Willcox	30 September 2021	3 of 5
Public – Horsham	John Davies*	Retired 31 March 2021	3 of 5
Public – Worthing	John Bull	31 March 2021	4 of 5
Public – Worthing	Pauline Constable	30 June 2022	4 of 5
Public – Worthing	Patricia Peal	31 March 2021	2 of 5
Out of Area	Stuart Fleming*	30 September 2021	3 of 5

¹ Given the merger for those Governors not continuing their term of office end date is shown as 31 March 2021 rather than their three year elected term end date

² Shows the Number of Council of Governor meetings attended by the individual Governor as a proportion of the number of meetings they were eligible to attend, reflecting new members to the Council in year.

Staff Governors			
Medical & Dental	Anna Mathew*	30 September 2021	4 of 5
Nursing & Midwifery	Moira Whitlock	30 September 2021	3 of 5
Scientific, Technical & Professional	Ryan De-Vall	31 October 2021	5 of 5
Additional Clinical Services	Miranda Jose	31 October 2021	4 of 5
Administrative & Clerical	Jacqui Campbell	30 November 2021	0 of 5
Estates & Ancillary	Warwick George	30 June 2022	0 of 5
Appointed Governors			
Brighton & Sussex Medical School	Professor Somnath Mukhopadhyay	31 March 2021	2 of 5
University of Brighton School of Nursing & Midwifery	Professor Kathleen Galvin	31 March 2023	2 of 5
Chichester District Council	Councillor Donna Johnson	30 March 2021	1 of 5
West Sussex County Council	Councillor Mike Magill	28 February 2023	2 of 5
Worthing Borough Council	Councillor Val Turner	31 March 2021	3 of 5
Arun District Council	Councillor Gill Yeates	31 March 2021	3 of 5
Friends of WSHFT Hospitals	Jane Ramage	31 March 2021	4 of 5

*Note * these are associate (non voting governors)*

2.2.4 Stakeholder (Appointed) Governors

Under the Trust's Constitution, an appointed Governor may hold office for a period of up to three years and at the end of each term they can, subject to satisfactory performance, be re-appointed for a further two terms of up to three years (ie 9 years in total).

During the period year, there were three appointed governors who's terms of office ended. All three were reappointed by the relevant organisation for a further term. These Governors were, Cllr Val Turner from Worthing Borough Council, Professor Kathleen Galvin from University of Brighton School of Nursing & Midwifery and Professor Somnath Mukhopadhyay from Brighton & Sussex Medical School.

2.2.5 Elected Governors.

Taking into account the impact of Covid-19 on the Country a decision was taken by the Council to defer the elections that would have returned candidates for June 2020. Following that decision, the Council agreed to ask those governors whose terms of office expired in June 2020 if they would be prepared to extend their current term until September 2021, which was the next round of planned elections.

Confirmation was received from those affected Governors that they would be willing to have their term of office extended until September 2021, noting that for none of those affected were within the last three year term of office.

2.2.6 Governor expenses

The Trust is required to disclose the value of expenses claimed by the Council of Governors during the financial year.

	1 April 2020 to 31 March 2021	1 April 2019 to 31 March 2020
Total number of governors in office (as at 31 st March)	27	28
Number of governors receiving expenses	5	12
Aggregate sum of expenses paid to governors	£832.98 *	£8,578.53

* with the move to virtual meetings in response to the national social distancing requirement this saw a significant reduction in travel expenses

2.2.7 Lead Governor

NHS Improvement (NHSI) requires that a Council of Governors elects a Lead Governor to be the primary link with the Foundation Trust. A Lead Governor is elected by the full Council and would also be the formal link to NHSI if circumstance required direct communication between the Council of Governors and the Regulator. On 1 October 2019 Lyn Camps, Public Governor for the Arun constituency was elected by the full Council to the role

of Lead Governor. John Thompson, Public Governor for Arun constituency was elected to act as Deputy Lead Governor.

2.2.8 Governor engagement

There were five Council of Governors meetings held in public in the year. Due to impact of the Covid-19 pandemic and, following the guidance from NHS on social distancing restrictions, the Council of Governor meetings that took place between August 2020 and March 2021 were conducted via MS Teams. The public were not invited to attend in person, but were provided with a link to view the meeting and given the opportunity to submit questions prior to the meeting. The agenda at each meeting includes reports from Governors in respect of their work on the Governor Committees and working groups. They also receive regular presentations from the Non-Executive Directors on their work and that of the Committees on which they Chair. The Council also receive regular reports in respect of the Trust's financial and operational performance along with the Trust's delivery of its quality priorities.

In addition, the Board and Council met together to discuss key issues and developments. These meetings are augmented by assurance meetings held in private between the Governors and Non-Executive Directors only. In addition the Chair and Chief Executive have held a number of briefing sessions for Governors during this financial year.

To support Governors in their role the Trust runs information seminars on areas of interest. This year these included an IT Response to Covid, Capital Plan, Green Steering Group, Ophthalmology – Eye Clinic Improvements, Business Continuity, Reducing Abusive Behaviours and a Covid update. Ahead of the Trust's planned merger with Brighton and Sussex University Hospitals NHS Trust, a number of additional information seminars were added to inform Governors ahead of the merger of their activities and performance. These included 3Ts, BSUH Estates & Facilities, BSUH Finance, BSUH People, BSUH Patient Experience.

The CoG has an active and vibrant Membership Committee and Patient Experience and Engagement Committee, The Council also has a Nomination and Remuneration Committee which meets as required during the year.

NHS Improvement requires Foundation Trusts to provide a forward plan for each financial year, prepared by the Board of Directors. Governors are consulted on the development of these forward plans and are able to input views from the public and members they represent via relevant workshops.

Governors are involved in many aspects of the Trust including improvement programme workgroups, Trust conferences, Stakeholder meetings, and

undertaking PLACE visits. Given the impact of Covid, governors have not been able to attend the Trust to the same levels as in previous years but there were a number of meetings that took place utilising MS Teams.

2.2.9 Governors Annual Programme

Each year the Council set an annual work programme, for 2020/21 in light of plans for the Trust to merge with Brighton and Sussex University Hospitals NHS Trust, the Governors were invited to contribute to a Reference Group which had been established to support the Trust as it developed its future organisational arrangements, with the drive to developing a framework that would support a resilient and thriving new organisation. The role of the Reference Group included the review and development of the Trust's Constitution, the processes for the development of the membership for the new constituencies, the training and induction programme for new Governors ahead of elections to the extended FT Trust, a review of the code of conduct and the revision to the Trust's membership strategy.

2.2.10 Holding the Non-Executive Directors to account for the performance of the Trust Board

Governors have an important role in making an NHS Foundation Trust publicly accountable for the services it provides. They bring valuable perspectives and contributions to its activities. Importantly, Governors are expected to hold Non-Executive Directors to account for the performance of the Trust Board of Directors and the following sets out the principles of how Governors discharge this responsibility.

- To ensure that the process of holding to account is transparent and fulfils the statutory duties of the COG
- To share successes and discuss any concerns that NEDs or Governors have.
- To reflect the NHS Improvement guidance that Governors should, through the NEDs, seek assurance that there are effective strategies, policies and processes in place to ensure good governance of the Trust.
- To work effectively together and make the best use of the time NEDs and Governors have together.

The Governors discharge this function through regular reports from the NEDs to the Council on their role as Committee Chairs and through the scheduled meetings held in private between the Governors and Non-Executive Directors only.

At no time during the period has the Council of Governors exercised its formal power to require a Non-Executive Director to attend a Council meeting and account for the performance of the Trust Board.

2.2.11 Appraisal and appointments

It is the responsibility of the Council of Governors to appoint the Chair and other Non-Executive Directors and to oversee the appraisal process of the Chair and Non-Executive Directors.

The Governors Nomination and Remuneration Committee (GNARC) oversee these processes on behalf of the Council. The Chair and other Non-Executive appraisals for 2020/21 have been undertaken and reported to the GNARC in June 2020 who then reported to the full Council in public on the 24 August 2020.

The Committee during the year received the

- Chair and NEDs appraisals
- The Outcome from the recruitment process for a new Non-Executive Director (NED)

It is the responsibility of the Governor Nomination and Remuneration Committee, with the Chair of Western Sussex Hospitals NHS Foundation Trust, to consider appropriate Non-Executive Director (NED) succession planning. During the latter part of 2020/21 the Governor Nomination and Remuneration Committee met to support the appointment of two Non-Executive Directors. These appointment processes continue with interviews taking place in early 2021/22.

2.2.12 Membership Strategy

The Trust currently has a Membership Strategy for the period 2020-2023, which is updated annually with the help of the Governor's Membership and Engagement Committee. This strategy acknowledges that it is a responsibility of a Foundation Trust to recruit, communicate and engage with members as a means of ensuring service provision meets the needs of service users. The Trust's strategy aims to recruit a representative membership base that is actively engaged in working for the good of the Trust. It also considers and monitors engagement levels through annual surveys and by tracking responses rates to in year activity. Other work includes targeting specific groups of members to ensure that the Trust membership is representative of the population it serves.

The merger provided an opportunity to comprehensively review this three year strategy and establish a strategy for University Hospitals Sussex NHS Foundation Trust for 2021 – 2024. As mentioned earlier this work was supported by a Governor reference group. The Strategy is scheduled to be taken to the first meeting of the University Hospitals Sussex Council's Membership and Engagement Committee where it will be considered prior to its approval.

The Trust's Membership Strategy is supported by a full action plan which outlines how the strategic aims will be implemented and the objectives of the strategy achieved. Performance against this Strategy will be overseen by the Council's Membership and Engagement Committee.

2.2.13 Keeping in touch with members

Governors are accessible to members via email and at the regular Council of Governors meetings. They also attend our Medicine for All and other public events (see Stakeholder Relations), and play an important role in recruiting new members. However, Covid-19 had impacted on the Governors ability to hold meetings or engage with other organisations such as local GP practices. As the Country moves out of its national lockdown the Council will seek to recommence a number of membership engagement events. These events allow Governors to describe the role of a Trust member and gather feedback on services across the Trust and its future plans. All feedback is then shared with our Patient Engagement and Experience Committee to help us continue to improve services.

Governors can be contacted via a Trust generic email address which is advertised on the Trust website and through other communications sent to members. Governor "Who's who" posters have also been developed and contain information on how to contact your local Governor. These have been designed so that they can be displayed in Doctors Surgeries, Libraries and Community Centres.

An individual must be at least 16 years old to become a member of the Trust.

At the 31 March the Trust had 7756 public members, the table below summaries the constituencies these fall within.

Constituency	Membership as at 31 March 2019	Membership as at 31 March 2020	Membership as at 31 March 2021
Adur	1139	1142	1151
Arun	2364	2353	2417
Chichester	2023	1999	2028
Horsham	494	493	561
Worthing	1283	1294	1369
Patient / Out of Area	252	249	230

All staff are automatically enrolled as members on starting employment with the Trust.

2.2.14 Disclosures and declarations of interests

The Chair of the Council of Governors has not declared any other significant commitments that require disclosure. The Chair submits an Annual Declaration of Interest Statement and Fit and Proper Person Declaration.

Governors are required to complete a Declaration of Interest which is held on a Trust Register and is made publicly available on the Trust's website. This is available at <https://www.westernsussexhospitals.nhs.uk/your-trust/board/declarations-of-interest/>

2.2.15 Resolution of disputes

The Trust Constitution sets out at Section 12 the process for dealing with any dispute between the Council of Governors and Trust Board. The Council of Governors and Trust Board have a positive working relationship and the process has not been used during the 2020/21 year.

2.3 Staff Report

Western Sussex Hospitals NHS Foundation Trust employs more than 7,000 people in a range of different roles across the organisation. Each and every member of our staff works to ensure our patients receive excellent quality care.

Our staff continue to consistently demonstrate their willingness to go over and above to ensure high quality care is delivered to the people of West Sussex. This was recognised and praised by the CQC in their inspection. We ensure that we take opportunities to thank our staff in a variety of ways including Employee of the Month awards, an annual staff award ceremony and long service awards. Following feedback from our Ambassadors rather than

holding Thank You lunches this year we provided our staff with a reusable cup thanking them for their commitment and support to patients, families, carers and each other.

Average number of employees (WTE basis not actual staff employed)

Average number of employees (WTE basis)	Permanent	Other	Total	Total
	31-Mar-21	31-Mar-21	31-Mar-21	31-Mar-20
	2020/21	2020/21	2020/21	2019/20
	No.	No.	No.	No.
Medical and dental	852		852	775
Ambulance staff			-	-
Administration and estates	1,746		1,746	1,732
Healthcare assistants and other support staff	1,021		1,021	810
Nursing, midwifery and health visiting staff	1,820		1,820	1,731
Nursing, midwifery and health visiting learners			-	-
Scientific, therapeutic and technical staff	849		849	983
Healthcare science staff			-	-
Social care staff			-	-
Agency and contract staff		68	68	106
Bank staff		529	529	501
Other			-	-
Total average numbers	6,288	597	6,885	6,636
Of which:				

Average number of employees (WTE basis)	Permanent	Other	Total	Total
	31-Mar-21	31-Mar-21	31-Mar-21	31-Mar-20
	2020/21	2020/21	2020/21	2019/20
	No.	No.	No.	No.
Number of employees (WTE) engaged on capital projects	25	4	29	27

Total staffing costs for the year were £360,874,000 comprising £319,219,000 substantive employees and £41,655,000 for bank and agency workers.

2.3.1 Diversity and inclusion policies, initiatives and longer term ambitions

Our vision is for equality, diversity and inclusion to be a 'golden thread' running through, and central to, how we work together to provide sustainable, high-quality patient-centred care for all people we serve.

Our vision is intended to provide a focus for the delivery and development of all our services as follows:

Our patients and service users:

- Have confidence their individual needs and beliefs are taken seriously, and they are treated with dignity and respect.
- Know their individual life chances and wellbeing are enhanced by the Trust's commitment to Equality, Diversity and Inclusion.
- Are happy to choose, to use and to recommend the organisation.

Our staff:

- Feel valued and fairly treated in an organisation that really cares.
- Know the Trust as an organisation that people want to come and work for, stay with and thrive in, because of its commitment to Equality, Diversity and Inclusion.
- Are proud to work in an open and inclusive organisation.

Our communities:

- Are assured that the Trust engages with the diverse communities based on mutual interest and respect.
- Have confidence that the Trust is active in tackling inequality, making services accessible, solving problems, delivering solutions and willing to learn.
- Know that the Trust is responsive to the challenges faced by people in relation to diverse needs and communicates appropriately.

Our organisation:

- Lives its values consistently across all sites.
- Demonstrates long-term, consistent commitment to Equality, Diversity and Inclusion for the people it serves.
- Is a positive, innovative and 'can do' place to be.

Our Equality, Diversity and Inclusion policies and practices are all aimed to support our vision where regardless of their connection with our organisation, everyone has a lived experience which is free from discrimination, harassment and abuse.

We take our duties and responsibilities as an inclusive employer in the public sector, and more specifically in the NHS, very seriously. As a public sector organisation extra care is taken to monitor decisions that could unfairly affect any particular protected characteristic of staff, carers, volunteers, patients and their families.

We also really value the work of our many volunteers across the Trust who are integral to our workforce, have very diverse backgrounds and support our equality agenda.

Our Trust Board is actively engaged with our work on Equality, Diversity and Inclusion. In the last 12 months this has extended to the Sussex Health and Social Care Partnership with active representation on the recently established Turning the Tide Board working to eliminate the disparity in outcomes specifically for staff who identify themselves from Black, Asian and Minority Ethnic (BAME) communities. The trust and its staff participated in a Sussex-wide event for BAME staff and engaged in a number of subsequent workshops. This has informed the system wide work plan aimed to improve Board and senior management diversity as well as reducing the amount of discrimination, harassment and abuse our BAME communities are subjected to.

In the last year, the impact of the global coronavirus pandemic has been significant both on the way in which services are delivered and accessed but also on our workforce. As our understanding of the virus has developed, we

now know that the risk factors for those exposed to Covid-19 are higher in individuals who identify with one or more protected characteristics.

As a result, a number of changes have been made that include:

- Improving the risk assessment process, for both departments and individuals to identify those at higher risk and to take appropriate actions to ensure health and safety is protected. These processes were continuously strengthened throughout the pandemic.
- Introducing a risk assessment advisory panel - an independent panel reviewing complex individual risk assessment and providing advice and solutions to issues highlighted.
- Obtaining access to the National 'Interpreter Now' software to improve communication for deaf British Sign Language users utilising hospital services.
- Introducing the use of 'virtual clinics' both telephone and video conferencing.
- Widespread use of working from home for those who could do so and/or where this was the safest option available
- Significantly reducing travelling across sites through the use of MS Teams
- Expanding the provision of staff health and wellbeing services (emotional, physical and financial) that were widely promoted and uptake encouraged. This ranged from comfort packs, pop-up shops and hotel accommodation to Employee Assistance programmes with emotional and financial support.
- Establishing a bronze, silver and gold Covid-19 command centre - to take trustwide decisions on issues affecting capacity and flow in services.
- Establishing a Covid-19 Workforce hub - to help address questions and resourcing of departments.
- Providing additional pastoral care for those accessing our services including at end of life, through the chaplaincy service.

In addition to how we have supported staff through the pandemic, the Trust has continued to progress its equality obligations. This has been managed in collaboration with Brighton and Sussex University Hospitals where learning and experience has been shared.

During 2020/2021 the Trust strengthened its inclusion networks and particularly those for staff from a BAME background. Examples of their work in the last year are set out below.



BAME Celebrating Cultures Network - works towards improving patient care and working conditions for all staff from BAME (Black, Asian, Minority, Ethnic) and non-British backgrounds. This group is also involved in our policy development, to ensure issues relating to culture are taken into account.

The BAME Celebrating Cultures network was relaunched with active sponsorship from the Chief Executive.

The objective of the refreshed BAME Celebrating Cultures Network was first and foremost to be a support network for the BAME staff during this challenging time and to provide a voice directly to the Board on matters of race equality and reducing disparity of outcomes.

The network has increased its representation from across the Trust's staff groups and provides a safe space for members to share stories and learning and through coaching, training and mentorship to help support race equality within the organisation.

A programme of health checks and advice specifically for BAME was established during 2020/21 with high uptake. A number of BAME champions also received Mental Health First Aid training as part of a wider trust programme to support staff in the workplace.



Disability Forum – this forum has continued to be active throughout 2020/21, providing a mechanism to ensure disabled people have a voice within the Trust. One of the key objectives is to ensure that monitoring systems and processes are put in place to support disabled people, are fit for purpose.

This group is also involved in our policy development, to ensure issues relating to disability are taken into account. The Forum has been active in supporting the development of the Workforce Disability Equality Standard (WDES) action plan for the Trust along with developing resources including the Trust's Health Passport.



Disability Confident – this replaces the 'Two Ticks - Positive about Disabled People' scheme. The aim of this national programme is to ensure that the Trust has mechanisms, systems and processes to support existing and newly disabled employees throughout their employment journey. JobCentre Plus administers the programme.

The Disability Forum has expressed a desire to be involved in supporting the Trust in achieving Level Three of Disability Confident.

The Trust has had its Disability Confident status at level 2 extended until April 2021.

The forum has been instrumental in the implementation of Changing Places at Southlands and Worthing Hospitals with a further facility being developed for St Richards Hospital in Chichester.



Diversity Matters Group - this key steering committee helps to ensure that equality, diversity and human rights are at the heart of the Trust's strategic plans. All of the staff and patient networks and forums feed into this committee.



LGBTQ+ Forum - the network helps to raise the profiles of Lesbian, Gay, Bisexual and Trans issues within the Trust. The network provides support to LGBTQ+ staff, patients and visitors.

This group is also involved in our policy development, to ensure issues relating to sexual orientation and gender identity are taken into account. During 2020/21 the LGBTQ+ forum has benefited from the leadership and experience from Brighton and Sussex University Hospitals in raising awareness of issues and to ensure that the voice of this community remains strong. This included promoting International Pronouns Day and a deeper understanding of the Rainbow Warriors' Initiative.

The impact of Covid 19 sadly resulted in the Worthing Pride and Chichester's first ever Pride being cancelled for 2020. However plans are in place for 2021/22 and preparations well advanced.



Religion or Belief Forum - established in 2019/20 in partnership with BSUH the forum leads on Religion or Belief issues in the Trust and local health community and works in collaboration with faith groups and various local organisations. The forum provides a framework in which to support and monitor the religious needs of patients, relatives and staff and influence cultural change in attitudes and behaviour.

In readiness of the merger between WSHFT and BSUH from 1 April 2021, we took the opportunity to refresh the values of our new organisation in the autumn of 2020. This was informed by wide scale engagement with our staff and patients. As a result, Inclusion has been added to our values and is informing how we develop and shape the organisational culture, building on our work to date and accelerating the realisation of our vision.

More information about our work on Equality, Diversity and Inclusion can be found in our Equality Monitoring Report 2019/20 located on our public website.

NHS England Equality Standards

Reporting against the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) was delayed during the first wave of the pandemic and resumed later in 2020/21. The data, extracted from the annual Staff Survey (2019) and the Electronic Staff Records (ESR) system, reflects the Trust's position against a number of key indicators. This informs the improvement required and the interventions that follow.

WRES data for 2020/21 showed that:

- BAME staff were relatively:
 - less likely to be appointed from shortlisting
 - less likely to enter the formal disciplinary process
 - as likely to access non mandatory training and CPD
- BAME staff reported a worse experience than white staff for two of the NHS staff survey questions relating to violence and aggression, whilst the number of staff who personally experienced discrimination at work improved.
- BAME representation on the board is not representative of the 16.7% BAME workforce.

These outcomes, together with NHSE/I national recommendations are informing a review of our recruitment processes. A key tenant of the work being undertaken across the Sussex Health and Care Partnership is to improve representation of BAME staff in senior roles from pay band 8a and above.

Regular reports updating on Equality and Diversity actions are also provided to the Trust Board and assurance sought through its Quality Assurance

Committee. In June, a specific Equality and Inclusion seminar was conducted with the Trust Board.

WDES data for 2020/21 showed that:

- 27.8% of staff have not declared their disability status compared to 30.2% in 2019. This is an improved position and follows the introduction of ESR Self Service where individuals can update their status.
- Disabled staff were relatively:
 - less likely to be appointed from shortlisting
 - unlikely to enter a capability process process

We are now working with the Shaw Trust to review our recruitment processes including how applicants access our services. This will also help us in our aim to move from a level 2 to a level 3 Disability Confident organisation.

In year, the Trust introduced a Carers Passport and maintained its Disability Confident Scheme status.

Copies of the Trust’s WRES and WDES reports are available on the Trust’s website.

<https://www.westernsussexhospitals.nhs.uk/your-trust/about/equality-diversity/>

2.3.2 Gender and Gender Pay Gap

The composition of the Trust’s workforce by gender is:

	Male	Female	Total
Executive and Non Executive Directors (includes voting and non voting Directors)	6	8	14
Senior Managers (8c and above)	16	37	53
Other staff	1738	5780	7518

Gender Pay Gap reporting shows the difference in average hourly pay and bonus payments between men and women. The Trust is required to analyse

the information to identify any underlying root causes for Gender Pay Gap and put in place remedial actions to address and mitigate this. The results will be used to assess:

- the level of gender equality
- the balance of male and female employees in each of the four salary range quartiles
- how effectively talent is being maximised and rewarded

The benefits of reporting Gender Pay Gap include building a reputation for being known as a fair and progressive employer, attracting a wider pool of recruits, enhancing productivity and creating a culture committed to tackling inequality.

Table 1 below shows the mean and median hourly rates for male and female employees in the Trust and the actual gap in monetary and percentage terms in 2020. The 2019 figures are shown in brackets.

Table 1: mean and median hourly rates

Gender	Mean Hourly Rate (prior yr)		Median Hourly Rate (prior yr)	
Male	£ 19.71	(£ 19.31)	£ 14.33	(£ 13.30)
Female	£ 15.93	(£ 15.44)	£ 14.17	(£ 13.55)
Difference	£ 3.78	(£ 3.87)	£ 0.16	(£ 0.25)
Pay Gap %	19.17%	(20.0%)	1.18%	(2.78%)

There is a 19.17% (20% in 2019) difference in favour of male employees when using the mean hourly rate; this is an improvement from 2019.

This however, moves to 1.18% in favour of male employees when the median hourly rate is used (noting that the median is a more indicative measure). This compares to 2.78% in favour of female employees in 2019.

Data obtained for the 2020 snapshot has been provided by staff group and pay banding. This shows outliers in the gender pay gap in favour of male employees of 15.81% for Medical and Dental staff and 19.08% Administration and Clerical. When reviewing the 2021 snapshot data these staff groups will be reviewed further.

As part of the Agenda for Change contract refresh during the reporting period the pay band transition from band 1 to band 2 evidences that there are 3 times more women in band 2. This reflects the significant number of female

staff in Healthcare Assistant roles in particular. This is impacting on the pay medium, compared to pay band 1 where the numbers of male to female are comparative. There is however a 0.47 difference (4.68%) pay gap. This is the first year data has been gathered in this way and to understand what changes have influenced the pay gap, a working group will be established.

Table 2 includes Medical and Dental employees who received a Clinical Excellence Award (CEA) and Very Senior Managers (VSM) who received a bonus. There is a general reduction in the gap in both the mean and median, which is a positive decrease. The values in brackets are those for the prior year.

Table 2: Bonus payments including CEAs

Gender	Mean Bonus (prior yr)	Median Bonus (prior yr)
Male	£12,308.88 (€12,913.65)	£ 8,818.67 (€ 9,048.00)
Female	£ 7,072.63 (€ 7,558.75)	£ 3,019.68 (€ 5,428.80)
Difference	£ 5,236.25 (€ 5,354.90)	£ 5,798.69 (€ 3,619.20)
Pay Gap %	42.54% (41.47%)	65.75% (40.00%)

Note: The 2019 Local Clinical Excellence Awards (LCEA) round was paused and payments incorporated into the 2020 LCEA round. Payments have been applied equally amongst all eligible consultants in February 2021. Part time staff will receive the same amount as full-time colleagues.

It is reasonable to assume that the recognition of part time staff, as these are predominantly female, will have a positive impact on next year's report.

Addressing the gender pay gap is an important aspect of equality. For the coming year this will mean stratifying the data by all protected characteristics to really understand where there are disparities will therefore be a key objective of the newly established working group.

The Trust's information on the gender pay gap can be found on our website at <https://www.westernsussexhospitals.nhs.uk/your-trust/about/equality-diversity/>. Further information is also available on the cabinet office website <https://gender-pay-gap.service.gov.uk/>

2.3.3 Strategies and Processes applied in respect of Health and Wellbeing

The health, safety and wellbeing of staff have been a key component to overall staff engagement for a number of years. However, during 2020/21,

this has been fundamental to our ability to manage and respond to the coronavirus pandemic.

We have strengthened our health and wellbeing programme with a wide variety of interventions to support the emotional, physical and financial health of staff. This ranged from comfort packs, pop up shops for essential goods and hotel accommodation at the outset of the pandemic through to additional counselling provision, mental health first aid training, emotional resilience support, online exercise and meditation classes and an employee assistance programme including debt management.

We have been very fortunate to have received national and local charity funds that have enabled us to improve the psychological support for staff and introduce health checks specifically for our BAME staff. Through the Project Wingman initiative, First Class lounges were established at our two main hospital sites, to enable staff to have a break with refreshments and access to a listening ear from highly skilled volunteers from the airline industry. Over 4,000 staff accessed this service and its popularity has led to its continuation, albeit on a scaled down basis.

Frontline clinical services particularly affected during the pandemic, have had access to our Listening Ear volunteers, trained through our staff mental health first aid programme. This has supplemented our counselling and chaplaincy services who have also been actively supporting the pastoral care of our staff.

At the outset of the pandemic a trust-wide workforce hub was established. The use of the Trust's electronic rostering systems enabled the capture of absence in real time enabling the workforce hub to assess the impact on skills and capacity and therefore manage the rapid and safe deployment of staff. At a trust wide level, this informed the decisions of the incident control command. The role of the hub was extended to manage staff testing through the hospitals' testing pods. This provided same day testing facilities for staff and their families, immediate advice to manage and mitigate the risks and enabled the trust to manage immediate and future workforce capacity.

Throughout 2020/21 we have been undertaking and reviewing risk assessments for staff, volunteers, bank and agency workers with higher risk factors if exposed to Covid 19. This has been a dynamic process and enabled us to manage the safe deployment of staff at all times. During the peak of the pandemic circa 600 staff were absent from work, including 200 who were shielding.

Workplace assessments were completed for all areas of the Trust and appropriate safety measures taken in line with Infection, Prevention and Control guidance. This included the designation of clinical areas for covid and non-covid patients (red and green zones), the supply and issue of Personal and Protective Equipment (PPE), hand sanitizer and wipes, screens and

barriers and ensuring the national public health messages were promoted and enforced.

Every member of staff was issued with a lateral flow kit to enable home self testing and since December 2020, an extensive programme for the roll out of a Covid-19 vaccination has been in place, with over 96% uptake. This roll out followed the seasonal influenza programme that takes place annually.

In September 2020 we reviewed our staff appraisal processes and strengthened the staff welfare component to enable managers to focus on this aspect of work, signposting to other services where appropriate. This will continue to be a feature of appraisal as we return to business as usual and restore services.

Throughout 2020/21, the Trust Board, through its sub-committees, has been kept informed and updated on the health, safety and wellbeing of staff. This is a strategic risk for the Trust and how it is managed and mitigated is regularly reviewed through the Board Assurance Framework.

2.3.4 Sickness absence

Sickness absence has continued to be monitored and appropriately managed throughout the year. Sickness rates are reported monthly as a percentage of absence in month and as a 12 month rolling rate. This highlights the seasonal fluctuations that occur month on month but also whether improvement is being made.

During 2020/21, the 12 month rolling rate reduced by 0.2% to 3.2%. The percentage of short term sickness reduced by 1% to 1.1% and long term sickness also reduced from 1.7% to 1.1%. There has been significant improvement in the sickness rates across all the divisions but particularly within the Estates and Facilities and Women and Children's divisions.

The Trust's sickness absence data can be found on NHS Digital's publication series on NHS Sickness Absence Rates. This can be found at [NHS Sickness Absence Rates - NHS Digital](#)

Sickness absence rates do not include covid-related absence which is monitored and reported separately.

The health and wellbeing and impact on staff absence will continue to be a priority for 2021/22. Interventions and programmes will continue to be in place to support staff as they recover from the impact of the pandemic.

2.3.5 Improving staff engagement

Improving staff engagement is the strategic objective for the People domain of Patient First and it is the Trust's aim to become the top performing acute trust.

2020/21 has required different approaches to staff engagement to be adopted. Our traditional trust-wide face to face events (staff conference, thank you lunches, awards ceremonies) and leader gemba walks (visiting clinical and other areas) etc had to be suspended. This also extended to face to face training where staff participated in a local 'pulse' survey that mirrored the staff engagement questions contained in the national staff survey.

However, the introduction and extensive use of MS Teams across the organisation provided an opportunity to engage with staff more widely. Weekly Executive-led briefings were held throughout the year to update staff on the impact of the pandemic on the hospitals and how this was being managed. This was supplemented with preparations in readiness for the Trust's planned merger with Brighton and Sussex University Hospitals NHS Trust from 1 April 2021. The use of technology has enabled staff to engage on important topics and to post questions of importance to them. 'Live' attendance at the weekly briefings now exceeds circa 1,000 participants and provides a platform for staff unable to attend to catch up on the events at a later date.

A series of workshops and surveys with staff in the autumn informed the development of a set of refreshed organisational values for University Hospitals Sussex NHS Foundation Trust and the People Strategy for 2021/22.

Staff engagement, as measured through the annual staff survey, was 7.2 (out of 10) in 2020. In particular staff advocacy about the trust as a place to work improved by 1% to 76% and as a place to receive care and treatment by 2% to 84%. Given the context within which the staff survey was conducted (Sep-Dec 2020), this is very encouraging.

The Trust also engages with its recognised trade union and staff side representatives both informally and formally through its Employee Partnership Forum and Joint Local Negotiating Committee. We have developed a good relationship with our staff side colleagues over the years and our approach is early engagement and resolution on matters of concern.

In readiness for the Trust's merger in April 2021, separate arrangements have also been in place to engage, consult and prepare for the TUPE transfer of staff from Brighton and Sussex University Hospitals including jointly run workshops on the transfer.

2.3.6 Staff survey 2020

The annual staff survey was conducted wholly on-line during 2020. Whilst this presented challenges to some staff groups, the response rate remained high

at 53%. This compares to the new benchmark group extended to include Acute and Community Trusts, of 45%.

Table 3: 2020 staff survey results

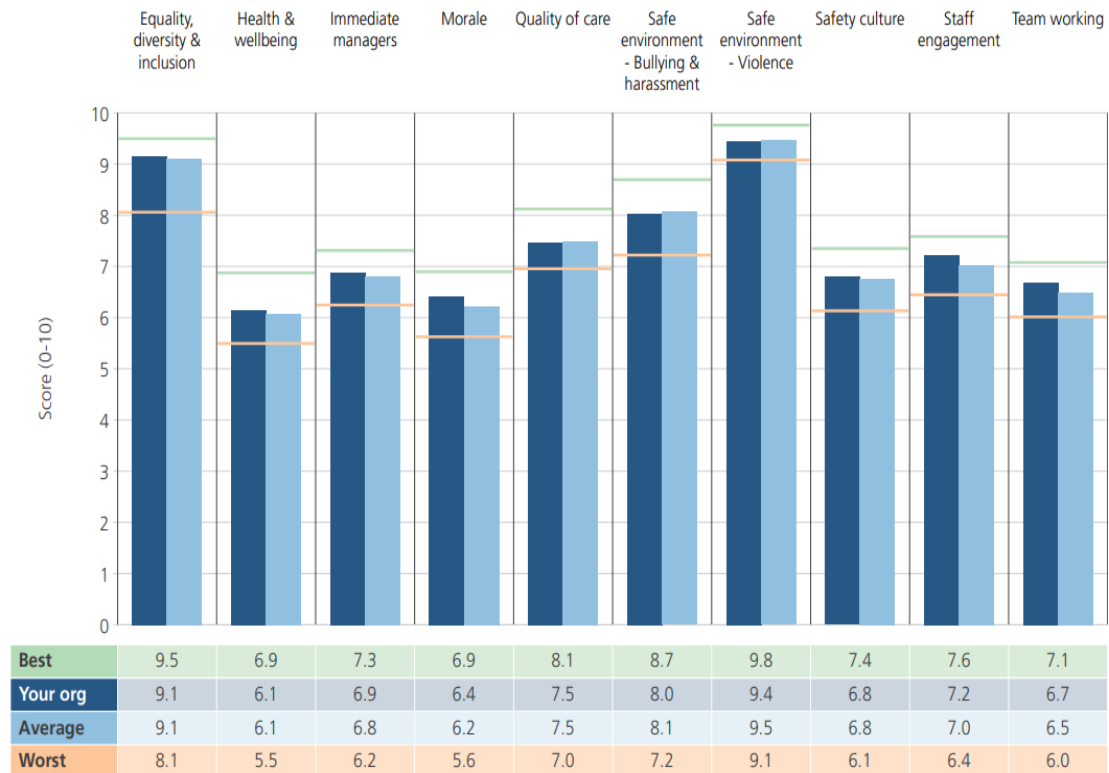


Table 3 shows that the Trust was above average in four of the ten categories:

- Immediate managers
- Morale
- Staff engagement
- Team Working

However, improvement in the Safe Environment categories (bullying and harassment and violence) is still required. This is also reflected in the WRES and WDES data set out in section 2.3.1 above.

The staff survey results are used to inform workforce priorities for 2021/22.

2.3.7 Staff Turnover

Staff Turnover in the Trust is low and fell from 6.8% in 2019 to 5.9% in 2020. This is one of the lowest in the NHS and reflects the high level of staff satisfaction. Nursing turnover rates are also good at 5.1%.

Turnover is higher in our Core division (7.3%) where postholders in post-registration band 5 roles seek improved career opportunities or specialist roles

elsewhere. Retention strategies in place, particularly for therapies, has improved the position and it is expected to improve further as a larger Trust.

Noting the potential impact of the pandemic on staff retention in the longer term, staff turnover will continue to be one of the key performance indicators used to measure of the success of our strategies.

Further information can be obtained at [NHS workforce statistics - NHS Digital](#)

2.3.8 Process applied to support Learning and development

At Western Sussex Hospitals NHS Foundation Trust we aim to foster an inclusive culture of education, training and development for all staff and are particularly proud of the career progression pathways we offer. We have team of staff dedicated to supporting individuals' development including qualified nurse teachers and researchers.

We have established partnerships with a number of education providers including the Universities of Surrey and Brighton who provide learning and development opportunities for healthcare professionals. During 2020/21 a number of Year 2 and Year 3 students were supported to work in the organisation in paid roles to strengthen workforce capacity as universities suspended or postponed studies.

The Trust receives non-medical educational funding from Health Education England and during 2020/21 this was used to support the Continuous Professional Development (CPD) of registered nurses and allied health professionals; advancing clinical practice and the development of new workforce roles.

During 2020/21, the Trust has worked very closely with the University of Chichester supporting them in their application to provide a Nursing Degree programme starting in September 2021. Subject to NMC validation, recruitment is going well and a large number of local applications have been received. Further investment in a clinical skills simulation suite at St Richards Hospital is also planned to support this initiative.

Last year the Trust had 259 staff enrolled on an apprenticeship qualification or as an apprentice. This included 217 clinical apprenticeships with 27 undertaking a level 6 (degree) qualification and a further 7 undertaking a level 7 (masters) qualification. 40 staff are completing their 2-year trainee nurse associate apprenticeships with 13 having completed since 2018.

Our speciality programmes aim to produce high-quality clinicians with a broad range of skills that will enable them to practice as Consultants across the United Kingdom.

Attendance on statutory and mandatory training was impacted by the pandemic as face to face training was stopped. Whilst on-line training has remained available, capacity to attend has been challenged and compliance has fallen to 82%. Recovery to 90% is anticipated by June 2021.

2.3.9 Health and safety

Health and safety compliance at Western Sussex Hospitals NHS Foundation Trust is managed by the Risk (Non-Clinical) Team and monitored at Board level by the Health and Safety Committee on a quarterly basis which reports to the Quality Assurance Committee. A Health and Safety Report is also published annually and made available to staff via along with the Policy for the Management of Health, Safety and Risk.

The Health and Safety Committee reviews reports, policies and accident data on issues relating to the following areas of health and safety: fire, manual handling, security, training, estates and facilities, occupational health, staff incidents, stress, radiation protection and non-clinical risk management.

Health and safety incidents are logged on the Trust's Datix incident reporting system, while risk assessments around issues such as dangerous substances, display screen equipment, fire and manual handling tasks are carried out using the Safety, Health and Environment (SHE) software package.

Health and safety training is mandatory for all staff on induction and then on a triennial cycle.

2.3.10 Fraud, bribery and corruption statement

Western Sussex Hospitals NHS Foundation Trust is committed to eliminating fraud and corruption within the NHS, freeing up public resources for better patient care. To this end, the Trust employs a specialist counter-fraud service to provide a comprehensive programme against fraud and corruption which is overseen by the Trust's Audit Committee.

All anti-fraud and corruption legislation is complied with. It is a criminal offence to give, promise or offer a bribe, and to request, agree to receive, or accept a bribe. A bribe may take the form of any financial or other advantage to another person in order to induce a person to perform improperly.

Although the Bribery Act permits hospitality, all staff are required to consider on an individual basis whether accepting any hospitality offered is appropriate

and should they then elect to take it, to record it within the Trust's Hospitality register (in line with the Receipt of Hospitality, Gifts and Inducements Policy) so that it has been fully disclosed.

It is also important that all of our contractors and agents comply with our policies and procedures.

When entering into contracts with organisations the Trust follows the NHS standard terms and conditions of contract for the purchase of goods and supplies.

We ask all who have dealings with the Trust, as employees, agents, trading partners, stakeholders and patients, to help us in our fight against fraud and corruption and to contact the counter-fraud service in confidence if they have any concerns or suspicions.

We have maintained across 2020/21 our increased our anti-fraud surveillance work that commenced at the start of Covid-19 pandemic recognising the increased pressure the Trust is under and recognising the intelligence provided by the NHS Counter Fraud Authority who through the Local Counter Fraud Specialist provide regular and frequent anti-fraud bulletins.

2.3.11 Exit packages

There were two exit packages in 2020/21 in the range of £50,001 - £100,000 (There was one in 2019/20 in the range £0 to £10,000)

2.3.12 Off-payroll engagements

The Trust did not make any off-payroll engagements in the financial year.

2.3.13 Trade Union Facility Time

Our relationship with our trade unions is a key tenant of our employee relations strategy and we work hard to foster a strong partnership where areas of concern are identified and we pay attention to resolution and learning.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 with further guidance provided by the Cabinet Office require the Trust to disclose the amount of facility time undertaken by trade union officials.

The table below relates to the period 1 April 2020 to 31 March 2021 and the Trust is required to publish this information annually by the 31 July each year.

Table 1 - Relevant Union Officials	
Number of employees who were relevant union officials during the relevant period 2020/21 (2019/20)	Full-time equivalent employee number 2020/21 (2019/20)
28 (34)	22.52 (23.53)

Table 2 - Percentage of time spent on facility time	
How many employees who were relevant union officials employed during the relevant period spent their working hours on facility time	
Percentage of time	Number of employees 2020/21 (2019/20)
0%	16 (22)
1%-50%	12 (12)
51%-99%	0
100%	0

Table 3 - Percentage of pay bill spent on facility time	
The percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period 2020/21 (2019/20)	
Total cost of facility time	£1,933.71 (£19,878)
Total pay bill	£360,874,000 (£315,821,331)
Percentage of the total pay bill spent on facility time	0.0% (0.0%)

Note due to the pandemic there has been considerably less training and courses which has driven a reduced costs in 2020/21

Table 4 - Paid trade union activities
Time spent on paid trade union activities as a percentage of total paid facility time hours 2020/21 (2019/20)
34.22% (32.61%)

2.3.15 Statement on social responsibility

WSHFT reflects its social responsibility within the way it undertakes its business, this is from the recruitment, retention and development of our staff as noted within this report in respect of our equality, diversity and inclusion work through to way we deliver of services making them accessible and environmentally sustainable again as detailed within this report through to our wider responsibility to work with our partners with regard to our responsibilities under safeguarding to protect our patients and their families and careers.


.....

14 June 2021

Dame Marianne Griffiths, Chief Executive

2.4 Remuneration Report

2.4.1 Annual statement on remuneration

It is the responsibility of the Appointment and Remuneration Committee of Non-Executive Directors to oversee the pay arrangements of Executive Directors and Very Senior Managers, details of the committee can be found within the 'How the Trust is Run' section of this report. During the period of this report there have been no substantial changes to the base salary of Senior Managers.

2.4.2 Senior Managers Remuneration Policy

All Directors' performance is subject to an annual appraisal the outcome of which is reported to the Appointment and Remuneration Committee by the Chief Executive. This is prior to any decision being made on Executive remuneration.

For the Chief Executive Officer, their appraisal is undertaken by the Chair of the Trust with a report then submitted to the Committee.

The annual appraisal method is chosen as it is an effective way to assess performance against a range of performance targets and leadership responsibilities and includes feedback from Non-Executive Directors and peers as part of a 360 degree feedback process.

In coming to any decision on remuneration, the Committee takes account of the circumstances of the Trust, the size and complexity of the role, any changes in the Directors portfolio, the performance of the individual and any appropriate national guidance. Senior managers are remunerated based on these decisions. Any performance related pay award by the Committee is within the context of the NHS Very Senior Managers Pay Framework.

In considering Senior Managers Pay the Committee took note of national benchmark data provided by NHS Providers and the requirement to consider any pay above a threshold of £150,000 as per Cabinet Office guidance.

2.4.3 Future policy table

Please see in the following table details of the components of the remuneration package for senior managers. This is made up of;

Components of Senior Managers remuneration:
Base Salary
Performance related pay (where appropriate).

Base salaries are set in line with market information and are designed to ensure retention, or recruitment, of the calibre and experience required to deliver the aims of the Trust. Salaries are revised annually and uplifted only if:

- There is demonstrable evidence that an uplift is required to keep in line with the market
- A change in portfolio necessitates an uplift

The performance related pay scheme is based on the NHS Pay framework for Very Senior Managers. The Appointment and Remuneration Committee would, annually, consider whether the overall performance of the Trust warrants consideration of a performance related element being paid and if so the parameters of such an award.

2.4.4 Service contracts obligations and Policy on payment for loss of office

HM Treasury has issued specific guidance on severance payments within 'Managing Public Money' and special severance payments when staff leave requires Treasury approval.

All contracts are permanent with no fixed end date. There are no contractual provisions for payments on termination of contract.

The table below shows the date of contracts and notice periods.

Name	Title	Date of Contract	Notice period from the Trust	Notice period to the Trust
Mrs Marianne Griffiths	Chief Executive	01/04/2009	6 months	6 months
Mr Peter Landstrom	Chief Delivery and Strategy Officer	18/04/2016	6 months	6 months
Mrs Karen Geoghegan	Chief Financial Officer	01/02/2014	6 months	6 months
Mrs Maggie Davies	Chief Nurse	01/05/2019	6 months	6 months
Mrs Denise Farmer	Chief Organisational Development Director	03/02/2020	3 months	3 months
Dr George Findlay	Chief Medical Officer and Deputy Chief Executive	27/01/2014	6 months	6 months
Mrs Fiona Ashworth	Chief Operating Officer	01/01/2020 to 30/9/2020	6 months	6 months
Mr Gethin Hughes	Interim Chief Operating Officer	01/10/2020	6 months	6 months

2.4.5 Statement of consideration of employment conditions elsewhere in the Foundation Trust

In considering any decision on remuneration the Committee takes note of both the organisational and national context, and as described in section 2.4.3 national NHS (market) benchmarking provided from sources including NHS Providers.

2.4.6 Salary and pension entitlements of senior managers (subject to audit)

Remuneration 2020/21

	Salary Bands of £5,000 a	Total expenses Nearest £100 b	Bonus Bands of £5,000 c	L/term bonus Bands of £5,000 d	Pension Benefit* Bands of £2,500 e	Total Bands of £5,000 f	Western Sussex Hospitals Remuneration Bands of £5,000 g
Marianne Griffiths Chief Executive	270 - 275	14	20 - 25	-	25 - 27.5	320 - 325	145 - 150
George Findlay Chief Medical Officer	215 - 220	8	-	45 - 50	57.5 - 60	325 - 330	130 - 135
Karen Geoghegan Chief Financial Officer	190 - 195	-	5 - 10	-	82.5 - 85	280 - 285	100 - 105
Denise Farmer Chief Workforce Officer	125 - 130	58	5 - 10	-	-	135 - 140	65 - 70
Peter Landstrom Chief Delivery and Strategy Officer	160 - 165	39	5 - 10	-	32.5 - 35	200 - 205	85 - 90
Maggie Davies Chief Nurse	135 - 140	7	5 - 10	-	20 - 22.5	160 - 165	140 - 145
Gethin Hughes Chief Operating Officer (from October 2020)	60 - 65	-	-	-	Not Available	60 - 65	60 - 65
Fiona Ashworth Chief Operating Officer - WSHT (April 2020 to September 2020)	125 - 130	1	-	-	N/A	125 - 130	125 - 130
Alan McCarthy Chairman	70 - 75	4	-	-	-	70 - 75	55 - 60
Patrick Boyle Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15
Joanna Crane Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15
Jonathan Furnsten Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15
Elizabeth Peers Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15
Michael Rymer Non-Executive Director	10 - 15	5	-	-	-	10 - 15	10 - 15
Kirsten Baker Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15
Lilian Philip Non-Executive Director (from May 2020)	5 - 10	-	-	-	-	5 - 10	5 - 10

The Non-Executive Director remuneration disclosed in this table is that which is incurred and paid directly by Western Sussex Hospitals NHS Foundation Trust. Several Non-Executive Directors are also paid directly by Brighton and Sussex University Hospitals NHS Trust (BSUH) for separate services to BSUH and this is disclosed within BSUH Annual Report.

Pension Entitlements as at 31 March 2021

	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2021 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021 (nearest £1,000)	Cash Equivalent Transfer Value at 31 March 2020 (nearest £1,000)	Real increase in Cash Equivalent Transfer Value (nearest £1,000)	Employer's contribution to Stakeholder Pension
Marianne Griffiths Chief Executive	2.5 - 5	7.5 - 10	55 - 60	165 - 170	0	1,288	0	Nil
George Findlay Chief Medical Officer	2.5 - 5	-	70 - 75	135 - 140	1,361	1,249	91	Nil
Karen Geoghegan Chief Financial Officer	2.5 - 5	0 - 2.5	70 - 75	155 - 160	1,377	1,269	86	Nil
Denise Farmer Chief Workforce Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter Landstrom Chief Delivery and Strategy Officer	2.5 - 5	-	35 - 40	60 - 65	523	479	37	Nil
Maggie Davies Chief Nurse	0 - 2.5	2.5 - 5	40 - 45	125 - 130	926	856	56	Nil
Gethin Hughes Chief Operating Officer	Not Available	Not Available	35 - 40	60 - 65	531	Not Available	Not Available	Nil
Fiona Ashworth Chief Operating Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Notes:

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 provides further information on the pension benefits accruing to the individual.'

As set out in paragraph 8(3) of the Regulations, where the calculations of any of these columns result in a negative value (other than in respect of a recovery or withholding), the result is expressed as zero in the relevant column in the table.

"a" is salary and fees (in bands of £5,000)

"b" is all taxable benefits (total to the nearest £100)

"c" is annual performance-related bonuses (in bands of £5,000)

“d” is long-term performance-related bonuses (in bands of £5,000). The long term performance bonus for George Findlay relates to a national Clinical Excellence Award

“e” is all pension-related benefits (in bands of £2,500). As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. Information on accrued pension benefits is provided by the NHS Pensions Agency

“f” is the total of items “a” to “e” (in bands of £5,000).

“g” On 1st April 2017, the Trust (WSH) entered into a long-term agreement with NHS Improvement and Brighton and Sussex University Hospitals NHS Trust (BSUH). This agreement provides for collaboration between the Trusts, including arrangements for board membership and governance in common, as well as the provision of management support to BSUH by WSH. The initial term of this agreement is for three years. Contracts for employment continue to be held by Western Sussex Hospitals NHS Foundation Trust. The remuneration disclosed in columns “a” to “f” therefore includes the remuneration in respect of duties undertaken in relation to BSUH. Column “g” shows the element of remuneration (excluding pension) that relates to duties undertaken in relation to WSH. Pension benefits include benefits accrued as a result of total pension in the pension scheme and not just service in a senior capacity to which disclosure applies. Pension benefits are therefore not able to be split between BSUH and WSH roles. A more detailed analysis of the components of remuneration (excluding pension) directly relating to WSH are summarised below:

Trust Splits i.e. Directly relating to Western Sussex Hospitals NHS FT

	Salary	Total expenses	Bonus	L/term bonus	Total
	Bands of £5,000	Nearest £100	Bands of £5,000	Bands of £5,000	Bands of £5,000
Marianne Griffiths Chief Executive	135 - 140	7	10 - 15	-	145 - 150
George Findlay Chief Medical Officer	105 - 110	4	-	20 - 25	130 - 135
Karen Geoghegan Chief Financial Officer	95 - 100	-	0 - 5	-	100 - 105
Denise Farmer Chief Workforce Officer	60 - 65	29	0 - 5	-	65 - 70
Peter Landstrom Chief Delivery and Strategy Officer	80 - 85	19	0 - 5	-	85 - 90
Alan McCarthy Chairman	55 - 60	3	-	-	55 - 60

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 accumulated benefits and any contingent spouse'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 disclosure applies. The CETV figures and the 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. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Total Pension Entitlement

Normal retirement age for the NHS Pension Scheme is either 60 (for members in the 1995 scheme) or 65 (for members in the 2008 scheme). On retirement members receive their accrued pension and members in the 1995 scheme receive a lump sum equal to three times their annual pension. Members may choose to retire from work before their normal pension age and draw their benefits although these will be reduced because they will be paid earlier than expected. Further information about scheme rules and entitlements is available from <http://www.nhsbsa.nhs.uk/pensions>.

Remuneration 2019/20

	Salary Bands of £5,000 a	Total expenses Nearest £100 b	Bonus Bands of £5,000 c	L/term bonus Bands of £5,000 d	Pension Benefit* Bands of £2,500 e	Total Bands of £5,000 f	Western Sussex Hospitals Remuneration Bands of £5,000 g
Marianne Griffiths Chief Executive	265 - 270	76	20 - 25	-	17.5 - 20	320 - 325	150 - 155
George Findlay Chief Medical Officer	190 - 195	272	-	45 - 50	2.5 - 5	270 - 275	130 - 135
Karen Geoghegan Chief Financial Officer	190 - 195	7	5 - 10	-	42.5 - 45	245 - 250	100 - 105
Denise Farmer Chief Workforce Officer	145 - 150	112	5 - 10	-	-	160 - 165	80 - 85
Peter Landstrom Chief Delivery and Strategy Officer	155 - 160	59	5 - 10	-	25 - 27.5	195 - 200	85 - 90
Nicola Ranger Chief Nurse (to 30th June 2019)	45 - 50	48	5 - 10	-	Not available	60 - 65	30 - 35
Maggie Davies Chief Nurse (from 1st May 2019)	120 - 125	28	-	-	Not available	125 - 130	125 - 130
Jayne Black Chief Operating Officer	155 - 160	1	5 - 10	-	185 - 187.5	350 - 355	5 - 10
Amanda Fadero Managing Director - WSHT (to September 2019)	80 - 85	28	-	-	Not available	85 - 90	85 - 90
Fiona Ashworth Chief Operating Officer - WSHT (from January 2020)	35 - 40	-	-	-	Not available	35 - 40	35 - 40
Alan McCarthy Chairman	70 - 75	23	-	-	-	70 - 75	55 - 60
Patrick Boyle Non-Executive Director	10 - 15	15	-	-	-	10 - 15	10 - 15
Joanna Crane Non-Executive Director	10 - 15	14	-	-	-	10 - 15	10 - 15
Jonathan Furnsten Non-Executive Director	10 - 15	4	-	-	-	10 - 15	10 - 15
Elizabeth Peers Non-Executive Director	10 - 15	13	-	-	-	10 - 15	10 - 15
Michael Rymer Non-Executive Director	10 - 15	19	-	-	-	10 - 15	10 - 15
Kirsten Baker (from July 2019) Non-Executive Director	5 - 10	-	-	-	-	5 - 10	5 - 10
Martin Sinclair (to June 2019) Non-Executive Director	0 - 5	-	-	-	-	0 - 5	0 - 5

Pension Entitlements as at 31 March 2020

	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019 (nearest £1,000)	Cash Equivalent Transfer Value at 31 March 2018 (nearest £1,000)	Real increase in Cash Equivalent Transfer Value (nearest £1,000)	Employer's contribution to Stakeholder Pension
Marianne Griffiths Chief Executive	2.5 - 5	7.5 - 10	50 - 55	155 - 160	1,288	1,169	91	Nil
George Findlay Chief Medical Officer	0 - 2.5	-	65 - 70	135 - 140	1,249	1,183	38	Nil
Karen Geoghegan Chief Financial Officer	2.5 - 5	-	65 - 70	150 - 155	1,269	1,169	72	Nil
Denise Farmer Chief Workforce Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Peter Landstrom Chief Delivery and Strategy Officer	2.5 - 5	-	30 - 35	60 - 65	479	437	31	Nil
Nicola Ranger Chief Nurse	Not available	Not available	50 - 55	155 - 160	1,155	Not available	Not available	Nil
Maggie Davies Chief Nurse	Not available	Not available	40 - 45	120 - 125	856	Not available	Not available	Nil
Amanda Fadero Managing Director	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Nil
Fiona Ashworth Chief Operating Officer	Not available	Not available	55 - 60	175 - 180	1,432	Not available	Not available	Nil

* Cash Equivalent Transfer value as at 31st March 2017 has been restated to include benefits from the 2015 Pension Scheme that were incorrectly excluded from the 2016/17 annual report

Fair Pay Multiple (median pay) (subject to audit)

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

The banded remuneration of the highest paid director in the financial year 2020/21 was £290k - £295k (2019/20: £290k - £295k). This was 11 times (2019/20: 10) the median remuneration of the workforce, which was £27.7k (2019/20: £29.5k).

In 2020/21, no employees (2019/20: nil) received remuneration in excess of the highest-paid director. Remuneration ranged from £6k to £267k (excluding

the highest-paid director (2019/20: £12k to £263k excluding highest-paid director).

The banded salary referenced above includes the total remuneration paid for roles undertaken at Western Sussex Hospitals and Brighton and Sussex University Hospitals. Taking into account only that part of the director remuneration that relates to Western Sussex Hospitals, the banded remuneration of the highest paid director is £145 - £150k, This was 5 times the median remuneration of the workforce and in 2020/21, 43 employees received remuneration in excess of this.

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


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14 June 2021

Dame Marianne Griffiths, Chief Executive

2.5 Regulatory ratings

The Trust is assessed under NHS Improvement's Use of Resources Rating. Financial risk is covered under the Financial Sustainability Risk Rating which is driven by a range of financial metrics. The highest rating that can be achieved is 1. A score of 2 indicates no significant financial concerns. The Trust was rated at 1 for each of the quarters during 2020/21.

2.6 Statement of Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Western Sussex 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 Western Sussex 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 Western Sussex 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 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 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

Signed.....

Dame Marianne Griffiths, Chief Executive 14 June 2021

2.7 Annual Governance Statement for the period 1 April 2020 to 31 March 2021

1. Scope of responsibility

1.1 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.

1.2 The Trust's Standing Orders and Scheme of Delegated Authority outline the accountability arrangements and scope of responsibility of the Board of Directors ('the Board'), Executive Directors and Trust officers.

1.3 The Board receives regular reports from each of the nominated Committees that report into it. The terms of reference of the Committees of the Board are regularly reviewed to ensure that governance arrangements continue to be fit for purpose.

1.4 The Trust works in close partnership with other Health and Social Care organisations in the area, but notably with the Coastal West Sussex Clinical Commissioning Group. In addition, the Trust attends the West Sussex County Council Health and Adult Social Care Scrutiny Committee.

1.5 Merger with Brighton and Sussex University Hospitals NHS Trust

1.6 Western Sussex Hospitals NHS Foundation Trust continued with the management contract arrangements with Brighton and Sussex University Hospitals NHS Trust. These arrangements are formalised within an agreement between both the Trusts and NHS Improvement for an initial period of three years from 1 April 2017 to 31 March 2020, which has been extended to 31 March 2021.

1.7 The Board and Council of Governors agreed to merge with Brighton and Sussex University Hospitals NHS Trust under section 56a of the NHS Act 2006. As part of the merger preparedness the Board agreed a revised Board Governance structure seeing the Board committees aligned to the Trust's patient first domains of patient, quality, people, sustainability and systems & partnerships. This alignment will give a more efficient route for the flow of assurance from the operational areas of the Trust to the Board over the delivery of the Trust's stated objectives, vision and values.

1.8 As part of this work revised Committee terms of reference, scheme of delegation, and the Trust's constitution were developed and approved by the Board and the Constitution was also approved by Council of Governors. The Standing Financial Instructions for the legacy Trusts were aligned and approved in 2019 thus ensuring there is a sound system of internal control and assurance oversight established for the enlarged Foundation Trust.

2. The purpose of the system of internal control

2.1 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 Western Sussex 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 Western Sussex Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 Trust Board

3.2 The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors. The Board of Directors recognise that risk management is an integral part of good management practice and to be most effective should be embedded in the Trust's culture. This recognition is embodied within the Strategy and Policy as this documents the Board's risk appetite and the processes applied across the Trust which see the oversight of the Trust's key risks assigned to a Board Committee with each key risk have an named executive lead. The Board is committed to ensuring that risk management is embedded as part of the Trust's philosophy, practice and planning and is not viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

3.3 The Board recognised the continued challenges facing the Trust as it manages the Covid-19 pandemic and maintained its proactive adaptation of its Board and Committee Governance processes which had commenced at the end of 2019/20. These changes have seen the continued provision of updates on Covid-19 at each Board meeting, the maintenance through the Quality Assurance Committee meetings on the review of quality in line with the Board's risk appetite. There has been a continued use of technology to deliver both Committee and Board meetings. Supporting the Board meetings there is a regular information flow to all Board members including the Non Executives to ensure they are aware of any issues and actions taken to

address these. Within the second wave of the pandemic these were enhanced with regular Board (NED) briefings from the Chief Executive complemented by wider Executive updates from the Executive Gold meetings. The information flow to the Board Members is provided from the bronze, silver and gold command structure established to oversee the development and delivery of the Trust Covid-19 incident response plan.

3.4 Board Committees

3.5 The Audit Committee has overall responsibility for ensuring effective risk management across the Trust. The Audit Committee receive information annually from the Trust's internal auditors and from its own review of the Trust's Board Assurance Framework and through this work supports the Board to be assured over the robustness of the Trust's application of sound risk management processes. To enable the Audit Committee to fulfil its role one Non Executive Member sits on each of the other Board Committees providing a clear link to and from the Audit Committee's oversight of the Board Assurance Framework and the work undertaken in each Committee in respect of the key risks they have assigned oversight for.

3.6 The other key Board Committees of Finance & Performance and Quality Assurance regularly receive and consider the strength of assurance reflected within the Board Assurance Framework and the actions being taken to manage risks that are outside the Board's stated risk appetite. Each Committee reports the outcome of their review of the Board Assurance Framework to the next Board meeting.

3.7 The Board has developed its Committee structure for 2021/22 with the establishment of the five Patient First thematic committees of Patient, Quality, People, Sustainability and Systems & Partnerships. Each Committee will report to the Board after their meetings continuing to provide assurance aligned to the Trust Board Assurance Framework complementing the Board's Integrated Performance Report.

3.8 Non-Executive Directors

3.9 All Committees are chaired by a nominated Non-Executive Director. The Audit Committee who play a pivotal role in providing assurance over the risk management processes of the Trust has a membership of only Non-Executive Directors. Through the Non-Executive Chairs and the Audit Committee membership all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control. This Non-Executive Director Committee chair membership of the Audit Committee continues into the enlarged Trust.

3.10 The Audit Committee maintains an overview of the Board Assurance Framework complementing the work of the other two Committees and through the receipt of both management assurance and assurance from Internal Audit

that the underpinning risk management processes operated within the Trust remained effective.

3.11 *Chief Nurse*

3.12 The Chief Nurse is responsible for the strategic development and implementation of organisational risk management system and ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) Registration legal requirements.

3.13 The Chief Nurse is also responsible for managing patient and non-patient safety, complaints, patient experience and medical legal matters.

3.14 *Chief Finance Officer*

3.15 The Chief Finance Officer oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud.

3.16 The Chief Finance Officer and the Trust Finance Director attend the Trust's Audit Committee and both liaise with internal audit, external audit and counter fraud services, who undertake programmes of audit with a risk based approach.

3.17 *Risk Management Training and Learning*

3.18 Risk management training forms part of the essential training package that all staff are required to complete. All new members of staff attend a mandatory induction covering key elements of risk management, supplemented by local induction. The organisation provides mandatory and statutory training that all staff must attend.

3.19 The Trust has established a culture of learning, through the work on the implementation of national clinical standards, the delivery of improvements flowing from local and national clinical audits and the focus on learning from all incidents. The reporting of this work flows to the Board through the work of the Quality Assurance Committee and from reports directly to the Board. This allows the Board to see the positive impact that the improvements from this learning has on the Trust's risk profile.

4. The risk and control framework

4.1 The Board of Directors has established a robust corporate governance framework which is detailed within the Annual Report section 'How the Trust is run'. The corporate governance structure is designed to ensure appropriate

oversight and scrutiny and to ensure good corporate governance practice is followed.

4.2 In support of the Trust's corporate governance processes the Trust continues to apply its clinical divisional governance processes. Each Clinical Division is led by a triumvirate of a Divisional Director of Operations, a Chief of Service and a Head of Nursing. Each division reports through the Quality Board to the Board's Quality Assurance Committee.

4.3 The Trust has a Risk Management Strategy that was updated in 2020, with this review confirming the stated Trust's risk appetite and the Trust's processes for identifying, reporting and managing risk.

4.4 Risk management training forms part of the essential training package that all staff are required to complete. All new members of staff attend a mandatory induction event which covers key elements of risk management.

4.5 Risks are raised and captured to a central risk management database known as Datix.

4.6 All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with appropriate Trust policies. Local management teams oversee local risk registers and the management and escalation, as appropriate, of risks.

4.7 The Trust has an established Board Assurance Framework (BAF), through which the Board is provided with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of principal objectives are at risk due to a gap in control and/or assurance.

4.8 The BAF records that the Trust has been managing 13 significant risks, and at the year end the Trust had three highly scored key risks remaining, these related to:

- Being unable to deliver ongoing efficiencies and flex our resources in an agile way resulting in an increasing or unmanaged deficit and inefficient, unaffordable and unsustainable services;
- Being unable to consistently meet the health, safety and wellbeing needs of our staff as we recover and restore services in line with Covid-19 restrictions; and
- Being unable to deliver and demonstrate consistent compliance with operational and NHS constitutional standards resulting in an adverse

impact on patient care and financial penalties and the Trust's reputation and the reputation of the Trust.

4.9 For each of these risks there is a detailed series of actions which will continue through 2021/22. The delivery of these actions and the impact on these risks is monitored through the appropriate oversight Committee of the Board.

4.10 The Trust took action during the year which saw its BAF financially related risk reduce but the risk relating to the Trust's ability to flex its resources did not reduce to the same level reflecting the level of uncertainty over the demands on the Trust to deal with the Covid-19 pandemic and the changing financial framework the NHS is subject too.

4.11 The Trust has taken a number of actions to enhance its processes to support the wellbeing of its staff. However, given the relentless pressure the pandemic has placed on the Trust's services and the prolonged period of the national incident the Trust has assessed the long term risk to staff wellbeing as increasing. The Board with the establishment of a dedicated People Committee will track the effectiveness of its plans to mitigate this risk alongside receiving direct information from staff feedback / surveys on the efficacy of the wellbeing programmes developed to support the Trust's staff.

4.12 During the year in respect of the compliance with regard to the key constitutional targets the Trust took action and has prioritised the treatment of patients according to their clinical needs. Like the majority of NHS providers, the Trust has taken action to support the NHS and the Country with their measures to deal with Covid-19 which has impacted on the Trust's ability to reduce further this risk.

4.13 During 2020/21 the Trust has responded positively to the national requirements placed on it with regards to countering Covid-19. The Trust has been supported through the established bronze, silver and gold incident control processes which include a robust process for the capturing of issues and risks and the follow through on actions to mitigate these. These processes were considered by Internal Audit to be robust and effective and have placed the Trust in a strong position to adapt its control environment to respond to the changing nature of the county's and national health service response to Covid-19.

Processes for Managing Cyber Security Risk

4.14 We have now deployed NHS Digital's Microsoft Advanced Threat Protection across both the client devices estate, and also now, the server estate of the Trust. This solution allows us to actively monitor the devices on our network and have very early detection of any malware or other cyber threats that enter our estate. We monitor this on a daily basis which has

allowed us to catch viruses and malware, isolate the machine in question and take the steps needed to remove the threat before any damage occurs. We also continue to act on every National CareCERT alert that we receive and update NHS Digital of our actions and progress.

4.15 We have deployed two new Cyber Security related solutions across the WSHFT estate during 2020.

- i) The ITHealth Dashboard uses an agentless design to monitor the Trusts network. It detects all devices that connect to our networks and scan them to ensure that they are compliant, up to date and most importantly – safe and secure. It also gives us vulnerability and assurance modules which enable us to ensure that we detect and can act on any vulnerabilities such as unpatched software etc. As well as the assurance that our patching and security solutions are in place on all Trust machines.
- ii) Trend Micro Deep Secure – this solution has now been deployed across the Trusts server estate and is an advanced Anti-Virus and Malware protection tool. It also brings with it the ability to place the Trusts servers into a protective ‘bubble’. In the event of a Zero Day Malware attack, we can deploy this bubble to ensure that our servers are fully protected from the threat, allowing us the time to patch them against the new malware.

4.16 We are proud to say that our Trust is still seen as a leader in the field of Cyber Security within the NHS. The Trust Board has continued to invest in tool sets that IM&T use to combat threats. However, this is a continually changing landscape so confirmed investment is always required.

Processes for assuring the Board that staffing processes are safe, sustainable and effective

4.17 There are a number of ways in which the Trust ensures that short, medium and long term workforce strategies and staffing systems are in place which assures the Board that staffing processes are safe, sustainable and effective. Informed by our clinical strategy and aligned to operational and financial planning, workforce demand and supply plans are developed at specialty and divisional level and include recruitment, retention and workforce transformation and efficiency plans.

4.18 National Quality Board standards, NICE guidance, NHSE/I guidance and recommendations from Royal Colleges and the output of national taskforces on workforce are used to inform the optimum staffing levels required to deliver high quality and safe services in an acute hospital environment. Changes to

staffing profiles (numbers and skills) are subject to a Quality Impact Assessment at divisional level and reviewed by the Chief Medical Officer and Chief Nurse prior to implementation.

4.19 Through regular reporting to the Board, workforce and safer staffing reports are provided and these are triangulated against quality metrics to ensure our staffing processes are safe, sustainable and effective.

4.20 The Trust has an active Guardian for Safe Working Hours who works closely with educational and clinical supervisors to ensure that the health, wellbeing and safety of junior doctors is maintained. Well attended monthly forums are in place to address issues and concerns raised by junior doctors. The Guardian provides a regular report to the joint local negotiating forum and to the Quality Assurance Committee on matters raised and how these are being addressed.

4.21 During 2020/21, the health and wellbeing of staff has been a key priority with an extensive number of interventions to support the physical, emotional and financial health needs of our workforce. Regular updates to the Board and committees are in place and in future the Chair of the newly established People Committee will be the Trust's Wellbeing Guardian.

4.22 Daily reporting of staffing capacity, including absence, has been in place through the use of e-rostering systems and processes during the pandemic. A workforce hub was established at peak times to monitor capacity across all staff groups and manage the rapid deployment of staff where required. Reporting through the incident control structure from Bronze to Gold command, workforce risks were identified and effectively managed.

4.23 There are robust governance structures in place that oversee the efficiency and effectiveness of our staffing systems that ultimately report into the Quality Assurance and the Finance and Performance Committees of the board. Maintaining workforce capacity and capability to ensure it is safe and appropriate is a key feature of risk management at divisional and trust level.

4.24 The Trust uses electronic systems to capture and collate staffing numbers and skill mix for nursing staff and this is currently being rolled out to medical staff. Electronic systems for managing temporary workforce supply provide an additional level of assurance.

Processes for managing regulatory risk

4.25 The Trust's last CQC inspection report was in 2019 and this confirmed that the Trust remains fully compliant with the registration requirements of the Care Quality Commission. The CQC concluded for each domain, including Well Led which has an assessment covering the Trust's risk management and patient safety regulatory compliance, that the Trust was outstanding.

4.26 The Trust continued to deploy its Patient First programme which ensures that there is a continued focus on improvement covering improving quality, the patient experience and ensuring the Trust is sustainable, which are key to the delivery of the Trust's True North and Breakthrough Objectives.

4.27 During the period of this report the Trust regrettably had three Never Events and one Prevention of Future Deaths notification from the Brighton Coroner. Never Events and Serious Incidents are subject to a thorough internal review to identify Root Causes and learning. The Trust applied its serious incident framework processes for undertaking a Root Cause Analysis in respect of the Coroner notification. All Serious Incidents including Never Events were reported as required to the Clinical Commissioning Group, NHS Improvement and to NHS England. A full investigation is undertaken and the outcome and recommendations reported to the Trust Board for each serious incident.

4.28 The Foundation Trust has maintained and published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. This register records the details of the Trust senior decision makers, including Board members and Trust Directors.

4.29 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.

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

4.31 The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

4.32 The Trust has undertaken a six-facet building condition survey with the delivery of the agreed actions reported to the Board.

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

5.1 The Board receives a monthly report from the Chief Financial Officer on financial performance. Financial performance is highlighted and reviewed at the Trust Executive Committee to ensure that all senior leaders have visibility on the position and the actions required. Financial performance is scrutinised in detail at the Finance and Performance Committee.

5.2 The Trust has maintained a robust structure for the identification and delivery of efficiency programmes. This is supported by a Programme Management Office and oversight provided by an Executive led efficiency and workforce steering group. Reports are also provided monthly to the Finance and Performance Committee. The Trust in 2020/21 has met its overall financial plan despite having to deploy significant resources to deal with Covid-19.

5.3 The Foundation Trust has maintained a financial risk rating of 1, which provides confidence over the Trust's financial stewardship.

5.4 The Board's last external well led review which judged the Trust against the NHSE/I well led key lines of enquiry, concluded in late 2019/20 that the Board is performing consistently strongly against the NHSE/I expected hall marks of an effective Board. This review's conclusion was corroborated by the CQC's inspection which provided an Outstanding rating well led as well as for each and every CQC domain assessed.

6. Information governance

6.1 In line with standing guidance from NHS Digital on the reporting and classification of Data Protection and Security Incidents, the Trust is pleased to confirm that it reported no incidents to the Information Commissioner's Office.

6.2 Each year the Trust completes and submits the Data Security and Protection Toolkit to demonstrate its compliance against the National Data Guardian's National Data Security Standards. NHS Digital has set a deadline of 30 June 2021 for submission, however the Trust made its submission before 31 March 2021 due to the pending merger with Brighton and Sussex University Hospitals Trust. The Trust is pleased to confirm that this submission, following an internal audit, was agreed that all Standards have been met.

7. Annual Quality Report

7.1 The requirement under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year has been suspended this year due to the

NHS focus on Covid-19. However, the Trust has continued to prepare its annual quality report on a similar basis to previous years.

7.2 In developing the Quality Account for 2020/21 quality improvement priorities for 2019/20 were identified following discussion within the Trust and with its Governors. The detail of the Trust's performance against these quality priorities is considered by the Quality Assurance Committee prior to their reporting to the Board. This process allows for the Board to be assured over the accuracy of the Trust's Quality Report prior to its subsequent publication.

7.3 To assure the Board that the Quality Accounts present a balanced view and that there are appropriate controls in place to ensure the accuracy of data, the Board has:

- Appointed the Chief Medical Officer supported by the Trust Medical Director and Chief Nurse to lead and advise us on all matters relating to the preparation of the Trust's annual Quality Accounts.
- Established a Quality Board to provide focus on continuously improving clinical practice.
- Put in place a system to receive and act upon feedback on the information contained in the Accounts from local stakeholders.

7.4 All service improvements are subject to robust Quality Improvement Assessments, the outcome of the initial assessment and subsequent re-assessments as the projects progress are reported to the Quality Assurance Committee who provide oversight of actions being taken in respect to any significant changes to the quality risk profile of that service improvement.

7.5 Service changes and Trust policies all include an Equality Impact Assessment which identifies any risk of individuals or groups being disadvantaged by that change or policy together with actions being taken to mitigate that risk. Such risks are captured within the Trust's risk management processes and mitigating actions are closely monitored via the Trust's divisional governance processes with any significant risks escalated to the Trust Executive Committee.

8. Data Quality and Governance

8.1 The Trust has a comprehensive suite of near real time daily reports, which allow detailed patient level review at an operational level, allowing for trend analysis. There is an established daily validation process undertaken by clinical leads for patients who exceed four hours in department, and approved by the Chief Operating Officer or the Deputy Chief Operating Officer each respective day. The Trust capture daily A&E breach information on 4 hourly site reports which are cross referenced against electronic Patient Administration System (PAS) reporting which helps ensure understanding and reconciliation of any discrepancies between daily performance (as reported

via the Patient Administration system) and that observed by site management teams.

8.2 For Referral to Treatment (RTT) performance, there is a comprehensive validation process undertaken, underpinned by the patient access policy and RTT Rules Suite, whereby month end over 18 week waiters are reviewed at a care group level for their accuracy, and the validated cohort of patients are updated daily up to the point at which reporting is finalised (approximately 18th of subsequent month). This is supported by divisional and corporate weekly meetings where trends and anomalies are tracked and rectified.

8.3 For cancer patient level information is reviewed daily as part of Multi-Disciplinary Team meetings and tracking processes, captured in detail on the National Somerset system, with a range of daily updated performance and operational tracking reports to support patient pathway management.

8.4 More widely, the Trust access the national Secondary User System Clinical Data Set data quality dashboards which provide a degree of assurance around completeness of key administrative data items (patient details) broken down by main activity types (A&E, inpatient and outpatient activities) where the Trust has performed well above target level in terms of completeness of records. The data quality team proactively undertake data cleansing activities on the Patient Administration System daily, acting on a suite of automated reports and results from the trace files sent to the national Personal Demographic Services (PDS). The data quality reports are shared with the Information Governance Group.

8.5 The Trust developed a data quality kite marking process in 19/20 which visually shows the quality of the underlying data across a number of elements, including the timeliness of the data, the strength of internal independent validation etc. This process has been applied to the key performance indicators reported to the Trust's Finance and Performance Committee which provides an easy reference point for the Committee when discussing the Trust's reported performance and the decisions it is faced with based on the Trust's reported position. The process is being expanded to True North and wider qualitative scorecards, and will influence where the Trust focusses further data quality improvements. This process was suspended during 2020/21 due to resource impact of Covid-19 information requirements, but is planned to be re-commenced during 2021/22.

8.6 The Trust adopted a Gold command business continuity plan as part of the Covid-19 response. This required a wealth of daily and weekly information to be gathered both covid related and the indirect impact of Covid-19 on constitutional performance, with scrutiny by Silver and Gold commanders each day. This provided an extra layer of data quality assurance, triangulated with clinical services.

8.7 As part of Trust merger, the Trust has reviewed current information relating to key constitutional standards with BSUH information teams, so as to be able to provide an aggregated view of the planned new Trust from April 2021. This has provided a further opportunity to review definitions and align methods of collection to improve consistency.

8.8 The Trust undertook Strategy Deployment Reviews (SDRs) at a divisional level in 2019/20 which allowed executive level scrutiny of performance trends which provides another layer of assurance in terms of performance (and its associated data quality). The process adopts a review of key performance metrics, whereby a drop in performance trend elicits a structured stratification of reasons for performance slippage, and mitigation and recovery actions to recover performance. This is an opportunity to cover data quality concerns alongside key operational constraints, or demand pressures. This is part of the Trust True North/Patient First governance arrangements all of which prioritise patient care, and allow the core operational priorities to be aligned and understood from board to floor. The Trust PFIS programme reviews data on a granular level to establish baselines, and monitor improvement, the scrutiny of which contributes to maintained high quality data. The SDR process was suspended for part of 2020/21 due to a focus being given by the Divisions on delivering the national covid response, however this process will be reinstated as part of 2021/22 performance assurance process.

9. Review of effectiveness

9.1 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.

9.2 Head of Internal Audit Opinion

9.3 Internal audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.

9.4 Based on work undertaken during 2020/21 the Head of Internal Audit has stated in their Head of Internal Audit Opinion that they “are able to provide 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”

9.5 In forming their opinion they took into account that, the Trust delivered a breakeven position, that the majority of audits provided moderate assurance including the key audits of key financial systems and data security and protection toolkit. Throughout all audit work completed, we raised only one

high priority finding within the Cyber security report and we noted that this was in an area of known and managed risk.

9.6 Internal Audit noted there had been an impact on the Trust's timely closing of agreed action in part driven by the Trust's focus on dealing with the national pandemic. However Internal Audit did not feel this adversely impacted on their overall positive moderate opinion.

9.7 *External Audit*

9.8 External Audit report to the Trust on the findings from their audit work, in particular their audit of the financial statements and the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources (Value for Money). For 2020/21 an unqualified audit opinion has been issued in respect of the financial statements and External Audit had no matters to report by exception in respect of the Value for Money Commentary.

9.9 *Counter-fraud*

9.10 The Trust is required under Service Condition 24 of the Standard NHS Commissioning Contract to ensure appropriate counter fraud measures are in place.

9.11 The Local Counter Fraud Specialist (LCFS) adopts a risk-based approach to counter fraud work, identifying areas of potential vulnerability. Relevant local proactive exercises (LPEs) are consequently built into the Trust's annual counter fraud work plan, which includes activity relating to the four main NHS Counter Fraud Authority (CFA) standards: Strategic Governance, Inform and Involve, Prevent and Deter, and Hold to Account and which is overseen by the Audit Committee. The LCFS helps to foster an anti-fraud culture within the Trust through delivery of an ongoing training programme across a wide range of staff groups. This features regular presentations on counter fraud and on compliance with the UK Bribery Act 2010. The LCFS attends each meeting of the Audit Committee to present a report on their work. The maintenance of strong systems of financial control and stewardship of public funds remains critical during the NHS response to Covid-19. The Trust has continued with its established separate coding processes for Covid-19 costs and their recovery has also been subject to review by NHSE/I.

9.12 The LCFS has not identified any significant control weaknesses during their work. Where improvements have been identified then, similar to Internal Audit they make recommendations and the delivery of these is tracked and reported to the Audit Committee.

9.13 HSE Inspections

9.14 The HSE did not undertake any inspections at the Trust during 2020/2021. The Trust responded ahead of the agreed deadline of 17 July 2020 in respect to the inspection of the pathology laboratory at St Richards Hospital. The HSE on receipt of the Trust's submitted information concluded there was no other actions required of the Trust. The delivery of the agreed action in respect of previous inspections in 2019/20 continue to be monitored by the Trust's health and safety group that reports directly to the Quality Assurance Committee.

9.15 Environmental Health Inspections

9.16 West Sussex County Council undertook inspections of the Trust's upgraded kitchen facilities and has awarded the Trust a five-star rating for these and made no recommendations.

9.17 Board Committees

9.18 The Board and its Committees form an important aspect of control and I have been advised during my review by the work of the Audit Committee where the results of the work of the Trust's auditors are received along with the Finance and Performance Committee and the Quality Assurance Committee which have met across 200/21. I have also been advised by the first meetings of the Patient, Quality, People, Sustainability and Systems and Partnership Committees in 2021/22 under the Board's revised governance framework.

9.19 Finance and Performance Committee

9.20 The Finance and Performance Committee which is chaired by a Non-Executive Director provides me and the Board with a flow of assurance over the effectiveness of the established systems of internal financial control and the systems of internal control supporting operational performance delivery and reporting.

9.21 During the year the Committee has received regular reports on the Trust's financial position, the management of its cash position and the delivery of the Trust's capital programme, along with the delivery of the Trust's efficiency programme and reports covering workforce, procurement and IM&T. The Committee also received regular reports on the delivery of the Trusts performance measures and has received a series of more in depth reports covering specific aspects of performance.

9.22 These reports have supported the Committee in its assurance flow to the Board that these key risks have been managed well during the year.

9.23 *Quality Assurance Committee*

9.24 The Quality Assurance Committee which is chaired by a Non-Executive Director provides me and the Board with a flow of assurance over the effectiveness of the established systems of internal control in respect of management of key quality risks.

9.25 During the year the Committee has received regular reports on the Trust's quality performance and quality risks, learning from complaints and investigations into untoward incidents along with regular reporting on the outcomes from clinical audits. The Committee have supported the assurance flow to the Board that quality key risks have been managed during the year especially that there have been no significant patient safety matters arising during the year.

9.26 *Board Assurance Framework*

9.27 During the year covered by this report the Board Assurance Framework reporting framework has been maintained which has seen the structured flow of assurance reporting to the Board on the controls managing the Trust's key risks to the delivery of the Trust's identified True North and associated breakthrough objectives. This process plays a key role in articulating where gaps in control exist and the tracking of devised actions to mitigate these.

9.28 *Wider processes*

9.29 My review is also informed by, the Trust's processes for:

- monitoring the delivery of improvements flowing from the receipt of the outcome of the Annual Staff Survey
- monitoring the delivery of improvements from the learning identified from complaints and the investigation of untoward incidents
- tracking the outcomes from the programme of work undertaken by internal and external auditors as well as Counter Fraud
- Delivering improvements from the outcomes of external assurance visits including the national Getting It Right First Time reviews across many of the Trust's services.

9.30 These processes culminate in reporting to the Board through the revised Divisional and Executive governance processes on the state of the Trust's systems of internal control.

9.31 I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their

management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, the finance and performance and the quality and assurance committee. Where improvements have been highlighted then and a plan to address weaknesses and ensure continuous improvement of the system is in place.

10. Conclusion

10.1 I have considered the factors described in the NHS Improvement guidance on the 2020/21 annual governance statement in respect of significant issues.

10.2 Whilst during the period 1 April 2020 to 31 March 2021 and up to the time of signing the accounts I have identified challenged areas with respect to the consistent achievement of Trust priorities I have not identified any significant internal control issues as defined as such within the FT Annual Reporting Manual.

10.3 Oversight of the Trust's management of these challenges continues at the Board and through its Committees with each being assured that the Trust has established and adapted these, as appropriate whilst dealing with the Covid-19 challenges, to ensure there remain adequate systems of internal control and where control improvements are identified that these are delivered in line with agreed action plans.

10.4 Where wider opportunities for improvement have been identified I have overseen actions to ensure that we continue to improve the systems of internal control we operate for the benefits of our patients, staff and the wider community we serve.

Signed (by order of the Board of Directors)



Dame Marianne Griffiths, Chief Executive 14 June 2021

Western Sussex Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Western Sussex Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Western Sussex Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 
Name **Dame Marianne Griffiths**
Job title **Chief Executive**
Date **15 June 2021**

Statement of Comprehensive Income

		2020/21	2019/20
	Note	£000	£000
Operating income from patient care activities	3	478,000	451,589
Other operating income	4	59,587	48,047
Operating expenses	6, 8	<u>(538,668)</u>	<u>(483,567)</u>
Operating surplus/(deficit) from continuing operations		<u>(1,081)</u>	<u>16,069</u>
Finance income	11	6	174
Finance expenses	12	(604)	(646)
PDC dividends payable		<u>(7,401)</u>	<u>(8,553)</u>
Net finance costs		<u>(7,999)</u>	<u>(9,025)</u>
Other gains / (losses)	13	<u>(3)</u>	<u>11</u>
Surplus / (deficit) for the year from continuing operations		<u>(9,083)</u>	<u>7,055</u>
Surplus / (deficit) for the year		<u>(9,083)</u>	<u>7,055</u>
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(2,388)	(2,843)
Revaluations	18	<u>9,049</u>	<u>2,148</u>
Total comprehensive income / (expense) for the period		<u>(2,422)</u>	<u>6,360</u>

Statement of Financial Position

		31 March 2021	31 March 2020
	Note	£000	£000
Non-current assets			
Intangible assets	15	16,490	13,476
Property, plant and equipment	16	286,209	273,361
Receivables	24	1,276	1,087
Total non-current assets		303,975	287,924
Current assets			
Inventories	23	8,194	8,279
Receivables	24	23,239	33,377
Cash and cash equivalents	27	43,877	19,814
Total current assets		75,310	61,470
Current liabilities			
Trade and other payables	28	(47,988)	(28,466)
Borrowings	30	(1,839)	(1,850)
Provisions	33	(851)	(373)
Other liabilities	29	(2,494)	(1,750)
Total current liabilities		(53,172)	(32,439)
Total assets less current liabilities		326,113	316,955
Non-current liabilities			
Borrowings	30	(15,155)	(16,925)
Provisions	33	(4,268)	(3,391)
Total non-current liabilities		(19,423)	(20,316)
Total assets employed		306,690	296,639
Financed by			
Public dividend capital		256,732	244,259
Revaluation reserve		68,930	62,269
Income and expenditure reserve		(18,972)	(9,889)
Total taxpayers' equity		306,690	296,639

The notes on pages 9 to 57 form part of these accounts.

Name Dame Marianne Griffiths



Position Chief Executive

Date 15 June 2021

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

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	244,259	62,269	-	(9,889)	296,639
Surplus/(deficit) for the year	-	-	-	(9,083)	(9,083)
Other transfers between reserves	-	-	-	-	-
Impairments	-	(2,388)	-	-	(2,388)
Revaluations	-	9,049	-	-	9,049
Transfer to retained earnings on disposal of assets	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Public dividend capital received	12,513	-	-	-	12,513
Public dividend capital repaid	(40)	-	-	-	(40)
Public dividend capital written off	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-
Other reserve movements	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2021	256,732	68,930	-	(18,972)	306,690

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

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	241,646	62,964	-	(16,945)	287,665
Prior period adjustment	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2019 - restated	241,646	62,964	-	(16,945)	287,665
Surplus/(deficit) for the year	-	-	-	7,055	7,055
Other transfers between reserves	-	-	-	-	-
Impairments	-	(2,843)	-	-	(2,843)
Revaluations	-	2,148	-	-	2,148
Transfer to retained earnings on disposal of assets	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Public dividend capital received	2,613	-	-	-	2,613
Public dividend capital repaid	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-
Other reserve movements	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2020	244,259	62,269	-	(9,889)	296,639

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	2020/21	2019/20
Note	£000	£000
Cash flows from operating activities		
Operating surplus / (deficit)	(1,081)	16,069
Non-cash income and expense:		
Depreciation and amortisation	6.1 16,513	15,228
Net impairments	7 9,116	7,218
Income recognised in respect of capital donations	4 (564)	(325)
(Increase) / decrease in receivables and other assets	10,837	7,933
(Increase) / decrease in inventories	85	(644)
Increase / (decrease) in payables and other liabilities	14,681	(10,329)
Increase / (decrease) in provisions	1,367	850
Net cash flows from / (used in) operating activities	50,954	36,000
Cash flows from investing activities		
Interest received	6	174
Purchase of intangible assets	(3,837)	(3,694)
Purchase of PPE and investment property	(25,093)	(18,284)
Sales of PPE and investment property	19	11
Receipt of cash donations to purchase assets	227	325
Net cash flows from / (used in) investing activities	(28,678)	(21,468)
Cash flows from financing activities		
Public dividend capital received	12,513	2,613
Public dividend capital repaid	(40)	-
Movement on loans from DHSC	(1,772)	(1,772)
Capital element of finance lease rental payments	(4)	(43)
Interest on loans	(463)	(501)
Interest paid on finance lease liabilities	(158)	(165)
PDC dividend (paid) / refunded	(8,289)	(8,349)
Net cash flows from / (used in) financing activities	1,787	(8,217)
Increase / (decrease) in cash and cash equivalents	24,063	6,315
Cash and cash equivalents at 1 April - brought forward	19,814	13,499
Cash and cash equivalents at 31 March	27.1 43,877	19,814

Notes to the Accounts

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts 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 DHSC Group Accounting Manual 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 DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation 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.

Going concern

International Accounting Standards (IAS1) require the Trust Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern.

In carrying out its assessment, the directors have taken account of the requirements in the NHS Foundation Trust Annual Reporting Manual. In particular, that the accounts should be prepared on a going concern basis unless the Trust Board either intend to apply to the Secretary of State for the dissolution of the trust without the transfer of the services to another entity, or have no realistic alternative but to do so. The directors have also taken into account revised guidance from The Public Audit Forum to auditors, and subsequent guidance published by NHS England and NHS Improvement on 1st April 2021 which states that for NHS bodies the assessment of going concern "should solely be based on the anticipated future provision of services in the public sector."

There has been no application to the Secretary of State for the dissolution of the trust. Moreover on 19th March 2021, the Trust Boards of Western Sussex Hospitals and Brighton and Sussex Hospitals made a joint application to NHS Improvement for their merger by way of the acquisition of Brighton and Sussex University Hospitals NHS Trust by Western Sussex Hospitals NHS Foundation Trust under section 56A of the NHS Act 2006. The Grant of Application for the Acquisition took effect on 1 April 2021. On this date, Western Sussex Hospitals NHS Foundation Trust acquired the assets, liabilities and operations and business of Brighton and Sussex University Hospitals NHS Trust. The newly merged trust is known, from 1st April 2021, as University Sussex Hospitals NHS Foundation Trust.

In preparation for the merger, the trust undertook long-term financial modelling covering the five-year period April 2021 to March 2026. This financial modelling demonstrated that there is no adverse impact on either organisation from merging and that University Hospitals Sussex is able to deliver a sustainable financial position and maintain a positive cash position from the point of merger. The modelling also considered a range of sensitivities and demonstrates that University Hospitals Sussex is able to respond to emerging financial and operational pressures and can continue to maintain a positive cash position.

For 2021/22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding available to support Elective Recovery / Mental Health Services / transformation of Community Services post COVID. Additional funding has also been received for the continuing costs of COVID.

For the second half of the year the Trust has assumed that income will continue at a value equal to the income blocks, which were integral to the financial frameworks in place in 2020/21 and underpin the financial framework which has been rolled forward in April 2021 to September 2021. Assumptions have been made regarding increased activity trajectories to support restoration and recovery, taking into account resource availability and close working with System partners. Additional funding is available from the Elective Recovery Fund and the Trust has been prudent in assuming a cost neutral basis for activity delivery, with no contribution from this activity being included to deliver the full year plan.

The Trust has produced its financial plans based on these assumptions which have been approved by the Trust Board. The Trust, in conjunction with the Sussex ICS, has submitted a breakeven plan, both individually and collectively for the first half of the year. The assumptions include an operational efficiency target of £6m for the first half of the year, which forms part of the Trust's annual efficiency plan of £24.4m for the full year, c. 2% of the Trust's cost base. This compares to efficiency targets of c.4% delivered by both legacy Trusts in years pre-COVID. In 2020/21, the Trust delivered efficiency savings of 1.1%. The Trust is therefore reasonably assured of the achievability of this financial target.

The Trust has prepared its financial plans and cash flow forecasts for the coming year on the assumption that funding will be received from the Department of Health and Social Care consistent with the revised funding arrangements in response to the COVID-19 pandemic. Discussions to date indicate that this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due and will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health and Social Care. Interim support is part of the framework and can be accessed if it were required, but there is currently no such identified requirement.

Taking into account the financial forecast for University Hospitals Sussex NHS Foundation Trust, the directors have a reasonable expectation that the trust will have access to adequate resources to continue in operational existence for at least 12 months from the date of approval of the accounts. For this reason they continue to adopt the going concern basis in preparing the accounts.

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.

1.1 Consolidation

The NHS foundation trust is the corporate trustee to the NHS charitable fund Western Sussex Hospitals Charity and Related Charities, which operates as Love Your Hospital Charity (Registered charity No. 1049201).

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns, where those funds are determined to be material. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

The trust has reviewed its NHS charitable funds and concluded that they are not material and so are not consolidated within these accounts.

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 trust has no subsidiaries.

Associates

Associate entities are those over which the trust has the power to exercise a significant influence. The trust has no associates.

Joint arrangements

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. The trust has no joint ventures.

Joint operations

Joint operations are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the assets, and obligations for the liabilities relating to the arrangement. The trust does not have joint operations.

1.2 Revenue

In the application 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 will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;
- The trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard where the right to consideration corresponds directly with value of the performance completed to date;
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the trust accrues income relating to performance obligations satisfied in that year.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a [Integrated Care System/Sustainability and Transformation Partnership] 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

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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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.

Other forms of income

Grants and donations

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

Apprenticeship service income

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

1.3 Employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

No employees are members of the Local Government Superannuation Scheme.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of "other comprehensive income".

1.4 Other expenses

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

1.5 Corporation tax

The trust has determined that it has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

1.6 Value added tax

Most of the activities of the NHS foundation trust are outside the scope of value added tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.7 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 either:
 - 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, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment is 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.

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

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

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost (DRC), modern equivalent asset (MEA) basis;

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

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.

Revaluation gains and losses

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

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

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

Depreciation

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised. Freehold land is considered to have an infinite life and is not depreciated.

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

Impairments

At each financial year end, the trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, in accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

De-recognition

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

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

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

Donated assets 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.

They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grant and other grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Private Finance Initiative (PFI) transactions

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the trust.

The trust has not entered into any PFI transactions.

Useful lives of property, plant and equipment

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

Life Years	Min	Max
Buildings, excluding dwellings	1	89
Dwellings	17	83
Plant & Machinery	5	35
Information Technology	1	7
Furniture & Fittings	1	15

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

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of 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 and where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software

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.

Internally generated intangible assets

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets e.g. goodwill, brands, mastheads, publishing titles, customer lists and similar items 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 trust intends to complete the intangible asset and use it;
- The trust has 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

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition 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 current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

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

Useful lives of intangible assets

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

Life Years	Min	Max
Internally Generated Information Technology	5	30
Purchased Software Licenses	1	7
Purchased other intangible asset	1	7

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) cost formula.

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.

1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, 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 for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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

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

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.

1.12 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

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

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

Leases of land and buildings

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

The trust as a lessor

Finance leases

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

Operating leases

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

1.13 Provisions

Provisions are recognised when the NHS foundation trust has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. 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.

HM Treasury's discount rates effective for 31 March 2021:

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

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

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 33.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The NHS foundation 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 the 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.

1.14 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
- 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, contingent liabilities and contingent assets are disclosed at their present value.

1.15 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance, which 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 NHS foundation trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for: donated and grant funded assets, average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, approved expenditure on COVID-19 capital assets, assets under construction for nationally directed schemes, any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. The PDC dividend calculation is based upon the trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

1.16 Foreign currencies

The functional and presentational currencies of the trust are pounds sterling and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. The trust has not entered into any material foreign exchange transactions and has no assets or liabilities held in foreign currencies.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts.

1.18 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 NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.19 Early adoption of standards, amendments and interpretations

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

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

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 16 Leases - The Standard is effective 1 April 2021 as adapted and interpreted by the FReM. HM Treasury and the Financial Reporting Advisory Board (FRAB) have confirmed deferral of IFRS 16 implementation for a further year until 1 April 2022 for NHS and DHSC group bodies.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. IFRS 17 on insurance contracts (replacing IFRS 4) is expected to apply to the public sector from 2022.

<https://www.england.nhs.uk/financial-accounting-and-reporting/financial-reporting/> [8th August 2019]

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

1.21 Critical accounting judgements and key sources of estimation uncertainty

In the application of Western Sussex Hospitals NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying Western Sussex Hospitals NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Valuation of Buildings

Department of Health guidance specifies that the trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the trust holds, but a theoretical valuation for accounting purposes of what the trust could need to spend in order to replace the current assets. In determining the MEA, the trust has to make assumptions that are practically achievable; however the trust is not required to have any plans to make such changes.

The trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the trust, and would not impact on service delivery or the level and volume of service provided. The trust does not intend to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purpose of the MEA valuation, the trust has defined all of the St Richards Hospital in Chichester and Worthing Hospital as buildings that provide specialist health care services. The MEA valuation in the accounts assumes that the Chichester and Worthing based hospitals could theoretically be provided from a location on the outskirts of Chichester and Worthing.

The MEA valuations used by the trust have been provided to the trust by the external District Valuers. The trust has used component lives based upon contractual information provided by District Valuers to depreciate buildings and dwellings on a component basis.

Assets Under Construction

The trust has taken the judgement that capitalised expenditure will be classified as Assets Under Construction until the asset is complete and ready to be operational, at which point the assets will be reclassified into the relevant asset category. Changes in the valuation basis between cost and fair value, when these reclassifications occur for any buildings, may result in significant changes in the carrying value of the assets.

Provision for Pensions

The trust has estimated the provision for pensions relating to former staff using estimates provided by the NHS Pensions provided at the time of the member's early retirement. These are updated annually using national life expectancy tables and if it becomes apparent that the provision is not sufficient to meet the liability.

1.21.2 Sources of estimation uncertainty

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

Depreciation

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and physical asset verification exercises.

The estimated economic lives of each class of asset are disclosed in notes 1.7, and the carrying values of property, plant and equipment and intangible assets in notes 15.1 to 16.2.

Land and Buildings Valuations

All land and buildings are restated at current value by way of annual professional valuations carried out by an independent external valuer.

Provision for impairment of receivables

Provisions are based on a combination of the age of the debt and disputes with debtors. The trust follows the guidance issued in the Department of Health Group Accounting Manual 2020-21 in relation to the recommended rate for Injury Cost Recovery receivables.

Note 2 Operating Segments

Consistent with previous years , the trust takes the view that there is a single operating segment - the provision of healthcare.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.2

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	(Restated)
		£000
Acute services		
Block contract / system envelope income*	397,075	366,039
High cost drugs income from commissioners (excluding pass-through costs)	28,724	30,323
Other NHS clinical income	12,674	11,683
Mental health services		
Block contract / system envelope income*	1,580	1,537
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
Community services		
Block contract / system envelope income*	17,093	17,398
Income from other sources (e.g. local authorities)	4,606	4,970
All services		
Private patient income	2,093	5,031
Additional pension contribution central funding**	13,536	12,651
Other clinical income	619	1,957
Total income from activities	478,000	451,589

*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, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
	£000	£000
Income from patient care activities received from:		
NHS England	74,676	73,790
Clinical commissioning groups	395,116	364,238
Department of Health and Social Care	-	142
Other NHS providers	890	1,027
NHS other	-	-
Local authorities	4,606	4,971
Non-NHS: private patients	2,093	5,031
Non-NHS: overseas patients (chargeable to patient)	29	257
Injury cost recovery scheme	553	1,215
Non NHS: other	37	918
Total income from activities	478,000	451,589
Of which:		
Related to continuing operations	478,000	451,589
Related to discontinued operations	-	-

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

	2020/21	2019/20
	£000	£000
Income recognised this year	29	257
Cash payments received in-year	66	223
Amounts added to provision for impairment of receivables	197	59
Amounts written off in-year	334	-

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,134	-	1,134	1,216	-	1,216
Education and training	14,076	-	14,076	13,837	-	13,837
Non-patient care services to other bodies	12,894	-	12,894	15,409	-	15,409
Provider sustainability fund (2019/20 only)	-	-	-	9,111	-	9,111
Financial recovery fund (2019/20 only)	-	-	-	-	-	-
Marginal rate emergency tariff funding (2019/20 only)	-	-	-	3,262	-	3,262
Reimbursement and top up funding	20,132	-	20,132	-	-	-
Income in respect of employee benefits accounted on a gross basis	120	-	120	-	-	-
Receipt of capital grants and donations	-	564	564	-	325	325
Charitable and other contributions to expenditure	-	7,852	7,852	-	-	-
Support from the Department of Health and Social Care for mergers	-	-	-	-	-	-
Rental revenue from finance leases	-	-	-	-	-	-
Rental revenue from operating leases	-	532	532	-	668	668
Amortisation of PFI deferred income / credits	-	-	-	-	-	-
Other income*	2,283	-	2,283	4,219	-	4,219
Total other operating income	50,639	8,948	59,587	47,054	993	48,047
Of which:						
Related to continuing operations			59,587			48,047
Related to discontinued operations			-			-

*Other operating income includes revenue streams such as; Car Parking income, staff accommodation rental income, non NHS Pharmacy sales & Clinical Excellence Awards income.

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	97	1,666
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	(325)	-

Note 5.2 Transaction price allocated to remaining performance obligations

There were no transaction price allocations to remaining performing obligations in 2020/21 or 2019/20.

Note 5.3 Income from activities arising from commissioner requested services

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 licence and are services that commissioners believe would need to be protected in the event of provider failure. The trust has no commissioner requested services. In 2019/20 accounts a figure was disclosed as commissioner requested services in error. The trust had no commissioner requested services in 2019/20.

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,066	3,664
Purchase of healthcare from non-NHS and non-DHSC bodies **	3,095	-
Purchase of social care	-	-
Staff and executive directors costs	352,346	321,602
Remuneration of non-executive directors	167	158
Supplies and services - clinical (excluding drugs costs)	44,653	38,919
Supplies and services - general	4,026	3,736
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	45,958	45,245
Inventories written down	94	-
Consultancy costs	1,235	467
Establishment	3,149	3,183
Premises	18,144	13,600
Transport (including patient travel)	1,367	1,548
Depreciation on property, plant and equipment	15,864	15,061
Amortisation on intangible assets	649	167
Net impairments	9,116	7,218
Movement in credit loss allowance: contract receivables / contract assets	214	59
Movement in credit loss allowance: all other receivables and investments	614	-
Increase/(decrease) in other provisions	292	-
Change in provisions discount rate(s)	281	(54)
Audit fees payable to the external auditor		
audit services- statutory audit	193	72
other auditor remuneration (external auditor only)	-	-
Internal audit costs*	82	-
Clinical negligence	15,890	13,965
Legal fees	1,578	421
Insurance	433	712
Research and development	2,280	1,989
Education and training	7,408	5,537
Rentals under operating leases	1,923	1,857
Early retirements	11	-
Car parking & security	735	568
Losses, ex gratia & special payments	71	131
Other services	2,526	708
Other	1,208	3,034
Total	538,668	483,567
Of which:		
Related to continuing operations	538,668	483,567
Related to discontinued operations	-	-

* In 2019/20 Internal audit costs of £86k were disclosed within Other.

** In 2019/20 Commercial sector purchase of healthcare costs of £2,933k were disclosed within Other

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	<u>-</u>	<u>-</u>

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	10,454	7,218
Other	(1,338)	-
Total net impairments charged to operating surplus / deficit	<u>9,116</u>	<u>7,218</u>
Impairments charged to the revaluation reserve	2,388	2,843
Total net impairments	<u>11,504</u>	<u>10,061</u>

Note 8 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	275,164	251,087
Social security costs	28,848	23,600
Apprenticeship levy	1,343	1,258
Employer's contributions to NHS pensions*	44,491	40,621
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	11,028	11,626
Total gross staff costs	360,874	328,192
Recoveries in respect of seconded staff	-	-
Total staff costs	360,874	328,192
Of which		
Costs capitalised as part of assets	780	747

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

Note 8.1 Retirements due to ill-health

During 2020/21 there were 3 early retirements from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £125k (0k in 2019/20).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

The trust is required to auto-enrol employees who are not eligible to join the NHS Pension scheme into the NEST workplace pension scheme. Employees can then choose to opt out of the scheme. National Employment Savings Trust (NEST) is a low cost, defined contribution, occupational pension scheme backed by the Government. It was set up by the Government to give employers an auto enrolment scheme that makes the process as simple as possible.

Note 10 Operating leases

Note 10.1 Western Sussex Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Western Sussex Hospitals NHS Foundation Trust is the lessor.

These include the lease of:

- Restaurant space to The Compass Group;
- Hyperbaric unit to Qinetiq; and
- Nursery/childcare facility to The Co-operative Nursery.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	532	668
Contingent rent	-	-
Other	-	-
Total	532	668
	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	605	965
- later than one year and not later than five years;	2,045	3,415
- later than five years.	448	928
Total	3,098	5,308

Note 10.2 Western Sussex Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Western Sussex Hospitals NHS Foundation Trust is the lessee.

The Trust has the following significant leasing arrangements including building leases, vehicle leases, and implicit equipment leases within Managed Equipment Services (MES) contracts.

In addition, the trust entered into a sublease arrangement with Coastal West Sussex CCG for office buildings in 2019/20.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	2,283	1,857
Contingent rents	-	-
Less sublease payments received*	(360)	-
Total	1,923	1,857
	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	2,008	2,284
- later than one year and not later than five years;	3,205	4,937
- later than five years.	980	1,264
Total	6,193	8,485
Future minimum sublease payments to be received*	(1,260)	-

* In 2019/20 the sublease arrangement with Coastal West Sussex CCG (now merged into NHS West Sussex CCG) was presented within operating lease revenue [19/20 values £61k minimum lease payment, £360k not later than one year, one to five years £1,260k]

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	6	174
Total finance income	6	174

Note 12.1 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	458	495
Finance leases	158	165
Interest on late payment of commercial debt	-	-
Total interest expense	616	660
Unwinding of discount on provisions	(12)	(14)
Other finance costs	-	-
Total finance costs	604	646

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

	2020/21	2019/20
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	428	627
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	-	11
Losses on disposal of assets	(3)	-
Total gains / (losses) on disposal of assets	(3)	11
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-
Other gains / (losses)	-	-
Total other gains / (losses)	(3)	11

Note 14.1 Discontinued operations

There were no discontinued operations in 2020/21

Note 14.2 Corporation Tax

The trust did not pay any Corporation Tax in 2020/21

Note 15.1 Intangible assets - 2020/21

	Software licences £000	Licences & trademarks £000	Internally generated information technology £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	10,854	-	-	7,119	1,112	19,085
Transfers by absorption	-	-	-	-	-	-
Additions	1,531	-	2,306	-	-	3,837
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	116	-	6,829	(7,119)	-	(174)
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-
Valuation / gross cost at 31 March 2021	12,501	-	9,135	-	1,112	22,748
Amortisation at 1 April 2020 - brought forward	5,609	-	-	-	-	5,609
Transfers by absorption	-	-	-	-	-	-
Provided during the year	649	-	-	-	-	649
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-
Amortisation at 31 March 2021	6,258	-	-	-	-	6,258
Net book value at 31 March 2021	6,243	-	9,135	-	1,112	16,490
Net book value at 1 April 2020	5,245	-	-	7,119	1,112	13,476

The gross carrying amounts of fully amortised intangible assets as at 31st March 2021 is £5,371k.

Note 15.2 Intangible assets - 2019/20

	Software licences £000	Licences & trademarks £000	Internally generated information technology £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	6,769	-	-	6,342	1,112	14,223
Transfers by absorption	-	-	-	-	-	-
Additions	2,917	-	-	777	-	3,694
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	1,168	-	-	-	-	1,168
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-
Valuation / gross cost at 31 March 2020	10,854	-	-	7,119	1,112	19,085
Amortisation at 1 April 2019 - as previously stated	5,442	-	-	-	-	5,442
Transfers by absorption	-	-	-	-	-	-
Provided during the year	167	-	-	-	-	167
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-
Amortisation at 31 March 2020	5,609	-	-	-	-	5,609
Net book value at 31 March 2020	5,245	-	-	7,119	1,112	13,476
Net book value at 1 April 2019	1,327	-	-	6,342	1,112	8,781

Note 16.1 Property, plant and equipment - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	21,464	206,070	7,720	678	81,177	282	27,049	2,519	346,959
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	495	-	16,929	9,138	-	4,453	-	31,015
Impairments	-	(19,833)	(139)	-	-	-	-	-	(19,972)
Reversals of impairments	-	2,514	-	-	-	-	-	-	2,514
Revaluations	-	5,286	310	-	-	-	-	-	5,596
Reclassifications	-	12,657	-	(13,585)	243	-	859	-	174
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(22)	-	-	-	(22)
Valuation/gross cost at 31 March 2021	21,464	207,189	7,891	4,022	90,536	282	32,361	2,519	366,264
Accumulated depreciation at 1 April 2020 - brought forward	-	-	-	-	53,017	271	18,121	2,189	73,598
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	9,295	112	-	4,411	3	1,996	47	15,864
Impairments	-	(5,179)	(25)	-	-	-	-	-	(5,204)
Reversals of impairments	-	(750)	-	-	-	-	-	-	(750)
Revaluations	-	(3,366)	(87)	-	-	-	-	-	(3,453)
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2021	-	-	-	-	57,428	274	20,117	2,236	80,055
Net book value at 31 March 2021	21,464	207,189	7,891	4,022	33,108	8	12,244	283	286,209
Net book value at 1 April 2020	21,464	206,070	7,720	678	28,160	11	8,928	330	273,361

The gross carrying amounts of fully depreciated tangible assets as at 31st March 2021 is £51,277k

Note 16.2 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	21,464	212,314	7,966	4,303	74,385	282	24,556	2,519	347,789
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	129	5,820	-	7,757	2,777	-	1,346	-	17,829
Impairments	(129)	(18,140)	(246)	-	-	-	-	-	(18,515)
Reversals of impairments	-	330	-	-	-	-	-	-	330
Revaluations	-	694	-	-	-	-	-	-	694
Reclassifications	-	5,052	-	(11,382)	4,015	-	1,147	-	(1,168)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2020	21,464	206,070	7,720	678	81,177	282	27,049	2,519	346,959
Accumulated depreciation at 1 April 2019 - as previously stated	-	-	-	-	49,320	268	16,385	2,142	68,115
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	9,470	108	-	3,697	3	1,736	47	15,061
Impairments	-	(7,324)	(108)	-	-	-	-	-	(7,432)
Reversals of impairments	-	(692)	-	-	-	-	-	-	(692)
Revaluations	-	(1,454)	-	-	-	-	-	-	(1,454)
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2020	-	-	-	-	53,017	271	18,121	2,189	73,598
Net book value at 31 March 2020	21,464	206,070	7,720	678	28,160	11	8,928	330	273,361
Net book value at 1 April 2019	21,464	212,314	7,966	4,303	25,065	14	8,171	377	279,674

Note 16.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	20,993	196,803	5,406	4,022	30,018	8	12,137	129	269,516
Finance leased	-	-	2,485	-	264	-	-	-	2,749
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - donated/granted	471	10,386	-	-	2,826	-	107	154	13,944
NBV total at 31 March 2021	21,464	207,189	7,891	4,022	33,108	8	12,244	283	286,209

Note 16.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	21,464	196,600	7,612	678	24,463	11	8,928	330	260,086
Finance leased	-	2,073	-	-	140	-	-	-	2,213
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - donated/granted*	-	7,397	108	-	3,557	-	-	-	11,062
NBV total at 31 March 2020	21,464	206,070	7,720	678	28,160	11	8,928	330	273,361

*Values in the note 16.4 should be £256,949k for Owned – purchased, and £14,199k for Owned – donated/granted, whereas in prior year it was stated as shown in note 16.4 above.

Note 17 Donations of property, plant and equipment

There is no difference between the cash provided and the fair value of the assets acquired.

Note 18 Revaluations of property, plant and equipment

The date of the valuation was 31st March 2021 and was carried out by the District Valuer. It was a desktop exercise using the latest BCIS indices and local market conditions to value Buildings, Dwellings and Land on an alternative site basis, with site optimisation applied.

Note 19.1 Investment Property

The trust had no investments in 2020/21.

Note 19.2 Investment property income and expenses

The trust had no investment property income and expense in 2020/21.

Note 20 Investments in associates and joint ventures

The trust has no investments in unconsolidated subsidiaries, joint ventures, associates or unconsolidated entities.

Note 21 Other investments / financial assets (non-current)

The trust has no other investments in 2020/21.

Note 22 Disclosure of interests in other entities

The trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated entities.

Note 23 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	3,150	3,481
Work In progress	-	-
Consumables	4,896	4,688
Energy	56	19
Other	92	91
Total inventories	8,194	8,279
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £37,493k (2019/20: £60,991k). Write-down of inventories recognised as expenses for the year were £94k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the trust received £7,780k 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 the expenses disclosed above.

Note 24.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	20,291	32,477
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(886)	(1,006)
Allowance for other impaired receivables	(821)	(207)
Deposits and advances	-	-
Prepayments (non-PFI)	2,769	1,937
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	903	15
VAT receivable	983	161
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total current receivables	<u>23,239</u>	<u>33,377</u>
Non-current		
Contract receivables	-	-
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	1,276	1,087
Total non-current receivables	<u>1,276</u>	<u>1,087</u>
Of which receivable from NHS and DHSC group bodies:		
Current	13,857	24,667
Non-current	1,276	1,087

Note 24.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	1,006	207	947	207
Transfers by absorption	-	-	-	-
New allowances arising	214	614	59	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write offs)	(334)	-	-	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2021	886	821	1,006	207

Note 24.3 Exposure to credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31st March 2021 are in receivables from customers, as disclosed in the trade and other receivables note to the accounts.

Note 25 Other assets

The trust has no other assets.

Note 26.1 Non-current assets held for sale and assets in disposal groups

The Board has not declared any assets being surplus to requirements in 2020/21.

Note 26.2 Liabilities in disposal groups

The trust has no liabilities in disposal groups.

Note 27.1 Cash and cash equivalents movements

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

	2020/21 £000	2019/20 £000
At 1 April	19,814	13,499
Prior period adjustments	-	-
At 1 April (restated)	19,814	13,499
Transfers by absorption	-	-
Net change in year	24,063	6,315
At 31 March	43,877	19,814
Broken down into:		
Cash at commercial banks and in hand	253	155
Cash with the Government Banking Service	43,624	19,659
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	43,877	19,814
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	43,877	19,814

Note 27.2 Third party assets held by the trust

Western Sussex Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021 £000	31 March 2020 £000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	-	-

Note 28.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	13,548	5,060
Capital payables	7,319	1,734
Accruals	14,749	10,352
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
Social security costs	4,058	3,667
VAT payables	-	-
Other taxes payable	3,900	3,190
PDC dividend payable	-	-
Other payables	4,414	4,463
Total current trade and other payables	47,988	28,466
Non-current		
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	2,750	6,591
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

The trust has no early retirements in NHS payables above.

Note 29 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	2,481	1,750
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	13	-
Total other current liabilities	<u>2,494</u>	<u>1,750</u>
Non-current		
Total other non-current liabilities	<u>-</u>	<u>-</u>

Note 30.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	1,801	1,806
Obligations under finance leases	38	44
Total current borrowings	<u>1,839</u>	<u>1,850</u>
Non-current		
Loans from DHSC	12,984	14,756
Obligations under finance leases	2,171	2,169
Total non-current borrowings	<u>15,155</u>	<u>16,925</u>

Note 30.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2020	16,562	-	2,213	-	18,775
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,772)	-	(4)	-	(1,776)
Financing cash flows - payments of interest	(463)	-	(158)	-	(621)
Non-cash movements:					
Transfers by absorption	-	-	-	-	-
Additions	-	-	-	-	-
Application of effective interest rate	458	-	158	-	616
Change in effective interest rate	-	-	-	-	-
Changes in fair value	-	-	-	-	-
Early terminations	-	-	-	-	-
Other changes	-	-	-	-	-
Carrying value at 31 March 2021	14,785	-	2,209	-	16,994

Note 30.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	18,339	-	2,256	-	20,595
Prior period adjustment	-	-	-	-	-
Carrying value at 1 April 2018 - restated	18,339	-	2,256	-	20,595
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,772)	-	(43)	-	(1,815)
Financing cash flows - payments of interest	(501)	-	(165)	-	(666)
Non-cash movements:					
Transfers by absorption	-	-	-	-	-
Additions	-	-	-	-	-
Application of effective interest rate	496	-	165	-	661
Change in effective interest rate	-	-	-	-	-
Changes in fair value	-	-	-	-	-
Early terminations	-	-	-	-	-
Other changes	-	-	-	-	-
Carrying value at 31 March 2020	16,562	-	2,213	-	18,775

Note 31 Other financial liabilities

The Trust has no other financial liabilities.

Note 32 Finance leases

Note 32.1 Western Sussex Hospitals NHS Foundation Trust as a lessor

There are no future lease receipts due under finance lease agreements where Western Sussex Hospitals NHS Foundation Trust is the lessor.

Note 32.2 Western Sussex Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	11,336	11,498
of which liabilities are due:		
- not later than one year;	200	207
- later than one year and not later than five years;	735	732
- later than five years.	10,401	10,559
Finance charges allocated to future periods	(9,127)	(9,285)
Net lease liabilities	2,209	2,213
of which payable:		
- not later than one year;	38	44
- later than one year and not later than five years;	105	101
- later than five years.	2,066	2,068
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as expense in the period	(152)	(151)

Note 33.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Other £000	Total £000
At 1 April 2020	853	1,678	145	1,087	3,764
Transfers by absorption	-	-	-	-	-
Change in the discount rate	12	80	-	189	281
Arising during the year	4	-	147	1,501	1,652
Utilised during the year	(123)	(107)	-	-	(230)
Reclassified to liabilities held in disposal groups	-	-	-	-	-
Reversed unused	(6)	(314)	(16)	-	(336)
Unwinding of discount	(4)	(8)	-	-	(12)
At 31 March 2021	736	1,329	276	2,777	5,119
Expected timing of cash flows:					
- not later than one year;	121	79	276	375	851
- later than one year and not later than five years;	433	414	-	1,126	1,973
- later than five years.	182	836	0	1,276	2,295
Total	736	1,329	276	2,777	5,119

Pension costs are based upon known amounts that will have to be paid to the NHS Pension Agency in respect of staff who have retired early. By their very nature, provisions are estimates, though informed. For the calculation of pension and injury benefit liabilities, government actuary figures for expected mortality have been used and for legal claims, data is provided by the NHS Litigation Authority.

Other includes an estimate of the provisions arising under the clinicians pensions tax scheme. NHS England has used information provided by the Government Actuaries Department and NHS Business Services Authority to calculate an 'average discounted value per nomination'. This figure per individual of £3,927 (2019/20: £3,345) has been multiplied by the number of eligible clinicians within the Trust and will be refined in future years.

Note 33.2 Clinical negligence liabilities

At 31 March 2021, £281,569k was included in provisions of NHS Litigation Authority in respect of clinical negligence liabilities of Western Sussex Hospitals NHS Foundation Trust (31 March 2020: £245,768k).

Note 34 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(60)	(47)
Gross value of contingent liabilities	<u>(60)</u>	<u>(47)</u>
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	<u>(60)</u>	<u>(47)</u>
Net value of contingent assets	-	-

The foundation trust has no contingent liabilities other than those advised by the NHSLA as at 31st March 2021 shown above.

Note 35 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	5,764	1,461
Intangible assets	-	-
Total	<u>5,764</u>	<u>1,461</u>

Note 36 Other financial commitments

The trust has no other financial commitments.

Note 37 Financial instruments

Note 37.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the trust has with commissioners and the way those commissioners are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The trust has some powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. The trust's treasury activity is subject to review by the 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 borrows from government for capital expenditure. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31st March 2021 are in receivables from customers, as disclosed in the trade and other receivables note to the accounts.

Liquidity risk

The trust's operating costs are incurred under contracts with Clinical Commissioning Groups (CCGs), which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from a combination of its own self-generated funds and capital investment loans with reference to NHS Improvement's Continuity of Services Risk Rating. The trust is not, therefore, exposed to significant liquidity risks.

Note 37.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	19,860	-	-	19,860
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	43,877	-	-	43,877
Total at 31 March 2021	63,737	-	-	63,737
Carrying values of financial assets as at 31 March 2020				
Trade and other receivables excluding non financial assets	32,351	-	-	32,351
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	19,814	-	-	19,814
Total at 31 March 2020	52,165	-	-	52,165

Note 37.3 Carrying values of financial liabilities

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	14,785	-	14,785
Obligations under finance leases	2,209	-	2,209
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	35,693	-	35,693
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2021	52,687	-	52,687
Carrying values of financial liabilities as at 31 March 2020			
Loans from the Department of Health and Social Care	16,562	-	16,562
Obligations under finance leases	2,213	-	2,213
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	17,540	-	17,540
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2020	36,315	-	36,315

Note 37.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	38,087	19,982
In more than one year but not more than five years	6,559	7,687
In more than five years	<u>20,462</u>	<u>21,682</u>
Total	<u>65,108</u>	<u>49,351</u>

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 37.5 Fair values of financial assets and liabilities

There are no financial assets held at book value or fair value by the trust.

Note 38 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	56	334	-	-
Stores losses and damage to property	-	-	-	-
Total losses	56	334	-	-
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	36	70	62	65
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	36	70	62	65
Total losses and special payments	92	404	62	65
Compensation payments received		-		-

Note 39 Related parties

The Department of Health and Social Care is regarded as the parent Department of the trust and is therefore a related party. During the year Western Sussex 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. Material transactions with these entities are summarised in the tables below.

On 1st April 2017, the trust (WSH) entered into a long-term agreement with NHS Improvement and Brighton and Sussex University Hospitals NHS Trust (BSUH). This agreement provides for collaboration between the Trusts, including arrangements for board membership and governance in common, as well as the provision of management support to BSUH by WSH. The initial term of this agreement was for three years which was extended for a further year. On 1st April 2021 WSH acquired the assets & liabilities of BSUH under section 56A of the NHS Act 2006. The newly merged trust is known as University Hospitals Sussex NHS Foundation Trust from this date.

Western Sussex Hospitals NHS Trust is sole corporate trustee of Western Sussex Hospitals Charitable Trust, from whom the Trust has received revenue and capital payments.

	Receivables		Payables	
	2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
NHS West Sussex CCG (previously Horsham & Midsussex, Coastal West Sussex and Crawley CCGs)	785	3,528	449	4,602
NHS England	2,335	12,235	1,557	11
NHS Brighton and Hove CCG	58	127	-	-
NHS South Eastern Hampshire CCG	-	239	-	144
Sussex Community NHS Foundation Trust	1,355	1,220	307	156
Sussex Partnership NHS Foundation Trust	2,815	1,664	36	215
Portsmouth Hospitals University NHS Trust (previously Portsmouth Hospitals NHS Trust)	1,096	1,176	35	96
Health Education England	339	94	1,012	14
NHS Litigation Authority	-	-	17	-
Brighton and Sussex University Hospitals NHS Trust	2,047	2,173	-	2,079
Western Sussex Hospitals Charities and Other Related Charities	139	17	-	-
Total	10,969	22,473	3,413	7,317

Details of related party transactions with individuals are as follows:

	Income		Expenditure	
	2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
University of Sussex (related to Kirsten Baker, Non-Executive Director Adviser ¹)	347	238	-	-
St Barnabas Hospice (related to Mike Rymer, Non Executive Director ²)	-	291	-	9

	Income		Expenditure	
	2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
NHS West Sussex CCG (previously Horsham & Midsussex, Coastal West Sussex and Crawley CCGs)	376,845	342,748	449	-
NHS England	80,925	73,962	23	32
NHS Brighton and Hove CCG	6,828	6,412	-	-
NHS South Eastern Hampshire CCG	7,303	6,948	-	-
Sussex Community NHS Foundation Trust	1,701	3,272	261	203
Sussex Partnership NHS Foundation Trust	3,220	3,761	265	392
Portsmouth Hospitals University NHS Trust (previously Portsmouth Hospitals NHS Trust)	3,838	4,090	241	483
Health Education England	13,764	13,494	-	3
NHS Litigation Authority	-	-	16,193	14,230
Brighton and Sussex University Hospitals NHS Trust	2,272	2,317	2,168	3,239
Western Sussex Hospitals Charities and Other Related Charities	112	184	-	-
Total	496,808	457,188	19,600	18,582

Notes to the above

1) K Baker is a Member of Council at the University of Sussex.

2) M Rymer was a co-opted member of the Quality Assurance Committee at St Barnabas Hospice 2019/20.

Note 40 Events after the reporting date

On 1 April 2021, Western Sussex Hospitals NHS Foundation Trust acquired the assets, liabilities and operations of Brighton and Sussex University Hospitals NHS Trust, forming University Hospitals Sussex NHS Foundation Trust through merger by acquisition under section 56A of the NHS Act 2006.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST IN RESPECT OF THE 2020/21 FINANCIAL STATEMENTS OF WESTERN SUSSEX UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Western Sussex Hospitals NHS Foundation Trust for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows, the Trust Statement of changes in equity and the related notes 1 to 40, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

In our opinion the financial statements:

- give a true and fair view of the financial position of Western Sussex Hospitals NHS Foundation Trust's affairs as at 31 March 2021 and of its income and expenditure and income for the year then ended; and
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2020/21 and the directions under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

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 for the audit of the financial statements section of our report below. We are independent of the Foundation 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 the Comptroller and Auditor General's (C&AG) AGN01 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.

Emphasis of matter – Acquisition by merger of Brighton and Sussex University Hospitals NHS Trust, 1 April 2021

We draw attention to Note 1 in relation to Going concern and Note 40 Events after the reporting date of the financial statements, which describes the acquisition by merger by the Foundation Trust of Brighton and Sussex University Hospitals NHS Trust on 1 April 2021 and the transfer of the Trust's assets, liabilities and operations to University Hospitals Sussex NHS Foundation Trust (the name of the new merged entity). Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable 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 Foundation Trust's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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 course of 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice issued by the NAO

In our opinion:

- the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff report identified as subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- we have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2020/21 and is not misleading or inconsistent with other information forthcoming from the audit; or
- we have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

The NHS Foundation Trust Annual Reporting Manual 2020/21 requires us to report to you if in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit; or
- otherwise misleading.

We have nothing to report in respect of these matters.

Responsibilities of Accountable Officer

As explained more fully in the Accountable Officer's responsibilities statement, the Accountable 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 Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Accountable Officer's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

We understood how Western Sussex Hospitals NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust's board minutes and through enquiry of employees to verify Trust policies, and through the inspection of HR policies and other information. Based on this understanding

we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance through improper recognition of revenue, inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trust's manual year end receivables and payables accruals, challenging assumptions and corroborating the income to appropriate evidence. We tested year-end cut-off arrangements by selecting samples of income and expenditure from either side of the 31 March 2021 balance sheet date and reviewing to supporting evidence to ensure these were recorded in the appropriate financial year. We also undertook cut-off testing of expenditure as at month 6 of the financial year to establish whether the Trust had incorrectly included expenditure relating to later months that would trigger reimbursement and top-up funding for that period of the financial year that it would otherwise not be entitled to.

To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested a sample of the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.

To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Western Sussex 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 issued by the National Audit Office on behalf of the Comptroller and Auditor General (C&AG).

Use of our report

This report is made solely to the Council of Governors of University Sussex Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 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, for our audit work, for this report, or for the opinions we have formed.

*Suresh Patel for & on behalf of
Ernst & Young LLP*

*Suresh Patel
Ernst & Young LLP (Local auditor)
Southampton
15 June 2021*



Western Sussex Hospitals
NHS Foundation Trust



QUALITY REPORT

2020/21

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Part 1: Statement on quality from the Chief Executive of Western Sussex Hospitals NHS Foundation Trust

Dame Marianne Griffiths, Chief Executive

What we do

This Quality Report refers to the legacy organisation Western Sussex Hospitals NHS Foundation Trust (WSHFT) for the reporting period 1st April 2020 to 31st March 2021. From the 1st April 2021 WSHFT has become part of University Hospitals Sussex NHS Foundation Trust along with Brighton & Sussex University Hospitals NHS Trust.

Western Sussex Hospitals NHS Foundation Trust served a population of around 450,000 people across a catchment area covering most of West Sussex. The Trust ran three hospitals: St

Richard's Hospital, Southlands Hospital and Worthing Hospital along with range of services in other community settings, including: Bognor War Memorial Hospital, Crawley Hospital, health centres, GP surgeries, and sexual health clinics.

WSHFT was inspected by the Care Quality Commission, the independent regulator of health and social care in England, during 2019/20 and awarded the highest possible rating, Outstanding, in October 2019.

Purpose of the Quality Report

Patients deserve to know about the quality of care they receive; we aim to ensure that this is the very best quality of care every time.

Our Quality Report is a narrative to patients, carers, professionals and the public about the quality and standard of services we provide. It is an important way to show improvements in the services we deliver to local communities and stakeholders.

The quality of our services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

NHS Improvement requires all NHS Foundation Trusts to report on the quality of care they provide as part of their annual reports. Foundation Trusts are also required to publish a quality account each year by the Government. Our Quality Report combines both requirements in this one document.

Statement on quality from the Chief Executive

We are committed to continually improving the quality of care our patients receive through our Patient First Improvement Programme focused on empowering and enabling everyone to be passionate about delivering excellent care every time. During 2020/21, in what has been a really challenging year, it has been great to see that our relentless focus on putting our patients at the heart of everything we do has continued with such vigour.

Quality Improvement programmes

Many of our quality improvement programmes were suspended during the course of 2020/21; staff were redeployed to front-line roles as our priority focus switched to caring for our patients and staff in the challenging time of national uncertainty. This year's quality report does not therefore always feature full year data or the breadth of improvements we had wished to pursue.

One improvement programme which has achieved amazing success is the elimination of severe pressure damage work; my congratulations go to everyone working on this programme. Our aim for 2020/21 was to reduce hospital-acquired category 3 and above pressure damage by 30% (from a baseline of 2018/19). Despite an operationally challenging year, we delivered above and beyond our target, delivering a reduction in hospital-acquired category 3 and above pressure damage of an astonishing 81%. The hard work and dedication of our ward and tissue viability teams also saw the successful implementation of measures to protect Covid-19 patients from device-related pressure ulcers

during the year.

Staff Survey

The results of the NHS Staff Survey have recently been published, and despite the national survey being undertaken during the second wave of the Covid-19 pandemic, staff engagement remained high; staff advocacy for WSHFT increased again with improvements in the 'recommendation as a place to work' and 'recommendation to family and friends as a place to receive treatment' categories. The NHS Staff Survey focuses on staff engagement because it's an established fact that more engaged staff provide better care and are better able to help their organisation improve.

Responding to the Covid-19 pandemic

2020/21 has certainly been an unprecedented year. A national and global pandemic in which we have had to make difficult choices to ensure that urgent work could continue whilst we provided emergency, acute and ongoing care for thousands of patients with the virus. Standing down non-urgent work was an agonising decision to take, but it was important because we wanted to do the right thing for our patients and protect our staff.

The effort across the organisation in terms of planning and refinement of plans has been absolutely amazing. The way in which services have adapted and the team work we have seen across the hospitals with everyone that's involved is just humbling and has given us the best opportunity possible to navigate the emergency. The impact of Covid-19 has been tough, and

continues to be, profound. The virus has had a huge impact on the delivery of NHS care, with staff having to adapt services under huge pressure, while ensuring our hospitals remain a safe environment for patients and staff.

Moves to running outpatient clinics online, introducing a host of methods to enable patients to communicate with their loved ones or members of the local community whilst they were not allowed visitors, introducing an online meeting platform for staff and welcoming volunteers from the airline industry to run 'first class' lounges for our staff have all been tremendous innovations during the year.

Research has been at the vanguard of efforts to reduce mortality and improve outcomes for those affected by Covid-19, to understanding more about transmission and immunity and to the development, testing and subsequent roll-out of vaccinations – research across WSHFT has contributed to all of these both locally, nationally and globally with a staggering 2430 patients and staff participating in Covid-19 research during 2020/21.

I would also like to acknowledge the amazing response that we have seen from our partners in the community, not just health and social care partners, but businesses, supermarkets, and a whole host of others.

University Hospitals Sussex NHS Foundation Trust

On the 1st April 2021, University Hospitals Sussex NHS Foundation Trust (UHSussex) was created

by the merger of WSHFT and Brighton & Sussex University Hospitals NHS Trust (BSUH), heralding the dawn of a new future for staff, volunteers and our patients in Sussex.

“This is a momentous day for healthcare in Sussex. As both a university hospital and foundation trust, we have all the tools we need to develop outstanding services for our communities, offer exciting new career opportunities for our colleagues and continue to put local people at the heart of our decisions and plans.”

“We will continue to invest in all our vibrant hospitals and all the services we currently provide, including emergency, specialist, tertiary and trauma care. And our new five year clinical strategy will explore where we can make the best improvements for our patients and develop new services that ensure fewer people in Sussex have to travel elsewhere for high quality hospital care.”

The merger sees the best of both legacy trusts brought together to create a new, larger organisation with seven hospitals across five main sites in Sussex, as well as numerous satellite services. Before the merger, WSHFT and BSUH had been working together under a shared leadership for nearly four years under a management agreement signed in April 2017.

We are immensely proud of the outstanding clinical services our newly formed Trust, UHSussex delivers. Integral to this, is the hard work and dedication of our staff. Within the context of the global pandemic, the care and commitment of our teams to provide excellent

clinical services have been particularly evident. The experience of the pandemic, far from dampening enthusiasm for improving our services, has only served to grow this further, with our teams repeatedly demonstrating their wish to learn from and embed the positive changes that were implemented at pace in response to the pandemic. This energy is also evident in the commitment of our staff to realise the benefits of our recent merger. There is a strong appetite to take the opportunities this brings to deliver patient benefits and enable our new organisation to best meet local need, as well as optimising the quality and sustainability of our clinical services.

Committed to quality improvement

I have the privilege to work with so many extraordinary and caring colleagues across the Trust, always committed to improving the care and the services we provide. I look forward to our continued focus on our quality improvement programmes during the year ahead and our first year as UHSussex.

I am pleased to confirm that the Trust Board has reviewed the 2020/21 Quality Report and confirm that it is a true and fair reflection of our performance. We hope that this Quality Report provides you with a clear picture of what we have achieved over the past year and how we will continually build upon these foundations.

We have written the report in plain English wherever possible to ensure it is widely accessible for all interested parties, and will continue to refine all our literature to meet this ambition.

The information contained within the Quality Report is, to the best of my knowledge, accurate.

Signed: 

Date: 29th June 2021

Dame Marianne Griffiths

Chief Executive

University Hospitals Sussex NHS Foundation Trust
(Legacy Western Sussex Hospitals NHS Foundation Trust)



Part 2.1: Priorities for quality improvement

'Thank You' murals — Hundreds of thank you pictures and cards were sent to us by local children and schools during the first national lockdown in 2020. Murals featuring some of the wonderful artwork have recently made for St Richard's, Worthing and Southlands Hospitals to say "Thank you for all the love and appreciation shown to our staff during the Covid-19 lockdown (23 March—4 July 2020)".

Our Trust approach to Quality Improvement

(Please note this forward section refers to the approach and priorities of University Hospitals Sussex as our newly merged organisation)

Patient First Programme

We recognise that the strength of our hospitals lies in our staff, and have built an organisational culture that empowers teams and individuals to make lasting changes that benefit our patients and community. To do this, we have developed Patient First – the Trust's bespoke approach to sustaining a culture of continuous improvement.

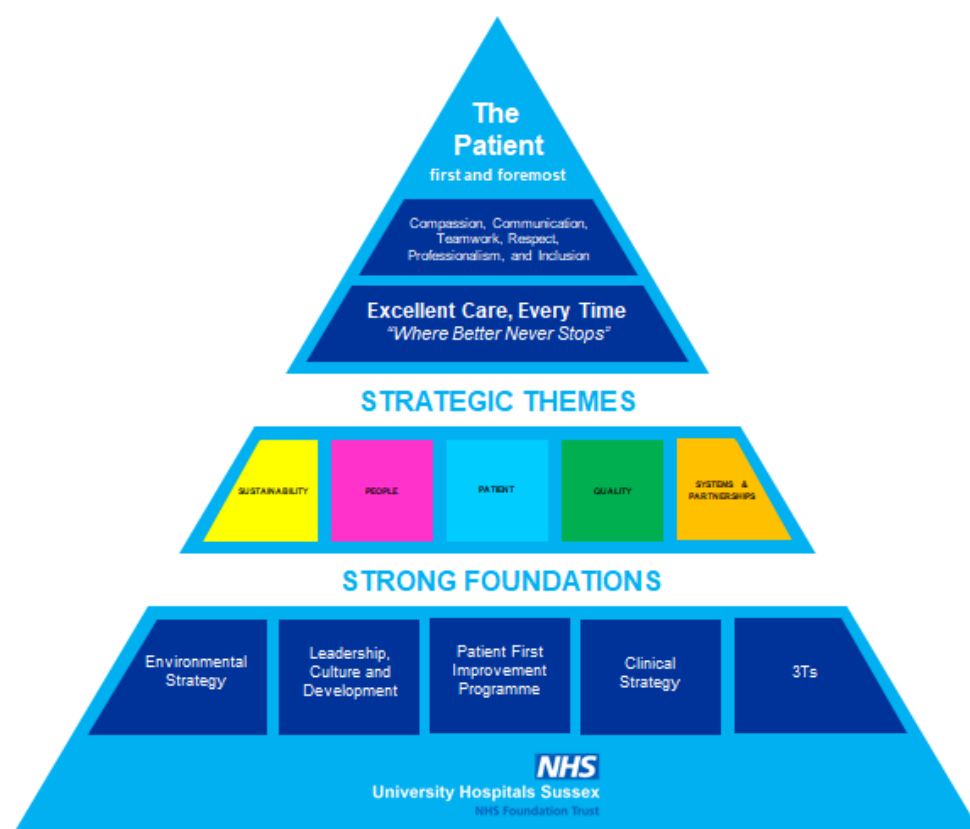
The Patient First Programme drives quality improvement at University Hospitals Sussex. It comprises five strategic themes: sustainability; people; patients; quality; and systems and partnerships; to enable excellent care for patients. In simple terms, the main aim of our Patient First

Programme is to empower and enable everyone to be passionate about delivering excellent care every time. Further information about Patient First can be found on the Trust website:

<https://www.uhsussex.nhs.uk/about/patient-first/>

True North

Our top priorities relate to the Trust's 'True North' quality and safety improvement metrics. These establish a measure of our organisational health and provide a system-wide improvement focus. True North is the compass that keeps our hospitals heading in the right direction – we should always refer to when identifying which improvements and projects to prioritise.



True North	Metric / Target
Patient	Patient Experience: To have 95% or more of patients rating FFT surveys as Very Good or Good
Sustainability	Financial Sustainability: To deliver the Trust's financial plan
People	Staff Engagement: To be within the top quartile of acute Trusts for the National staff engagement score
Quality	Harm: To achieve a 10% reduction in the levels of DATIX reported harm to patients Mortality: To achieve a 10% reduction in the crude mortality rate
Systems & Partnerships	Planned Care: To have no patients waiting in excess of 40 weeks on an RTT pathway to be seen and treated Emergency Care: To achieve 95% of patients are treated within 4 hours in Emergency Care services

For Quality Improvement our True North Metrics going forwards into 2021/22 are to achieve a 10% reduction in the levels of DATIX reported harm to patients, and to achieve a 10% reduction in the crude mortality rate. We focus relentlessly on our Breakthrough Objectives, those that will take us furthest and fastest towards our overall True North, as the key objectives to deliver this.

Our breakthrough objectives are regularly reviewed to ensure that we focus on the key improvements that will deliver our True North Metrics.

Our True North objectives are cascaded throughout the Trust and from Board to ward using a process referred to as 'catch ball'. This occurs with each Division and the Executive ensuring:

- Divisions understand how to contribute to achieving the organisational priorities;
- Agreement of what additional local priorities each division needs to achieve;
- Mutual agreement of these objectives, as well as the resources required to achieve them.

Clinical Strategy

As a newly emerged organisation, University Hospitals Sussex NHS Foundation Trust is developing a new clinical strategy. The strategy will be central to our achievement of our True North objectives by ensuring we develop and improve our services in a way that satisfies the requirements of all our True North domains and enables us to deliver the benefits of merger.

Quality improvement capacity and capability: Patient First Improvement System (PFIS)

Using the aforementioned Patient First approach, the Trust has developed a bespoke approach to sustaining a culture of continuous improvement. Our programme is based on Lean methodology, standardisation, system redesign, ongoing development of care pathways, and is built on a philosophy of incremental and continuous improvement by front-line staff empowered to initiate and lead positive change. PFIS helps our wards and departments to support and sustain large-scale improvement projects. The PFIS

system involves four months of training for each ward or department team through attendance at a series of modules and team days. Staff learn to implement PFIS in their areas and adopt new Lean management techniques including 'A3 problem

solving', testing solutions using a 'Plan Do Study Act' (PDSA) approach, standard work, and process observation, as well as implementing improvement huddles.

Priorities for quality improvement in 2021/22

(Please note this forward section refers to the priorities of University Hospitals Sussex as our newly merged organisation)

Our Quality Priorities for 2021/22 will form part of our broader ambition set out in our True North metrics. In order to develop our annual quality priorities and breakthrough objectives we analyse quality indicators and benchmarking data, and

engage widely. For 2021/22, with a background of an ongoing pandemic and Trust merger, quality priorities are currently under consideration at divisional level to fit with University Hospitals Sussex new True North goals:



Avoiding harm

Goal: to have zero harm occurring to our patients when in our care

Target: To achieve a 10% reduction in the levels of DATIX reported harm to patients



Reducing preventable mortality and improving outcomes

Goal: To achieve the lowest crude mortality within our peer group

Target: To achieve a 10% reduction in the crude mortality rate



Improving patient experience

Goal: To ensure that all our patients have a positive experience of the care they receive

Target: To have 95% or more of patients rating FFT surveys as Very Good or Good



Engaging our staff

Goal: To be the top acute Trust for staff engagement

Target: To be in the top quartile of acute Trusts for the National staff engagement score

The delivery of key Quality Priorities will be reported to the Trust Executive Board through regular reports and scorecards. The Trust Quality Committee will monitor the delivery of detailed quality improvement programmes set out in the Trust's strategic and annual plans. Divisional accountability for elements of our quality

improvement programme is achieved through early engagement work relating to setting meaningful annual improvement priorities and local objectives and the cascade of accountabilities through our strategy deployment processes.

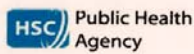
SIREN

SARS-CoV2 Immunity & Reinfection Evaluation

Certificate of Achievement

The Public Health England SIREN Study Team awards
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
this certificate to celebrate their successful recruitment of **252** SIREN participants.

Dr. Susan Hopkins
SIREN Chief Investigator



Part 2.2: Statements of assurance from the Board

SIREN study (SARS-CoV2 Immunity & Reinfection Evaluation) — Two of the Trust's research nurses, Aaron and Tan, discussing the SIREN study with Chief Nurse Maggie Davies. Our Research Team have recruited 252 members of staff across the organisation to help contribute to the national study of staff working in healthcare organisations, led by Public Health England, examining Covid-19 natural and vaccine-derived antibody protection.

Maintaining an Outstanding CQC rating

Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆
Are resources used productively?	Outstanding ☆

Inspected and rated
Outstanding ☆



Western Sussex Hospitals
NHS Foundation Trust

WSHFT participated in an inspection led by the CQC in July and August 2019. The CQC inspected our critical care units at Worthing and St Richard's Hospitals along with inspecting the responsive section of outpatients across all three sites; Worthing, St Richard's and Southlands Hospitals. During these inspections the CQC inspected the leadership of the Trust as a separate

inspection of the well-led question at provider level. The Trust received an inspection rating of 'Outstanding' across all five domains; safe, effective, caring, responsive and well-led and in addition for our 'use of resources' which was also rated as Outstanding. Western Sussex was the first non-specialist acute hospital trust in England to be given a full sweep of outstanding ratings across the board, and the only one to be rated 'Outstanding' for safety.

Due to the limitations of the pandemic, the peer review process has been suspended, however regular monthly meetings have continued with CQC as a virtual platform, these meetings have provided a valuable arena for providing quality assurance during both the first and second waves of COVID-19.

How we learn

We have robust systems in place for reviewing incidents, complaints, mortality reviews and inquests within our clinical divisions. Each clinical division has a clinical governance lead to coordinate this activity and help the Divisions to track and complete the actions arising out of each of these areas. The divisions also use safety huddles, the Theme of The Week, Patient Story newsletters and staff meetings to help communicate changes made in response to learning.

When harm occurs, talking to the person affected or their family/carer provides crucial context to any investigation. We continue to develop and encourage an open and honest approach to supporting patients who have been harmed, or their families, as candour and transparency are core values for the Trust. In 2020/21 WSHFT remained 100% compliant in the Health & Social Care Act – Regulation 20 – Duty of Candour.

Learning from incidents

The Trust Patient Safety Team is currently undertaking an improvement project regarding the Datix incident reporting system. The improvement programme has taken two years to plan, and has involved a variety of stakeholder feedback methods and engagement / training days. The revised system will enable the Trust to analyse safety themes and data more effectively, developing safety dashboards enabling robust reporting and a shared learning and solution focused model of care.

Due to the pandemic, our two day Serious Incident (SI) Investigator training programme accredited by the Royal College of Physicians and sponsored by the Kent Surrey and Sussex Quality and Patient Safety Collaborative (KSS AHSN) continued as virtual 'modular training' in 2020/21. The programme was facilitated by the WSHFT Head of Patient Safety and provided training on how to investigate SIs using a Human Factors approach, the Duty of Candour and involving the patient, their family and carers. The programme was extremely well received with a recommendation that all staff investigating serious incidents should attend the training in the future.

With the publication of the NHS Patient Safety Strategy 2019, a further revised training programme is planned for 2021/22 with an annual training programme under development. Trends and themes from incidents, complaints, inquests and deaths (mortality) are also shared at the

monthly WSHFT Triangulation Committee, with the learning translated into the Patient Safety and Learning Newsletter, for use by the teams in safety and improvement huddles.

Further regional learning events were held in December 2020 and February 2021; hosted by the WSHFT Patient Safety Team, all Sussex healthcare providers and commissioners were invited to attend. Focusing on the shared learning from SI investigation, infection prevention and control and the learning from inquest, the events were extremely well attended with positive feedback received. In addition, a family member also attended the learning event in February to give powerful insight into their experience of inquest.

In 2019, following the Care Quality Commission's inspection, the domain of *Safe* was rated as "*Outstanding*". WSHFT are the first acute non-specialist hospital to receive this rating. Feedback in the published CQC report particularly focused on the SI training provided, the quality of SI investigations and immediate actions taken, the sharing of the lessons learned and opportunities for improvement, and the involvement of patients, families and carers within the Duty of Candour process. In line with the recommendations detailed in the new NHSE Patient Safety Strategy; the Trust has now identified a Patient Safety Specialist for the organisation.

Learning from deaths

In accordance with national mortality guidance, the Trust has continued to run a screening and structured judgement review (SJR) process to identify and learn from deaths. The operational links between this activity and the SI, complaints and legal process have been established and are now well embedded. The thematic learning from this activity links to other key work streams and groups such as the End of Life & Mortality Board, the Deteriorating Patient Group, the Triangulation Group and the HSMR Programme Board to ensure the learning informs strategic planning and development in key areas.

The Trust has also actively participated in the NHS England funded Learning Disabilities Mortality Review Programme (LeDeR) both at investigation level and as active members of the Sussex LeDeR Programme steering group.

In June 2018 the Government announced its intention to introduce a medical examiner system into the NHS. From April 2022, every NHS Trust will have a statutory responsibility to host a medical examiner service to securitise all deaths.

The aim is to:

- Provide bereaved families with greater transparency and opportunities to raise concerns
- Improve the quality/accuracy of medical certification of cause of death
- Ensure referrals to coroners are appropriate
- Support local learning/improvement: patient safety/end of life care
- Improve public confidence/greater safeguards via consistent scrutiny of all non-coronial deaths
- Support all healthcare providers to improve care via increased learning opportunities.

WSHFT introduced phased medical examiner activity during 2020 following the recruitment of medical examiners and medical examiner's officers as per the national model. Reviews commenced in line with gold standard practice according to national guidance from the beginning of August 2020.

Review of services

During 2020/21 the Western Sussex Hospitals NHS Foundation Trust provided and/or sub-contracted 159 relevant health services.

The Western Sussex Hospitals NHS Foundation Trust has reviewed all the data available to them

on the quality of care in 159 of these relevant health services.

The income generated by the relevant health services reviewed in 2020/21 represents 100% of the total income generated from the provision of relevant health services by The Western Sussex Hospitals NHS Foundation Trust for 2020/21.

Participation in clinical audits and confidential enquiries

National clinical audits

During 2020/21, 42 national clinical audits and two national confidential enquiries covered relevant health services that Western Sussex Hospitals NHS Foundation Trust provides.

During that period, Western Sussex Hospitals NHS Foundation Trust participated in 93% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Foundation Trust was eligible to participate in during 2020/21 are as follows (see below).

The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Foundation Trust participated in during 2020/21 are as follows (see below).

The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The national led clinical audit programmes were impacted by the COVID-19 pandemic, with some audits scheduled for 2020/21 on hold/cancelled externally, whilst others had data collection suspended or limited due to the reduction of routine/elective surgery and the redeployment of frontline staff. Therefore, the number of national clinical audits is lower than in previous years.

National clinical audits	Eligible	Participated	Percentage submitted
National Core Diabetes Audit (NHS Digital)	Y	Y	100%
National Diabetes Foot Care Audit (NHS Digital)	Y	Y	Ongoing
National Diabetes in Pregnancy Audit (NHS Digital)	Y	Y	Ongoing
Fractured Neck of Femur (and Care in Emergency Departments) (Royal College of Emergency Medicine)	Y	Y	100%
Pain in Children (and Care in Emergency Departments) (Royal College of Emergency Medicine)	Y	Y	Ongoing
Infection Control (and Care in Emergency Departments) (Royal College of Emergency Medicine)	Y	Y	Ongoing
Myocardial Ischaemia National Audit Project (National Institute for Cardiovascular Outcomes Research)	Y	Y	Ongoing

National clinical audits	Eligible	Participated	Percentage submitted
National Audit of Percutaneous Coronary Interventions (National Institute for Cardiovascular Outcomes Research)	Y	Y	Ongoing
National Heart Failure Audit (National Institute for Cardiovascular Outcomes Research)	Y	Y	Ongoing
National Cardiac Rhythm Management Audit (National Institute for Cardiovascular Outcomes Research)	Y	Y	Ongoing
Major Trauma Audit (The Trauma Audit & Research Network)	Y	Y	Ongoing
National Cardiac Arrest Audit (Intensive Care National Audit and Research Centre)	Y	Y	100%
National Asthma and Chronic Obstructive Pulmonary Disease – COPD Audit (Royal College of Physicians)	Y	Y	Ongoing
National Asthma and Chronic Obstructive Pulmonary Disease – Adult Asthma Audit (Royal College of Physicians)	Y	Y	Ongoing
National Early Inflammatory Arthritis Audit (British Society for Rheumatology)	Y	N	0%
SSNAP - Sentinel Stroke National Audit programme (King's College London)	Y	Y	Ongoing
National Gastro-oesophageal Cancer Audit (NHS Digital)	Y	Y	100%
Urology Audit - Cytoreductive Radical Nephrectomy (British Association of Urological Surgeons)	Y	Y	Ongoing
Urology Audit - Female Stress Urinary Incontinence (British Association of Urological Surgeons)	Y	Y	Ongoing
Urology Audit – Renal Colic (British Association of Urological Surgeons)	Y	Y	Ongoing
Case Mix Programme (Intensive Care National Audit and Research Centre)	Y	Y	Ongoing
Elective Surgery Knees - National PROMs Programme (NHS Digital)	Y	Y	Ongoing
Elective Surgery Hips - National PROMs Programme (NHS Digital)	Y	Y	Ongoing
Endocrine and Thyroid National Audit (British Association of Endocrine and Thyroid Surgeons)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme: The National Hip Fracture Database (Royal College of Physicians)	Y	Y	Ongoing
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls (Royal College of Physicians)	Y	Y	Ongoing
National Audit of Breast Cancer in Older People (Royal College of Surgeons)	Y	Y	Ongoing
National Bariatric Surgery Registry (British Obesity & Metabolic Surgery Society)	Y	Y	Ongoing
National Emergency Laparotomy Audit (Royal College of Anaesthetists)	Y	Y	Ongoing
National Joint Registry (Healthcare Quality Improvement Partnership)	Y	Y	Ongoing
National Ophthalmology Audit (Royal College of Ophthalmologists)	Y	N	0%
National Bowel Cancer Audit (NHS Digital)	Y	Y	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review	Y	Y	100%

National clinical audits	Eligible	Participated	Percentage submitted
Programme (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)			
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) (Royal College of Paediatrics and Child Health)	Y	Y	100%
National Maternity and Perinatal Audit (Royal College of Obstetricians and Gynaecologists)	Y	Y	Ongoing
Antenatal and Newborn National Audit Protocol 2019 to 2021 (Public Health England)	Y	N	0%
National Paediatric Diabetes Audit (Royal College of Paediatrics and Child Health)	Y	Y	Ongoing
NACAP Paediatric Asthma Secondary Care [RCP]	Y	Y	Ongoing
National Lung Cancer Audit (Royal College of Physicians)	Y	Y	Ongoing
National Prostate Cancer Audit (Royal College of Surgeons)	Y	Y	Ongoing
National Audit of Cardiac Rehabilitation (University of York)	Y	Y	Ongoing
National Pulmonary Rehabilitation Audit (Royal College of Physicians)	Y	Y	Ongoing

National Confidential Enquiries	Eligible	Participated	Percentage submitted
Alcohol Related Liver Disease – Organisational Questionnaire	Y	Y	Ongoing
MBRRACE-UK - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in UK)	Y	Y	Ongoing

The reports of 29 national clinical audits were reviewed by the provider in 2020/21 and Western Sussex Hospitals NHS Foundation Trust intends

to take the following actions to improve the quality of healthcare provided.

Title	Action taken or planned
National Lung Cancer Audit	<ul style="list-style-type: none"> Establish the 'RAPID' type early CT pathway with 'Straight to CT' initiative (as recommended under the National Optimal Lung Cancer Pathway initiative). Embed lung cancer nurse specialist follow up clinics at both Worthing and St Richards's centres. Plans to support the establishment of local lung cancer screening pilots for high risk groups as a means of reducing the very high rates of emergency presentation of lung cancer in West Sussex - discussion with Public Health England and Sussex system partners.
Sentinel Stroke National Audit	<ul style="list-style-type: none"> Progress early supported discharge with community – completed business case. Investigate faster COVID testing and prioritise patients going to specialist units. Ring fence stroke unit beds. Investigate thrombolysis data in more detail. Review weekend working model to ensure new patients on either site can be

	post-take reviewed to improve time to consultant review.
UK Parkinson's Audit	<ul style="list-style-type: none"> • Amend clinic letter proforma for improved information to patients. • Improve timely administration of dopaminergic medications for inpatients - additional staff education sessions and reporting of breaches to inform further improvement opportunities.
NACAP Chronic Obstructive Pulmonary Disease (COPD) Secondary Care Audit	<ul style="list-style-type: none"> • Plans to ensure that a spirometry result is available for all patients admitted with an acute exacerbation: <ul style="list-style-type: none"> - increased bedside spirometry; - Routine COPD bundle available to whole multidisciplinary team via online access. • Regular 'in reach' to outlying respiratory inpatients.
National Audit of Care at the End of Life	<ul style="list-style-type: none"> • Additional end of life communication training available to all staff groups in collaboration with local hospices. • Ensure an individualised care plan is in place to support the care of dying people and work to have this embedded onto Patientrack with an education programme to support this.
Sprint Audit - Maternity Care for Women with Multiple births and Their Babies	<ul style="list-style-type: none"> • Maternity information system to be updated to differentiate between urgent and planned caesarean births • Individual newborn baby NHS numbers generated and stored on maternity information system and linked to the mother's number.
National Chlamydia Screening Programme	<ul style="list-style-type: none"> • Improvement of partner notification by developing: <ul style="list-style-type: none"> - a dynamic partner notification tool to facilitate improved documentation and outcome reporting; - a staff training package to improve technical competency in relation to partner notification; - web-based patient information to facilitate understanding of partner notification and to support patient led activity.

Local clinical audits

The reports of 147 local clinical audits were reviewed by the provider in 2020/21 and Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Reports of local clinical audits are disseminated to the Trust's Clinical Divisions for their actions. Main points of action for a sample of local clinical audits reported in 2020/21 are shown below.

Title	Action taken or planned
Assessment of Venous Thromboembolism (VTE) Prophylaxis in Neuro-rehabilitation Patients	<ul style="list-style-type: none"> • VTE assessment tool introduced into the Donald Wilson House clerking proforma. • Introduction of mandatory prompt for a VTE assessment on the electronic prescribing system when a patient is electronically moved to Donald Wilson House.
Adherence to the British Society for Rheumatology Guideline for Screening Prior to Anti-TNF Therapy	<ul style="list-style-type: none"> • Screening undertaken at the point of recommending biologic treatment and a nurse education appointment is now arranged in parallel. • Education clinics established and a comprehensive biologic register maintained.
Virtual Clinic in Gastroenterology	<ul style="list-style-type: none"> • Suitable patients are now identified and virtual clinics implemented.
Results of Dacrocystorhinostomy Surgery	<ul style="list-style-type: none"> • Endoscope purchased to avoid unnecessary referrals to ENT and to assess surgical scar. • Patient reported success now documented.
Hospital Epidurals	<ul style="list-style-type: none"> • Business case prepared for additional pain nurse at St Richard's. • Epidural training sessions being provided by Inpatient Pain Service. • Anaesthetists siting epidurals consider referral of patients for HDU (level 2) support.
Ward & ICU Continuous Positive Pressure (CPAP) therapies during the COVID Pandemic	<ul style="list-style-type: none"> • Plan to extend audit of: <ul style="list-style-type: none"> - Clinical Frailty Score and age to all COVID-19 admissions, including outcome. - Blood gas baseline at institution of CPAP and six hour changes.
Management of Distal Radius Fractures: A Re-audit	<ul style="list-style-type: none"> • A safe structured service implemented where patients needing manipulation under anaesthetic are brought back for this to be done under Biers Block with orthopaedic registrar input.
Dietetic input with patients admitted with Crohn's disease as a primary diagnosis: A Re-audit	<ul style="list-style-type: none"> • Dietitians interrogate the patient administration system daily for patients admitted with Crohn's Disease. • Same day referral to ward dietitian for inpatient assessment.

Research

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Western Sussex Hospitals NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 2558.

Research as a driver for improving the quality of care and patient experience

Clinical research is considered a core part of NHS services with the huge contribution of clinical research to improving outcomes emphasised as a key feature of the national response to the COVID-19 pandemic. While prior to the pandemic there was already significant evidence that organisations which support high quality clinical research and innovation improve clinical outcomes for *all* their patients, not just those taking part in specific research trials, NHS clinical research has been at the forefront of learning about spread of COVID-19 and developing and testing medications, new treatments and vaccines. At Western Sussex, our ambition continues to be delivery of high quality patient care through innovation and continuous quality improvement, education and research. The Trust's 2019 CQC report demonstrated how research, embedded in everyday clinical practice across the organisation, is making a significant contribution to improving quality and experience for our patients and clinical research has been a

key part of the Trust's response to the current global pandemic in 2020/21.

The numbers of new participants taking part in clinical research at Western Sussex has continued to grow with 2558 patients and staff members taking part in 2020/21 predominantly in trials for COVID-19. Western was amongst the very first organisations in the country and the first in Kent, Surrey and Sussex to open and enrol participants to the RECOVERY trial, a globally important study testing medicines for those most severely affected by COVID-19 and mentioned regularly in the UK Government daily briefings. In the early days of the pandemic little was known about how to treat or care for people with COVID-19 and the RECOVERY trial has already been able to recommend two medicines effective in improving outcomes and reducing mortality whilst also demonstrating several medicines that are not of benefit to patients with COVID-19. Clinical, support service and research teams have worked collaboratively across the breadth of the organisation to support participation in 7 nationally prioritised Urgent Public Health COVID-19 trials and alongside also delivered a broad portfolio of other COVID and non-COVID related clinical trials, providing opportunities for patients and staff to participate in important research across a range of clinical services.

The Trust has also had ongoing support from the local patient Research Champions group who continued to meet virtually and have been able to contribute their expertise to the rapid design of

several new COVID-19 specific research studies developed within the organisation. These studies are vital to understanding more about the impact of the virus, for example the long term recovery of people severely affected by COVID-19 and its impact on local healthcare provision.

The Trust has continued to support the growth of their innovative clinical academic programme, developed in 2017/18 for nurses, midwives and allied health professionals (NMAHPs) across the Trust. The programme has increased opportunities to bring the latest research evidence into everyday practice to enhance patient care. The Trust has developed a number of new roles, including nurse, midwife, AHP and medical doctoral research fellowships and is supporting research education through the NIHR Integrated Clinical Academic Fellowship programme and with the support of a number of local Higher Education Institutes. The Trust has also partnered to support research development and clinical academic roles with colleagues at BSUH and St Barnabas Hospices and through the local NIHR Clinical Research Network and NIHR Applied Research Collaborative (ARC) Kent, Surrey and Sussex.

The Trust's award winning Clinical Improvement Scholarship programme, developed in 2017 in collaboration with Health Education England and cited by the CQC as an example of best practice, empowers NMAHPs to use research evidence to challenge and improve patient care. The programme, which is closely linked to Patient First, focuses on leading change and using and developing research evidence to improve the quality of everyday care. The programme has already supported 24 nurses, midwives and allied health professionals in developing their research, leadership and quality improvement experience to directly influence improvements in care alongside their everyday clinical roles. During the COVID-19 pandemic the programme has also been adapted to provide four new clinical research fellow roles to support locally developed COVID-19 research studies.

The Trust is one of only four organisations in Kent, Surrey and Sussex to be hosting a prestigious NIHR 70@70 Senior Nurse and Midwife Research Leader. This post has been appointed for a period of three years to work locally and nationally on engaging and involving more nurses and midwives in healthcare research.

Goals agreed with commissioners: use of the CQUIN payment framework

Associated Commissioning for Quality and Innovation (CQUIN) payments were suspended during 2020/21 in line with the NHS England financial framework instruction to do so as part of the NHS response to COVID-19 (although

payment was received within overarching block payments equivalent to CQUIN income).

Associated CQUIN payments received in 2019/20: £7,273K.

Statements from the Care Quality Commission (CQC)

Western Sussex Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered without conditions”.

Western Sussex Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission has not taken enforcement action against Western Sussex Hospitals NHS Foundation Trust during 2020/21.

Data Quality

NHS Number and General Medical Practice Code Validity

Western Sussex Hospitals NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (to end February 2021):

- which included the patient’s valid NHS number was:

99.78% for admitted patient care;

99.92% for outpatient care; and

Not applicable for accident and emergency care.

- which included the patient’s valid General Medical Practice Code was:

100% for admitted patient care;

100% for outpatient care; and

Not applicable for accident and emergency care.

Data Security and Protection Toolkit attainment levels

Each year the Trust completes and submits the Data Security and Protection Toolkit (DSPT) to demonstrate its compliance against the National Data Guardian’s National Data Security Standards. As organisations continue to focus on the operational priorities associated with the outbreak of COVID-19, NHS Digital (NHSD) agreed that the publication date for the 2020-21 submission would be 30th June 2021.

Given that the Trust merged with Brighton and Sussex University Hospitals NHS Trust to form the University Hospitals Sussex NHS Foundation Trust from 1st April 2021 the decision was taken to make the WSHD toolkit submission before the merger. A compliant DSPT submission was therefore made on 30th March 2021.

Clinical coding error rate

Western Sussex Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period 2020/21 by the Audit Commission.

Statement on relevance of Data Quality and your actions to improve your Data Quality

Western Sussex Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

1. NHS Digital Approved Clinical Coding Auditors have carried out a DSP Toolkit Clinical Coding audit for WSHFT despite social distancing restrictions due to the Covid-19 pandemic: overall 'Expectations Met' DSPT;
2. The Sepsis audit that was planned for April 2020 went ahead in July 2020. The audit concluded that documentation errors and inadequate clinical recording were contributing to errors in coding accuracy. Following this audit the local policy was refreshed and the historic diagnostic indicator of sepsis was removed;
3. The HSMR work-stream has led to an improvement in the Trust HSMR, increased depth of coding and greater recording of Palliative Care. The work-stream and frequent Dr Foster reviews are an ongoing process;
4. Clinical Coding processes were changed to allow the majority of Clinical Coders to work from home from the full electronic Medical Record at the start of first national lockdown. Case notes were collected from the wards and

sent to urgent scanning. The remote coders worked with no loss of clinical information to compromise their accuracy. A small onsite team were retained to code maternity, neonates, two week rule and patients with upcoming outpatient appointments.

5. The Trust's Data Quality Team cleanse data using an in-house data quality application on a daily basis.
6. Frequent reports are sent internally to the Trust's Commissioners via our data quality application, following a set of defined parameter reports.
7. The Trust follows a process for the rapid identification of duplicate registrations and validation of new patient registrations.
8. Provision of training for all Trust staff is ongoing.

Identifying, Reporting, Investigating and Learning from Deaths in Care

Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures that have taken place over the last few years. There is an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

Deaths in 2020/21

During 2020/21 2195 of Western Sussex Hospitals NHS Foundation Trust patients (*adult and paediatric*) died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Deaths in 2020/21					
	Deaths Apr-Jun 2020	Deaths Jul-Sep 2020	Deaths Oct-Dec 2020	Deaths Jan-Mar 2021	Total deaths by category 2020/21
Adults (inpatient)	454	456	460	737	2107
Adults (A&E)	17	23	24	23	87
Adults (maternal inpatient)	0	0	0	0	0
Paediatrics (inpatient)	0	0	0	1	1
Paediatrics (A&E)	0	0	0	0	0
Total deaths by quarter 2020/21	471	479	484	761	2195
<i>Data source: WSHFT</i>					

Other deaths in 2020/21					
	Deaths Apr-Jun 2020	Deaths Jul-Sep 2020	Deaths Oct-Dec 2020	Deaths Jan-Mar 2021	Total deaths 2020/21
Neonatal	0	1	0	0	1
Stillbirths	4	3	1	3	11
<i>Data source: WSHFT</i>					

Mortality Reviews

Adult and paediatric deaths

By 7th April 2021, 277 case record reviews and 64 investigations have been carried out in relation to 315 of the deaths included in the 'Deaths in 2020/21' tables above.

In 25 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 91 in the first quarter;
- 82 in the second quarter;
- 88 in the third quarter;
- 54 in the fourth quarter.

Stillbirths and neonatal deaths

By 7th April 2021, 11 case record reviews and two investigations have been carried out in relation to 11 of the deaths included in the item above.

In two cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 4 in the first quarter;
- 4 in the second quarter;
- 1 in the third quarter;
- 2 in the fourth quarter.

Patient deaths judged to be more likely than not to have been due to problems in the care provided to the patient

Adult and paediatric deaths

Three representing 0.14% of the patient deaths during the reporting period are judged to be more

likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- Zero representing 0% for the first quarter;
- Two representing 0.42% for the second quarter;
- Zero representing 0% for the third quarter;
- One representing 0.13% for the fourth quarter;

The above numbers may change pending the completion of on-going investigations for cases across all four quarters. Should the outcome of investigations judge the deaths 'to be more likely than not to have been due to problems in care provided to the patient' we will provide details in our 2021/22 report.

These numbers have been collated through a process of undertaking two reviews for each case which are then presented and discussed at the Trust's Learning from Deaths Panel where a judgement is made, which is led by the Medical Director. In addition, cases may have also proceeded through a serious incident investigation process including a root cause analysis.

Stillbirths and neonatal deaths

Zero of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- Zero representing 0% for the first quarter;
- Zero representing 0% for the second quarter;
- Zero representing 0% for the third quarter;
- Zero representing 0% for the fourth quarter

The above numbers may change pending the completion of on-going investigations for cases across all four quarters. The outcome of any outstanding investigations will be provided in our 2021/22 report.

These numbers have been collated through a process of formal structured review; the national Perinatal Mortality Review Tool is completed in each case by a multi-disciplinary team comprising obstetricians, midwives, neonatal nurses, neonatologists and the bereavement midwife as well as an external member. In cases where the death is being investigated externally by Healthcare Safety Investigation Branch (HSIB) the findings of their report are also considered.

Learning from case record reviews and investigations

Adult and paediatric deaths

Following the completion of case reviews over the past year a number of learning themes have been identified, namely:

- Late recognition of end of life leading to lost opportunities for palliative intervention at an earlier stage.
- Despite a comprehensive work programme focusing on the deteriorating patient – the early identification of deterioration and escalation, still requires attention.
- Patient pathways at the weekend and out of hours.
- Mortality associated with fractured neck of femur.
- Nosocomial cases of Covid-19.

Stillbirths and neonatal deaths

- Importance of clinical management of women who present with decreased fetal movements at any stage in pregnancy.
- The need to ensure a dedicated resource and consistency of advice and documentation of our telephone triage service for pregnant women.
- The importance of providing women with adequate information to make an informed decision about their care.
- The importance of clear and consistent communication about how quickly multi-disciplinary support is required when the need to urgently deliver a baby arises.

Actions following our learning

Adult and paediatric deaths

- Merged End of Life and Mortality Boards to form one overarching improvement forum.
- Further roll out of mobile alerting to 'nurse in charge' / night team from the Trust's track and trigger bedside monitoring system (which records patient observations and assessments electronically) to both acute hospital sites.
- Transfer of clinical results from A&E-based blood gas analysis to central pathology IT system to ensure the communication of essential results.
- Ongoing review of patient handover processes.
- Multi-divisional working group established to review pathway and outcome for fractured neck of femur patients.
- Relaunch of the Deteriorating Patient Group.
- Introduction of a Clinical Advisory Group.

Stillbirths and neonatal deaths

- In response to Saving Babies Lives (version two), specialist midwives have been appointed to support the clinical management of women who present with decreased fetal movements.
- Action taken to improve communication to the wider multi-disciplinary team around the urgency of birth when required.
- System change for the provision of neonatal blood required for emergencies.
- Development of a smoking cessation service within Covid-19 restrictions.
- Improvements to the continuity of carer midwife scheme.

The impact of our actions

Adult and paediatric deaths

- The new Clinical Advisory Group has led on Covid-19 shared learning themes and informed the required changes in processes and procedures according to national and local findings/research as they emerged.
- Improved HSMR to within expected range; Trust position nationally has returned to within the top 20% of organisations (data to December 2020 – latest available).
- The Trust has facilitated quarterly Medical Examiner and Trust Mortality Reviewer forums to develop a collaborative Learning from Deaths process.
- Strong inter-relationship of our SI, SJR and improvement programmes, where SJR and root cause analysis processes have helped to identify key challenges to drive forward improvement.

Stillbirths and neonatal deaths

- The Trust has developed a clear protocol for the management of women with decreased fetal movements.
- Use of Family Assist patient information portal to send bespoke information to women at the gestation they need.
- Increase in multi-disciplinary skills drills and training for staff.
- The development of the post of specialist midwife for bereavement.

An update on deaths in 2019/20

Adult and paediatric deaths

Three case record reviews and three investigations completed after the end of March 2020 which related to deaths which took place before the start of the reporting period.

Zero representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been collated through a process of undertaking two reviews for each case which are then presented and discussed at the Trust's Learning from Deaths Panel where a judgement is made, which is led by the Medical Director. In addition, cases may have also proceeded through a serious incident investigation process including a root cause analysis.

Adult and paediatric deaths 2019/20 – a revised estimate

Two representing 0.09% of the patient deaths during 2019-20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Stillbirths and neonatal deaths

Zero case record reviews and zero investigations were completed after the end of March 2020 which related to deaths which took place before the start of the reporting period.

Zero representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been collated through a process of formal structured review; the national Perinatal Mortality Review Tool is completed in each case by a multi-disciplinary team comprising obstetricians, midwives, neonatal nurses, neonatologists and the bereavement midwife as well as an external member. In cases where the death is being investigated externally by HSIB the findings of their report are also considered.

Stillbirths and neonatal deaths 2019/20 – a revised estimate

Zero representing 0% of the patient deaths during 2019-20 are judged to be more likely than not to have been due to problems in the care provided to the patient.



Part 2.3: Reporting against core indicators

Pathology Team — Behind the scenes of the Covid-19 pandemic, our pathology teams have been testing swabs for Covid-19, looking after vital blood gas analyser machines on ITU wards, and analysing thousands of blood samples for Covid-19 antibodies. Collaboration has been key; Covid-19 testing pod staff, phlebotomy, pathology, IT and clerical staff have worked together demonstrating excellent team-working skills.

Performance against the 2019/20 core set of indicators

Since 2012/13, NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available by NHS Digital. The following core quality indicators are relevant to Western Sussex Hospitals NHS Foundation Trust and relate to the NHS Outcomes Framework (NHS OF). A full description of each core indicator is available in the glossary section of this report.

The tables in this section show our performance for these core indicators, by NHS OF domain, over the last four reporting periods and, where the data source allows, a comparison with the national average and the highest and lowest performing trusts. The majority of core indicators are reported by financial year, e.g. from 1st April 2020 to 31st March 2021, however some indicators report on a calendar year or partial year basis. Where indicators report on a non-financial year time period this is stated in the data table. It is important to note that some national data sets report in significant arrears and therefore not all data presented are available to the end of the current reporting period (31st March 2021).

Summary Hospital-level Mortality Indicator (SHMI)

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: Mortality rates over the past 12 months have been around the national average, and within the expected range. The mortality rate has been reducing steadily since 2011/12. Provisional 2020/21 data shows that the mortality rate is continuing to remain within the expected range.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this number, and so the quality of its services, by:

- Maintaining monthly reporting of mortality statistics to Divisions and the Board;
- Continuing to focus on the implementation of care pathways in key mortality areas;
- Strengthening arrangements for identifying and treating patients who deteriorate suddenly.

Indicator: Domain:	Summary Hospital-level Mortality Indicator Preventing people from dying prematurely					
2020/21 Latest available data December 2019 - November 2020	National average Latest available data Dec 2019 - Nov 2020	Best performing Trust Latest available data Dec 2019 - Nov 2020	Worst performing Trust Latest available data Dec 2019 - Nov 2020	2019/20	2018/19	2017/18
1.00 As expected	1.00 As expected	0.69 Lower than expected	1.19 Higher than expected	1.02 As expected	0.97 As expected	0.97 As expected
<i>Data source: NHS Digital</i>						

Palliative care indicators are included below to assist in the interpretation of SHMI by providing a summary of the varying levels of palliative care coding across non-specialist acute providers.

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: the Trust has a well-established Palliative Care Team working to a reinvigorated End of Life Care Strategy.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Maintaining monthly reporting of mortality statistics to Divisions and the Board.
- We are working with our Clinical Coding Team to ensure all palliative care activity is accurately captured.

Indicator:	Percentage of patient deaths with palliative care coded at either diagnosis or specialty level					
Domain:	Enhancing quality of life for people with long-term conditions					
2019/20 Latest available data December 2019 - November 2020	National average Latest available data Dec 2019 - Nov 2020	Best performing Trust Latest available data Dec 2019 - Nov 2020	Worst performing Trust Latest available data Dec 2019 - Nov 2020	2019/20	2018/19	2017/18
42.4% As expected	36.3%	59.2%	8.1%	35.0% As expected	34.0% As expected	37.4% As expected
<i>Data source: NHS Digital</i>						

Patient Reported Outcome Measures (PROMs)

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: This data, which is based on quality of life measures, shows that our treatments are effective in improving the health of our patients.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to

improve this number, and so the quality of its services, by:

- Ensuring regular feedback of PROMs data to clinical teams;
- Working with commissioners to ensure that treatments are offered to those groups of patients most likely to benefit from the particular treatment.

Indicator:	Patient Reported Outcome Measures EQ 5D Index (case mix adjusted health gain)						
Domain:	Helping people to recover from episodes of ill health or following injury						
Surgery type	2020/21	National average	Best performing Trust	Worst performing Trust	2019/20	2018/19	2017/18
Groin hernia	No longer reported	No longer reported	No longer reported	No longer reported	No longer reported	No longer reported	0.080
Varicose vein	<i>WSHFT does not carry out sufficient numbers of varicose vein procedures to be included in PROMS data.</i>						
Hip replacement (primary)	Data not yet available	Data not yet available	Data not yet available	Data not yet available	Data not yet available	0.458	0.446
Knee replacement (primary)	Data not yet available	Data not yet available	Data not yet available	Data not yet available	Data not yet available	0.343	0.338

Data source: NHS Digital

Readmissions

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: While the Trust works hard to plan discharges appropriately, in some instances readmissions still occur.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to work closely with system partners to identify patients at risk of readmission and putting in place services to prevent them requiring further immediate hospital care;
- We will identify those cases where readmissions could have been prevented by organising care differently and make the appropriate changes to reduce the level of readmission.

Indicator:	Patients readmitted to a hospital within 28 days of being discharged						
Domain:	<i>Local Trust indicator</i>						
	2020/21 (Trust data)	National average	Best performing Trust	Worst performing Trust	2019/20 (Trust data)	2018/19 (Trust data)	2017/18 (Trust data)
Patients aged 0 to 15 years	14.44%	<i>Please note that this indicator was last updated by NHS Digital in December 2013 and future releases have been temporarily suspended pending a methodology review; we are therefore unable to provide comparative data for 2020/21.</i>			14.66%	14.66%	13.41%
Patients aged 16 years or over	14.05%				14.97%	14.51%	14.01%

Data source: NHS Digital has not updated this metric since 2013 and we have therefore used our own locally collected data to report against this core indicator.

Indicator: Domain:	Emergency readmissions within 30 days of discharge from hospital <i>Local Trust indicator</i>						
	2020/21 (Trust data)	National average	Best performing Trust	Worst performing Trust	2019/20 (Trust data)	2018/19 (Trust data)	2017/18 (Trust data)
All patients	14.89%	<i>Please note that this indicator was last updated by NHS Digital in March 2014; we are therefore unable to provide comparative data for 2020/21.</i>			14.98%	14.54%	14.31%
<i>Data source: NHS Digital has not updated this metric since 2013 and we have therefore used our own locally collected data to report against this core indicator.</i>							

Responsiveness to the personal needs of patients

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust monitors the responsiveness to the personal needs of patients through a number of mechanisms including a full programme of peer reviews involving key stakeholders (including patients with learning disabilities), regular FFT surveys and local detailed surveys. The Trust's responsiveness to the personal needs of patients in line with its peers as

compared through national survey programmes assessing compassionate care and responsiveness of care.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Using results from real time patient experience tracking to constantly identify areas for improvement;
- Identifying areas for further improvement from our peer review programme.

Indicator: Domain:	Responsiveness to the personal needs of patients Ensuring people have a positive experience of care					
2020/21	National average (2019/20)	Best performing Trust (2019/20)	Worst performing Trust (2019/20)	2019/20	2018/19	2017/18
Not available until August 2021	67.1%	84.2%	59.5%	66.3%	69.5%	70.8%
<i>Data source: NHS Digital</i>						

Staff who would recommend the Trust to their family or friends

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: An increasing proportion of staff are positive about the overall quality of the services and care offered by the Trust and would be happy to recommend the Trust as a place to work/receive treatment to their family or friends.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its

services, by:

- Delivering the Patient First Improvement System (PFIS) that trains and engages all staff to make continuous improvements to our services.
- Use regular feedback opportunities to capture staff views about how we can improve.

Indicator:	Percentage of staff who would recommend the Trust as a provider of care to their family or friends					
Domain:	Ensuring people have a positive experience of care					
2020	National average (acute NHS trusts) 2020	Best performing Trust (acute NHS trusts) 2020	Worst performing Trust (acute NHS trusts) 2020	2019	2018	2017
84.0%	73.4%	92.0%	50.0%	82.2%	81.4%	81.6%
<i>Data source: NHS Staff Survey Coordination Centre</i>						

Patients who would recommend the Trust to their family or friends

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: We aim to give every patient the opportunity to take the Friends & Family Test, either at discharge or within 48 hours of discharge. Recommendation rates are in line with peers and results are monitored on a monthly basis.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- We continue to focus on improving response rates to ensure we gather feedback from sufficient people to know that information is reliable, particularly in our A&E departments.
- We will work to address themes arising from the survey to improve patient experience.

Indicator: Domain:	Percentage of Patients who would recommend the trust to their family or friends - Ensuring people have a positive experience of care						
	2020/21	National average	Best performing Trust	Worst performing Trust	2019/20 Latest available data to February 2020	2018/19	2017/18
Inpatients	Data not yet available	Data not yet available	Data not yet available	Data not yet available	96.9%	97.3%	96.81%
Patients discharged from A&E	Data not yet available	Data not yet available	Data not yet available	Data not yet available	93.2%	95.2%	85.78%

Data source: NHS Digital/NHS England. NHS England / Improvement temporarily suspended FFT data submission from March to December 2020 by all settings due to the COVID-19 pandemic.

Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has focused on this area and made good progress on embedding it into normal practice with a sustained increase in the proportion of patients screened.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

One of the Trust's priorities for 2021/22 will focus on eliminating avoidable VTE through the following actions:

- Deliver improvements to VTE assessment and prescribing.
- Monthly reviews of any new hospital associated VTE to identify themes from root cause analysis.
- Ensure that learning identified from root cause informs divisional improvement plans.
- Continued work of the reformed Thrombosis Committee to work through clinical pathways to ensure compliance with NICE guidelines and to provide oversight of improvement plans.

Indicator: Domain:	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism Treating and caring for people in a safe environment and protecting them from avoidable harm						
	2020/21	National average	Best performing Trust	Worst performing Trust	2019/20 (Latest available data to Dec 2019)	2018/19	2017/18
	Data not available	Data not available	Data not available	Data not available	96.54%	96.22%	95.24%

Data source: NHS Digital - The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.

Rate of *C.difficile* infection

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: A relentless and constant focus is required to minimise the level of *C.difficile* infection. Particular challenges include the need for antibiotic usage in a frail and ill patient population and balancing this with the risk of causing *C.difficile* disease.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by:

- Focus on adherence to our antibiotic prescribing policies;
- Heightened environmental cleaning;
- Targeted review of the patient pathway for these patients.

Indicator:	The rate per 100,000 bed days of trust apportioned cases of <i>C. difficile</i> infection that have occurred within the trust amongst patients aged 2 or over					
Domain:	Treating and caring for people in a safe environment and protecting them from avoidable harm					
2020/21 (Trust data)	National average Latest available data: 2019/20	Best performing Trust Latest available data: 2019/20	Worst performing Trust Latest available data: 2019/20	2019/20 (Figure updated from last year's quality report due to more recent data being available)	2018/19	2017/18
14.2 Count of Trust apportioned cases: 38	15.5	0.0	64.6	7.2 Count of Trust apportioned cases: 24	9.4 Count of Trust apportioned cases: 32	10.3 Count of Trust apportioned cases: 35

Data source: Public Health England - national data for 2020/21 is not expected to be published until July 2021.

Patient Safety Incidents

The Western Sussex Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has a systematic approach to the management and investigation of events and we analyse these on an aggregated basis to ensure that safety lessons are learned and shared widely, leading to improvements in the quality and safety of care we provide.

The Western Sussex Hospitals NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by:

- Continuing to promote the reporting of patient safety incidents across the organisation in order to learn and improve.
- Themes, trends and learning from incidents will continue to be discussed and analysed through a variety of forums including divisional clinical governance sessions, Triangulation Group, Trust Brief newsletter, Huddle Headlines, Theme of The Week, Patient Story newsletter and the divisional governance reviews. Quarterly learning events are hosted by the Trust, inviting regional providers and commissioners to share learning from safety and mortality reviews.
- Review of incident reporting systems to promote ease of use and feedback.

Indicator: Domain:	Patient safety incidents Treating and caring for people in a safe environment and protecting them from avoidable harm						
	October 2019 to March 2020 Latest data available	National average Latest available data: October 2019 to March 2020	Best performing Trust Latest available data: October 2019 to March 2020	Worst performing Trust Latest available data: October 2019 to March 2020	April to Sept 2019	October 2018 to March 2019	April to Sept 2018
Rate of patient safety incidents (per 1,000 bed days)	27.6 Count of incidents: 4,709	50.7 Acute non-specialist trusts	15.7 Acute non-specialist trusts	110.2 Acute non-specialist trusts	30.6 Count of incidents: 5,029	29.54 Count of incidents: 4,936	28.04 Count of incidents: 4,727
Rate of patient safety incidents (resulting in severe harm or death)	0.32% Count of incidents: 15	0.30% Acute non-specialist trusts	0.00% Acute non-specialist trusts	1.49% Acute non-specialist trusts	0.12% Count of incidents: 6	0.45% Count of incidents: 22	0.44% Count of incidents: 21
<i>Data source: NHS Digital</i>							

Implementing seven-day services

During 2020/21 the Covid-19 pandemic has impeded the work of the seven-day services project as resources have been diverted to deal with the first two waves and the restoration and recovery process. Further information can be found in section 3.1.

Ways in which staff can speak up

The Trust has a Freedom to Speak Up Policy and a Dignity at Work policy which outline the various routes available to staff to raise a concern regarding quality of care, patient safety or bullying and harassment. They also detail the processes involved in addressing the concerns, including communication with the member of staff who has raised the concerns.

The Trust's Freedom to Speak Up (FTSU) Guardians continue to promote their role by attending training events, meetings, visiting

workplaces and attending forums and drop in events. The Trust's FTSU Guardians are available to give support and advice to staff, if they are worried about something they think may affect the quality or safety of patient care or is a risk to the Trust. The guardians provide advice on how to raise concerns effectively and guidance on how the Raising Concerns Policy and process works.

The Guardians work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Annual report on rota gaps and plans for improvement

A report from the Guardian of Safe Working Hours will be released later in 2021 following the cessation of COVID-19 operational pressures.



Part 3.1: Review of quality performance

New artwork — In connection with NHS Blood and Transplant, the Trust's Organ Donation Committee commissioned a mural for St Richard's entitled 'Angel Rainbow' by the Worthing-based graffiti artist Horace; the artwork is in recognition of the achievements of NHS ITU and clinical teams, especially our ITU nurses who work tirelessly supporting patients and their families. Horace also donated artwork for Worthing Hospital.

Performance against WSHFT 2020/21 quality improvement priorities

Below is a list of 2020/21 quality improvement programmes and their current status. Programmes are explained in more detail in the following individual programme sections.

Programme	Trust Target achieved / on plan	Close to target
Falls prevention	▲	
Elimination of severe pressure damage	▲	
Reducing orthopaedic surgical site infections	<i>Continuing in 2021/22</i>	
Reduction in hospital-associated venous thromboembolism (VTE)	▲	
HSMR optimisation programme	▲	
Deteriorating patient programme	<i>Continuing in 2021/22</i>	
Seven Day Services / Hospital at Night	<i>Integrated in to divisional deployment from 2021/22</i>	
Maternity transformation programme		▲
Avoiding term admissions into neonatal units	▲	
Patient experience of discharge	<i>Superseded by national directive</i>	
Reducing noise at night	<i>Continuing in 2021/22</i>	
Staff engagement programme		▲

Avoiding harm



True North goal: the NHS Patient Safety Thermometer was discontinued in March 2020 with no national replacement in place. For 2020/21 we monitored local data against our three key harms: falls, pressure ulcers and venous thromboembolisms

2020/21 achievement: True North Goal achieved

30% reduction in in-hospital falls (from baseline of 2016/17) – target 30%

81% reduction of hospital-acquired category 3 and above pressure damage (from baseline of 2018/19) – target 30%

65% reduction in avoidable hospital-associated VTE (from 2018/19 baseline) (data to Nov 2020) – target 50%

The Trust is committed to providing safe, high quality services. We aim to provide safe, harm-free care for all patients. Whilst we recognise that this is a challenging goal, we are committed to reviewing all harms to ensure that we learn and continuously improve care.

Hospital acquired infections; pressure ulcers and other complications are examples of harm which are sadly commonplace across hospitals in the UK. Despite the extraordinary hard work of healthcare professionals patients are harmed in hospitals every day. Most harm experienced by patients is minor or very minor, but in some cases it can be life-changing for the patient and their family, or can even tragically result in death.

The Trust previously used the national NHS Patient Safety Thermometer to monitor overall

harm free care, however this tool was discontinued in March 2020 and no national replacement has yet been arranged. For 2020/21 we monitored local data against our three key harms: falls, pressure ulcers and venous thromboembolisms (VTE).

In 2021/22 we will use Datix (an electronic, web based reporting incident reporting system used by many NHS organisations) to continue to monitor harm caused during inpatient stay across the new Trust. The new True North aim (three to five year goal) will be to reduce levels of Datix reported harm to patients by 10% (from baseline of 2019/20: pre-Covid-19), with a 12-18 month Breakthrough Objective to reduce low and moderate harms by 5% (from baseline of 2019/20: pre-Covid-19).

Falls prevention

Over 2020/21 we will work to ensure that learning and incremental change in falls management across divisions is ongoing. We will specifically aim to ensure that current position is maintained with no increase in harmful falls.

Trust target: To maintain 30% reduction in in-hospital falls (from baseline of 2016/17)

By when: March 2021

Outcome: 30% reduction in in-hospital falls (from baseline of 2016/17)

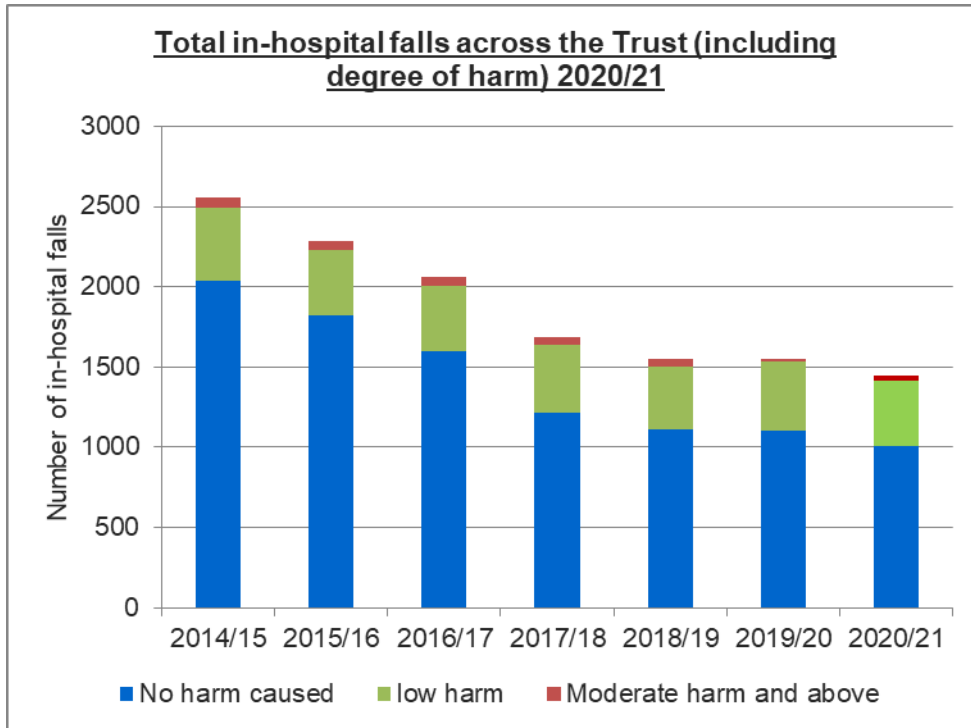
Progress: Target achieved

Falls are one of the most challenging harms to address with a complexity of factors contributing to an individual patient's risk of falling.

During 2020/21 we have continued to work with teams to ensure that the successful principles implemented through our improvement work over the last five years are embedded in 'business as usual'. Two core interventions have been shown to have a positive impact: SWARM, an immediate multidisciplinary review of the patient post-fall and 'Baywatch', a requirement to keep bays where patients are known to be at risk of falling manned at all times. The requirements to put in place Covid-19 infection control precautions and use of PPE and social distancing (maintenance of isolation) presented a significant challenge this year which required adaption to Baywatch approaches.

Teams where falls remain a challenge have continued to drive further incremental change using PFIS methodology. Wards have worked through improvement cycles to try to address the underlying reasons for patient falls. This methodology ensures a bespoke approach to the challenge as solutions will vary depending on the particular patient group and ward environment.

A key element to supporting improved outcomes whilst reducing falls is to ensure that our patients remain as active as possible whilst in hospital, preventing 'deconditioning'; once again Covid-19 precautions have limited ability to do this. It is also of note that patients have been presenting with deconditioning due to lack of activity at home during national 'Stay at Home' guidance.



Data source: WSHFT

Improvements achieved:

- We have maintained our reduction in falls delivered over recent years.
- The Covid-19 pandemic led to an adaption of the intended improvement plans to focus on delivering Baywatch whilst maintaining Covid-19 precautions.
- Focus on supporting teams who worked in a less familiar environment, for example in areas which redeployed staff were assigned to, to quickly learn and adopt ways of working which supported falls prevention activities.
- Continued to ensure that learning and incremental change in falls management across divisions is ongoing.

Further improvements identified:

- Revitalisation of deconditioning work.
- Continue to build on our deconditioning prevention work with an ambitious programme across areas to deliver our 'Active Hospital' ambition.
- A focus on the care of patients presenting with delirium.
- Refresh our multi-disciplinary approach to falls prevention.

Elimination of severe pressure damage

During 2020/21, we will work to deliver a 30% reduction in category 3 and above ulcers from our 2018/19 baseline.

Trust target: To deliver a Trust-wide 30% reduction of hospital-acquired category 3 and above pressure damage (from baseline of 2018/19)

By when: March 2021

Outcome: 81% reduction of hospital-acquired category 3 and above pressure damage (from baseline of 2018/19)

Progress: Target achieved

Pressure damage is one of the highest causes of patient harm across the Trust. It can cause physical harm, pain and can lead to poor patient outcomes; in severe cases, pressure damage can cause long-term debilitation resulting in a life changing impact on the patient.

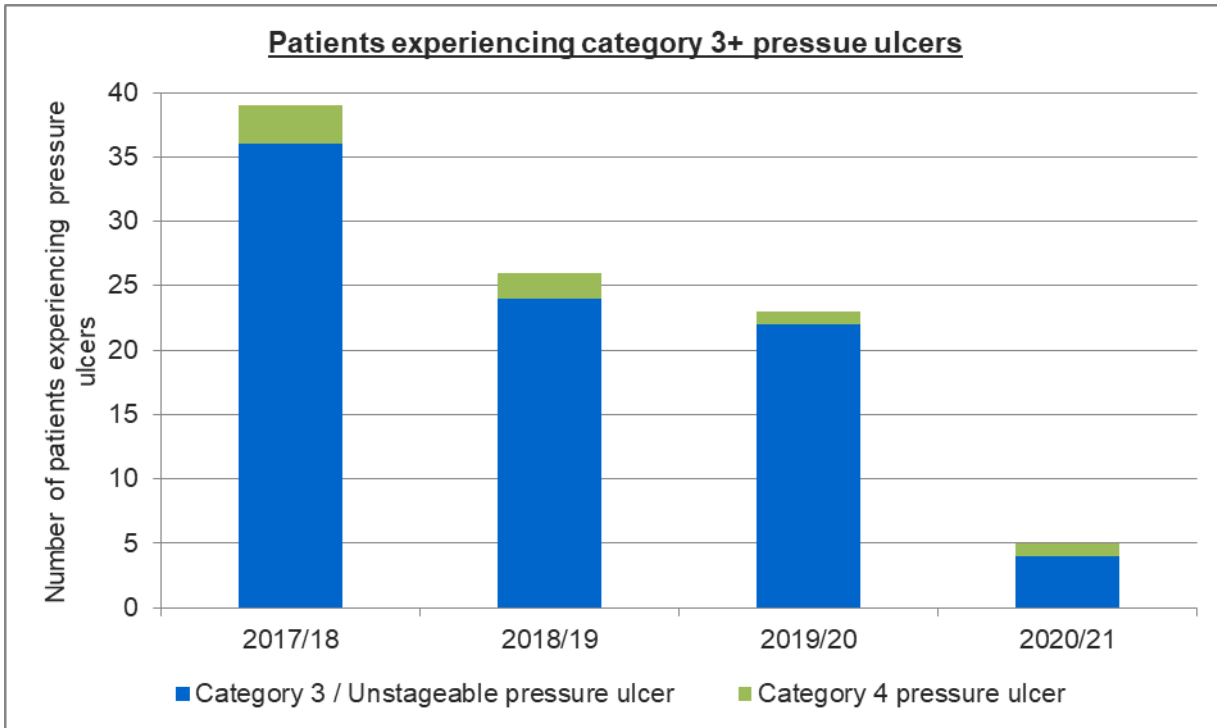
Whilst a high proportion of our patients with pressure ulcers are admitted to hospital with existing skin damage, we had seen a significant rise in hospital acquired pressure damage over recent years. We successfully delivered improvement in 2019/20 and aimed to build on this improvement in 2020/21.

Over 2020/21 we worked with wards that have high numbers of patients developing pressure ulcers to ensure they have the support required to implement remedial actions using PFIS.

In a similar way to falls, any new patients who develop a category 2 ulcer are reviewed using a SWARM approach of the SSKIN bundle elements in order to identify interventions to prevent deterioration for that patient and also learning opportunities for the ward team.

An identified theme which formed a core improvement priority this year was ulcers caused by the use of a medical device (such as oxygen tubing, plaster of Paris and spinal collars). Covid-19, and the need to care for patients in a prone position, along with the use of CPAP hoods, presented an additional significant challenge this year.

The Tissue Viability Nurses have worked closely with other specialist teams such as Critical Care in order to understand and address this difficult challenge.



Data source: WSHFT

Improvements achieved:

- We have achieved a fantastic 81% reduction in category 3 and above pressure ulcers contributing to our Trust ambition to eliminate category three and above pressure ulcers.
- Successfully implementing proactive measures to protect Covid-19 patients from device-related pressure ulcers.
- A reduction in heel ulcers through a successfully trial of 'offloading devices' in patients with a fractured neck of femur.

Further improvements identified:

- To continue work with partner colleagues at Sussex Community NHS Foundation Trust to improve the transitions of care for our patients.
- Further focused improvements on foot care and discharge communication.

Reducing orthopaedic surgical site infections

Reduce the number of total hip replacement and total knee replacement infections.

Trust target: To be in line with the national average for SSIs in hip and knee replacements

By when: March 2021

Outcome: Ongoing

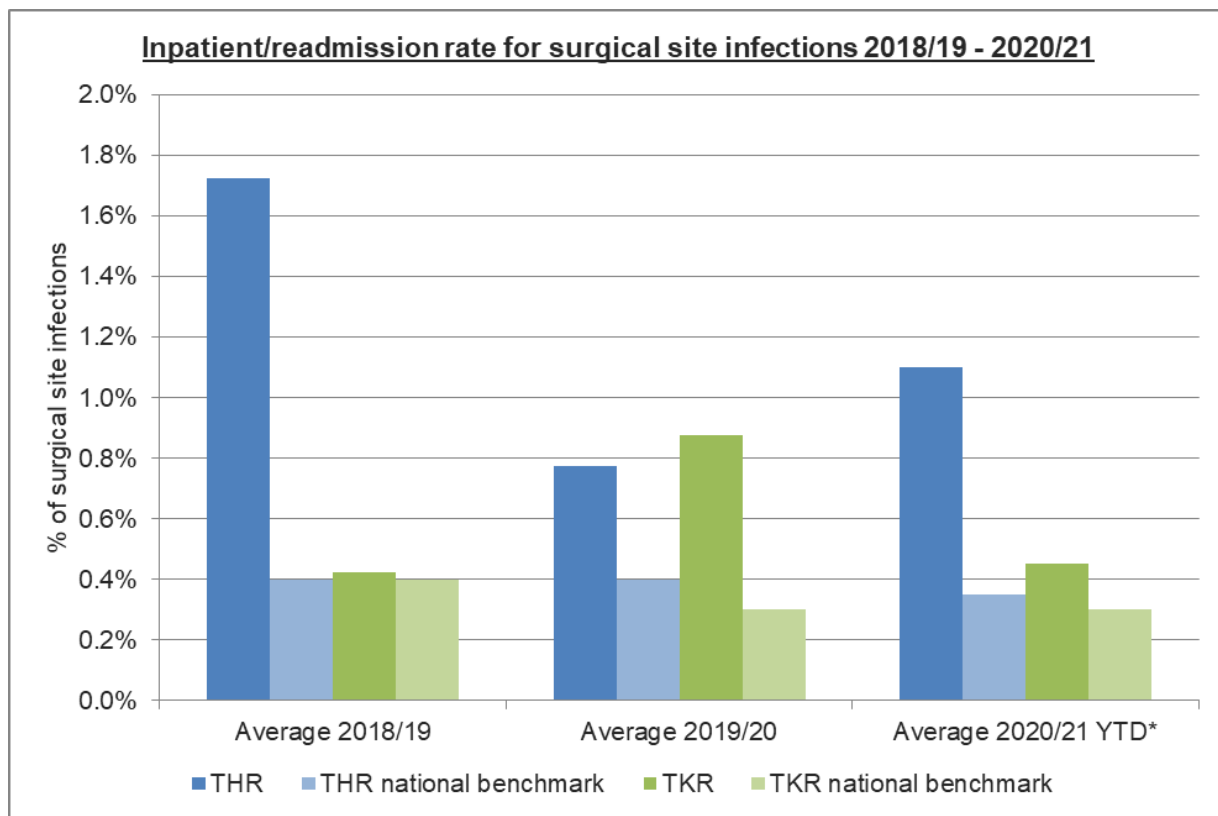
Progress: *Continuing in 2021/22*

Infection prevention and control is a vital part of the care we give to patients in our hospitals. Healthcare associated infections are well recognised as a cause of increased morbidity and mortality, and whilst some are not preventable, our objective is to prevent them where possible by good basic infection prevention and control practices such as hand hygiene, cleanliness and antimicrobial stewardship.

Surgical site infections (SSIs) have re-emerged as an area we wish to improve management of, in

particular rates of infection in inpatients and readmitted patients following total hip or total knee replacement surgery.

Surgical patients who are operated on in the categories for which we are undertaking SSI surveillance are monitored for signs of infection both during their initial admission and up to one year post surgery for hip and knee replacements (arthroplasty surgery).



Data source: Public Health England. *2020/21 YTD comprises July-December 2020 as the only data available for this period.

Improvements achieved:

- NICE guidelines implemented across the Trust for the anticoagulation of patients undergoing total hip and total knee replacements.
- Continued programme of education for patients and GPs regarding surgical site infections and their best management and treatment.
- The introduction of a dedicated regular Infection Prevention & Control Team ward

round on our elective orthopaedic ward, with outpatient follow up advice as required.

- Implementation of real-time SWARM session for every prosthetic joint infection (PJI), with root cause analysis instituted and discussed at divisional meetings to ensure learning from infections is gained and shared.
- Introduction of a weekly arthroplasty multi-disciplinary team meeting with every arthroplasty revision and PJI case.
- Continued partnership engagement with primary care, tier 3 weight management services and patients to follow revised guidelines for offering joint replacement surgeries to high BMI patients.

- Introduction of robust monitoring of SSI information and data before submission to Public Health England.

Further improvements identified:

- Improve compliance with monitoring of intra-operative patient temperatures.
- Our long term ambition is to host a dedicated standalone orthopaedic unit for elective arthroplasty and orthopaedic services, as part of an integrated care system model, to improve patient care and outcomes across the health economy.

Reduction in hospital-associated venous thromboembolism (VTE)

Maintain a 50% reduction in avoidable hospital-associated VTE cases from our 2018/19 baseline.

Trust target: Maintain avoidable hospital-associated VTE at a rate of 50% from 2018/19 baseline

By when: March 2021

Outcome: 65% reduction in avoidable hospital-associated VTE (from 2018/19 baseline) YTD

Progress: Target achieved YTD

Venous Thromboembolism (VTE) is the formation of a blood clot in a vein, often the deep veins of the legs and pelvis, which may dislodge from its site of origin to cause an embolism (for example in the lungs), sadly often an unavoidable consequence of a patient's illness. The development of VTE can lead to life changing harm requiring long term treatment.

We had seen a significant rise in reporting of VTE since 2015/16. Whilst the number of cases that

have been deemed avoidable fell in 2019/20, we still need to fully understand the nature of our challenge and ensure we have reliable processes in place in order to eliminate avoidable harm.

Patients are developing avoidable VTE whilst in our care due to errors in the prescription and administration of thromboprophylaxis across a range of pathways.

When a patient is found to have developed a VTE, initial review is conducted by VTE nurses to see

whether the patient has had a recent hospital admission (within the last 90 days) and whether NICE guidelines have been followed; if there is a discrepancy then the patient's care is reviewed by

Trust VTE panel where the case is deemed unavoidable or avoidable.

Avoidable VTE rates					
	2020/21 YTD to Nov20	2019/20	2018/19	2017/18	2016/17
Number of avoidable cases	4	7	17	22	23
<i>Data source: WSHFT</i>					

Improvements achieved:

- We have achieved a 65% reduction in avoidable hospital-associated VTE YTD.
- Specific guidance implemented to mitigate increased risk for Covid-19 patients developing VTE.
- Continued work to embed the use of electronic mismatch reporting from our Electronic Prescribing and Medicines Administration system which enables all Ward Round Teams to identify any patients requiring review of their anticoagulation prescription requirement.

Further improvements identified:

- Further ongoing work to improve the use of patient information resources.

- Improve the reliability of assessment and review of anticoagulation requirements across orthopaedic pathways, particularly for outpatient attenders.
- Improve the reliability of the system for review of patients who have anticoagulation therapy appropriately suspended, to ensure that it is restarted when appropriate without delay.
- Maintaining current achieved levels of avoidable thrombosis and aiming towards further reductions on an annual basis.
- Increasing VTE related education and awareness amongst staff via a VTE Champions programme and other ongoing initiatives led by the Trust Thrombosis Committee (e.g. GIRFT Thrombosis Survey participation).

Reducing preventable mortality and improving outcomes



True North goal: To be in the top 20% of NHS organisations for the Hospital Standardised Mortality Ratio (HSMR)

2020/21 achievement: True North Goal achieved

Hospital Standardised Mortality Ratio (HSMR): 92.4; 19th centile; 23rd of 124 trusts; within the top 19% - target top 20% of organisations (data to December 2020)

N.B. data to December 2020 – data runs three months in arrears

About half of all deaths in the UK take place in hospital. The overwhelming majority of these deaths are unavoidable. The person dying has received the best possible treatment to try to save his or her life, or it has been agreed that further attempts at cure would not be in the patient's best interest and the person receives palliative treatment.

We know, however, that in all healthcare systems things can and do go wrong. Healthcare is very complex and sometimes things that could be done for a patient are omitted or else errors are made which cause patients harm. Sometimes this means that patients die who might not have, had we done things differently. This is what we mean by 'avoidable mortality'. More often, if things go wrong with care, patients fail to achieve the

optimal level of recovery or improvement. By concentrating on this area we will end up with safer hospitals, save lives, and ensure the best possible clinical outcomes for patients.

In 2021/22 the Trust has moved to using crude mortality as the True North metric to monitor improvements in mortality having previously used the HSMR. This overcomes some of the challenges interpreting changes in HSMR that can result from factors such as variations in coding. Recent and significant fluctuations in the Trust HSMR are believed to have been a result of changes to the national coding rules on sepsis although these have now resolved. The use of crude mortality as the metric is expected to enable an even stronger focus on reducing preventable deaths.

Hospital Standardised Mortality Ratio (HSMR) optimisation programme

Implementation of improvement work to ensure the optimisation of HSMR scores across the organisation.

Trust target: To ensure HSMR is improved to ≤ 100

By when: September 2020

Outcome: HSMR improved to and remained at < 100 by June 2020

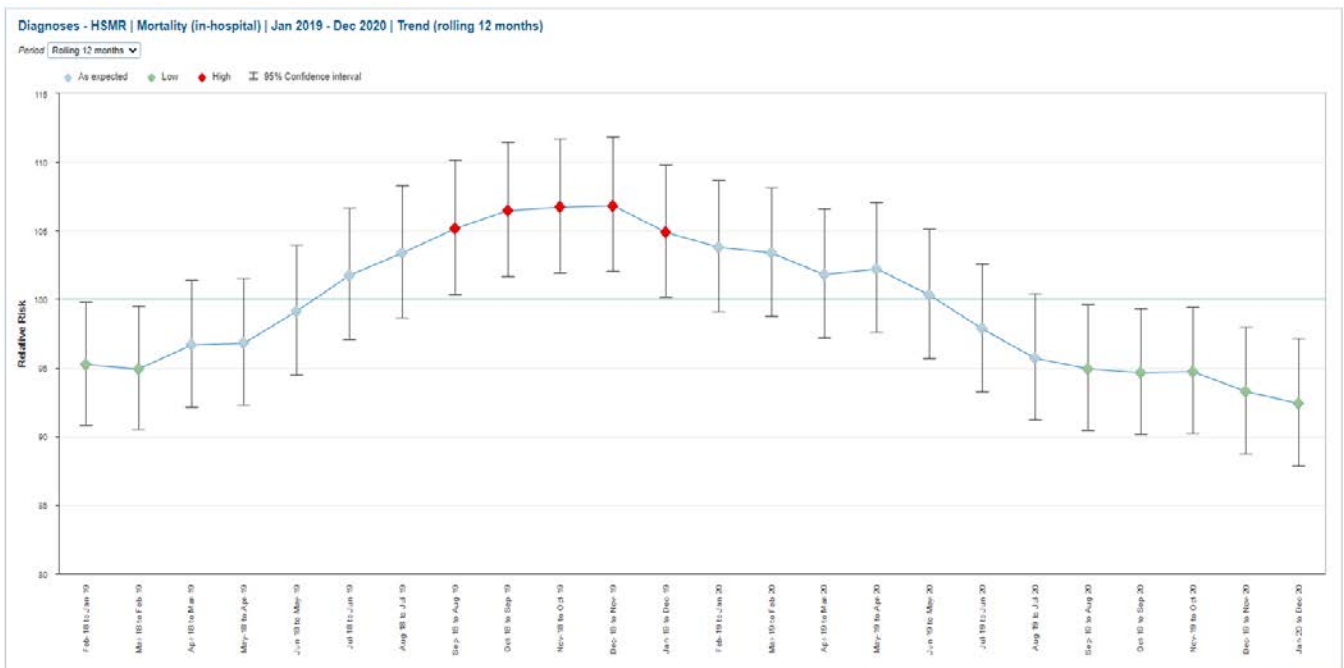
Progress: Target achieved

Our HSMR score improved from 107.48 in 2011/12 (ranked 112 of 141 acute trusts; 79th centile) to 94.9 in 2018/19 (ranked 51 of 133 acute trusts; 38th centile). However, over 2019/20 our HSMR sadly deteriorated to 102.3 (for the 12 months up to and including March 2020, ranked 73rd of 130 acute trusts) putting the Trust in the 56th centile nationally.

A Trust investigation with Dr Foster into the rising HSMR score showed causes included: a reduction in sepsis coding with fewer co-morbidities and palliative care activity captured on the St Richard's

site; an increase in HSMR for patients admitted at weekends.

An HSMR Programme Board was established in late 2019/20 to oversee the implementation of clinical and patient pathways to meet the HSMR target of ≤100. Three workstreams were formed to take forward improvement work: coding and data capture; clinical pathway improvement; weekend and out of hours working.



Data source: Dr Foster

Trust Hospital Standardised Mortality Ratio (HSMR)						
	2020/21 (latest data 12 months to December 2020)	2020/21 target	2019/20	2018/19	2017/18	2016/17
Trust HSMR (Reported in arrears: 12 months rolling data)	92.4	100	102.3	94.9	88.10	91.1
Data source: Dr Foster						

Improvements achieved:

- The formation of a clinical coding improvement group for multidisciplinary symposia regarding sepsis, HSMR, low risk deaths, comorbidities, palliative care and standardising documentation.
- Targeted training for the coding teams and awareness training for clinicians.
- Reviews of weekend and out of hours working.
- Continued ongoing work to improve sepsis and pneumonia patient pathways.
- Completion of an independent sepsis coding audit complete with recommendations about the capture of sepsis data by clinicians for coding and possible impact on expected deaths from sepsis influencing 12 month rolling HSMR.
- A review of the end to end coding pathway and implementation of standard work to support the

accuracy of coding, driving notable improvements in the completeness of palliative care and co-morbidity coding.

- Improvements in information flow through the coding process with enhanced input from relevant teams as required.

Further improvements identified:

- Further improvements in the consistency of sepsis coding.
- Further improvements regarding the differences in coding between Trust sites.
- Use of 'crude mortality' as the new True North metric to monitor improvements in mortality from 2021/22: this will overcome some of the challenges interpreting changes in HSMR that results from factors such as variations in coding.

Deteriorating patient programme

The deteriorating patient is a Trust-wide initiative to support Patient First objectives by improving our ability to identify patients at risk of a sudden and potentially life-threatening worsening of their condition, and to respond appropriately and promptly.

Trust target: To improve the recognition and early treatment of sepsis and acute kidney injury (AKI), and ensure the appropriate and early escalation of the deteriorating patient.

By when: Ongoing

Outcome: Ongoing

Progress: *Continuing in 2021/22*

Reducing avoidable mortality and improving clinical outcomes are key clinical priorities for the Trust and a major focus of the Patient First programme.

The deteriorating patient is a trust-wide initiative to support these objectives by improving our ability to identify patients at risk of a sudden and potentially life-threatening worsening of their condition, and to respond appropriately to avert harm.

The programme focuses particularly on three important conditions: sepsis, acute kidney injury and cardiac arrest.

Improvements achieved:

- Continued ongoing work to improve sepsis patient pathways.
- Identified new leadership for sepsis at St Richard's A&E and Worthing Emergency Floor.
- Ensured consistency in coding through an external review of sepsis coding in July 2020.
- Strengthened the identification of the deteriorating patient through improving the use of existing IT systems.
- Introduced the use of mobile alerts for patients with sepsis and / or AKI – the ward Nurse in Charge and Outreach Team now receive immediate alerts.

- Commenced the complex process of introducing the use of a raised lactate level as a clinical flag for patients at higher risk of deterioration.
- Updated the AKI alert system on Patienttrack.
- Electronic Covid-19 assessment tool and dashboard introduced to flag unwell patients to our Outreach Team.

Further improvements identified:

- Fully implement the use of a raised lactate level as a clinical flag for patients at higher risk of deterioration.
- Refresh the sepsis clinical patient pathway through three designated workstreams: A&E, Emergency Floor and other inpatient stream.

Seven Day Services / Hospital at Night

Ensuring patients receive high quality consistent care, whatever day or time they are admitted to hospital.

Trust target: Deliver sustainable Seven Day Services across the Trust to ensure our patients receive consistent high quality safe care every day of the week.

By when: March 2021

Outcome: Ongoing

Progress: *Integrated in to divisional deployment from 2021/22*

The Seven Day Services (7DS) programme is an NHS England programme designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

Four key priority standards were identified as the minimum set of clinical standards needed to address variation in mortality, patient flow and

experience: Standard 2: Time to consultant review; Standard 5: Diagnostics; Standard 6: Consultant directed interventions; Standard 8: Ongoing consultant-directed daily review. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

During 2020/21 the pandemic has impeded the work of the 7DS project as resources have been

diverted to deal with the first two waves and the restoration and recovery process. However, there has been a positive impact on the delivery of out of hours' services.

Improvements achieved:

- During the first and second waves of the coronavirus pandemic, rotas were re-organised to strengthen out of hours' medical cover.
- Some rota changes which were introduced during the early phases of the pandemic have

been maintained; the raised mortality noted by Dr Foster (for patients who were being admitted at weekends when compared to weekdays) has improved and there is no longer a disparity.

Further improvements identified:

- Integration of the programme in to divisional deployment from 2021/22 as part of the new University Hospitals Sussex clinical strategy.

Maternity Transformation Programme

To improve the safety, choice and personalisation of maternity care available to women booking their care with our Trust.

Trust target: Continuity of Carer as overall target: 35% of women booking to a continuity of care model

By when: March 2021

Outcome: 28.4%

Progress: Close to target

Western Sussex Hospitals maternity service is part of the Local Maternity System (LMS), working in collaboration with three other organisations – Brighton & Sussex University Hospitals, Surrey & Sussex Healthcare and East Sussex Healthcare.

We aim to implement the ambitious national programme to improve safety, choice and personalisation of maternity care.

We are reducing perinatal mortality and morbidity by implementing the Saving Babies Lives care bundle; providing the majority of women with 'continuity of midwife' throughout the antenatal, birth and postnatal period and improving the

pathways, environment and care for women experiencing mid-trimester pregnancy loss outside of the maternity department.

Improvements achieved:

- Established dedicated clinics for women at risk of pre-term birth on both acute sites.
- Development of a pathway, in line with the Saving Babies Lives care bundle, for the monitoring of women during pregnancy who are at risk of preterm birth.
- Redeveloped care pathways and guidance for women who suffer loss at any gestation.

- Six continuity of carer teams now operating in geographical areas across the Trust: three based at each acute site.
 - Following national recommendations, women living in areas of social deprivation have been included in our caseload model.
 - Minority ethnic groups are now offered antenatal and postnatal continuity following a bespoke pathway offering extra appointments in the antenatal period; we have taken this approach rather than a caseload model due to low numbers of women from a minority ethnic background residing in our catchment area.
- Further improvements identified:**
- Work with our service user group to develop a support group for women suffering the loss of a baby/babies (this improvement was unable to be delivered in 2020/21 due to Covid-19 social distancing requirements).
 - By July 2021 we aim to have plans identified to move towards continuity of carer by default for all women by March 2023.
 - Development of multi-disciplinary team emergency skills training to include regular live skills drills in the clinical areas supported by labour ward co-ordinators, the practise education team and our consultant obstetricians; this is a recommendation of the Ockenden Report and the Clinical Negligence Scheme for Trusts (Maternity).
 - Introduction of a dedicated multi-disciplinary team for elective caesarean sections to prevent planned deliveries being cancelled or delayed should there be an emergency.

Avoiding term admissions in to neonatal units

The national ambition is to ensure that unexpected term admissions to the neonatal unit are below 5%. This is to try and keep mothers and babies together and avoid separating them at the crucial time after birth.

Trust target: Reduce the admission of full-term babies to neonatal units to <5% (national target).

By when: March 2021

Outcome: 3% admission rate for 2020/21

Progress: Target achieved

ATAIN (Avoiding Term Admissions Into Neonatal units) is a national programme of patient safety work aiming to reduce the admission of full-term babies to a neonatal unit. The programme is focused on reducing harm and avoiding the

unnecessary separation of mothers and their babies.

NHS England identified that over 20% of admissions of full-term babies (over 37 weeks gestation) nationally to neonatal units could have

been avoided. There is compelling evidence that separating mothers and babies at the crucial time after birth interrupts normal mother-baby bonding; effects can be profound and long lasting for maternal mental health and maternal and neonatal morbidity. By providing services, pathways and staffing to keep mothers and their babies together we aim to reduce the potential harm caused by separation through unnecessary admission of babies to our neonatal units.

In 2019/20, 3.52% of full-term babies were admitted to our neonatal units – we successfully reduced this to 3.0% in 2020/21.

Improvements achieved:

- Change in clinical pathway for babies under 10 days old who had been discharged from St Richard's: babies now reviewed by the post-natal team or the children's assessment unit, thus avoiding unnecessary medicalisation.
- Completed audits on the use of antibiotics and reviewed associated prescribing policy.
- Implemented new support for breastfeeding mothers across maternity and neonatal services, providing glucogel to support babies rather than requiring intravenous access and the separation of mothers and babies.
- Commissioned a transcutaneous jaundice monitor for community and postnatal ward use.
- Refreshed feeding plans and hypoglycaemia pathways.

Further improvements identified:

- Development of pathway for transitional care bridging the gap between maternity and paediatric care, associated link nursing staff and dedicated ward space.
- Introduction of the Kaiser Permanente calculator to determine whether a baby (>34 weeks gestation) should receive antibiotics for potential early onset sepsis.

Improving patient experience



True North goal: Improving patient experience so our Friends & Family Test recommendations are above 97%

2020/21 achievement: True North Goal nearly achieved

FFT recommendation rate of 95.5% - target above 97% recommendation rate

N.B. data to December 2020 to March 2021 – national data collection was suspended prior to this due to the Covid-19

The Trust is committed to the delivery of patient centred care for all patients. Patients can expect to experience exceptional care which meets both their physical and emotional needs. Improving patient experience is at the heart of the Trust's vision and values, and is a central aspect of our Patient First Programme.

The experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness and safety. A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.

Our Friends and Family Test (FFT) patient feedback consistently ranks higher than the national average. The Trust's revised 'True North' long term goal from 2021/22 is to achieve 95% or more of patients rating FFT surveys as 'Very Good' or 'Good'.

The opportunity to hear the voice of the patient through the FFT gives staff the opportunity to listen to patients' experiences and to make improvements. Feedback is responded to on a regular basis and immediate and longer term actions taken to improve the experience for patients. Wards use the information to feedback within their area using the 'you said...we did' principle.

Friends and Family Test recommend rates

	2020/21* Data Dec 2020 to Mar 2021	National average	Best performing Trust	Worst performing Trust	2019/20 Data to February 2020**	2018/19	2017/18	2016/17
A&E	89.9%	<i>Not released by time of report publication</i>			93.2%	95.2%	85.8%	89.01%
Maternity delivery	96.2%	<i>Not released by time of report publication</i>			97.9%	97.3%	97.8%	97.64%
Inpatients	97.1%	<i>Not released by time of report publication</i>			96.9%	97.3%	96.8%	96.06%
Outpatients	98.8%	<i>Not released by time of report publication</i>			97.3%	96.8%	97.0%	95.43%
Overall rate	95.5%	<i>Not released by time of report publication</i>			95.74%	96.65%	95.06%	94.20%

*Data source: NHS Digital/NHS England. *Trust data – national data not yet released. **NHS England / Improvement temporarily suspended FFT data submission from March to December 2020 by all settings due to the COVID-19 pandemic.*

Patient experience of discharge

Improve the discharge experience for all patients by improving the discharge process and timeliness of discharge activities

Trust target: Improve satisfaction scores for discharge conversation from 51% (baseline 2019/20) to 65%

By when: March 2021

Outcome: Ongoing

Progress: *Superseded by national directive*

We want all our patients to have a safe and positive experience of being discharged from our hospitals; we know this issue has a substantial impact on our patient experience of care and it is therefore one of the key pillars of our Patient Experience Strategy.

The Trust has been working hard over the past few years to support patients to spend the shortest possible time in hospital; through our 'discharge before midday' workstream we have worked to ensure a smooth and timely process for our patients on their day of discharge.

During the COVID-19 incident the national policy and procedures for Discharge from Hospitals changed to a Discharge to Assess model, which enabled patients to be safely discharged to the community and all care act assessments with ongoing health assessments undertaken in community settings rather than in an artificial hospital setting.

This changed the Trust's internal procedures but offered an opportunity for improved and timely trusted referral processes to all community

services including pathways to home care, rehabilitation to social and continuing care.

The improved system partnership working has been extremely effective and the time taken to provide care at home, placements in residential and care homes and palliative care has reduced significantly with the end result being that patients were enabled to leave hospital without delay reducing the risks associated with a hospital stay.

The impact to patients has resulted in far fewer patients deconditioning in hospital as they have returned to a more conducive setting in the community. The numbers of patients returning to their own homes directly or following a short interim placement also increased.

The reduced hospital stays also released beds which enabled the various changes required in acute hospitals to manage the COVID surge and ensure safe capacity for urgent care and now the restoration of cancer and surgical treatment capacity.

The new process has been so successful that it is likely to be continued post COVID-19 and be the

adopted as the standard work for Hospital Discharge in future.

Reducing noise at night

All patients will feel safe, comfortable and listened to whilst in our care: Patients will be cared for at night in environments that are as quiet and calm as possible.

Trust target: 65% patient satisfaction with noise at night

By when: March 2021

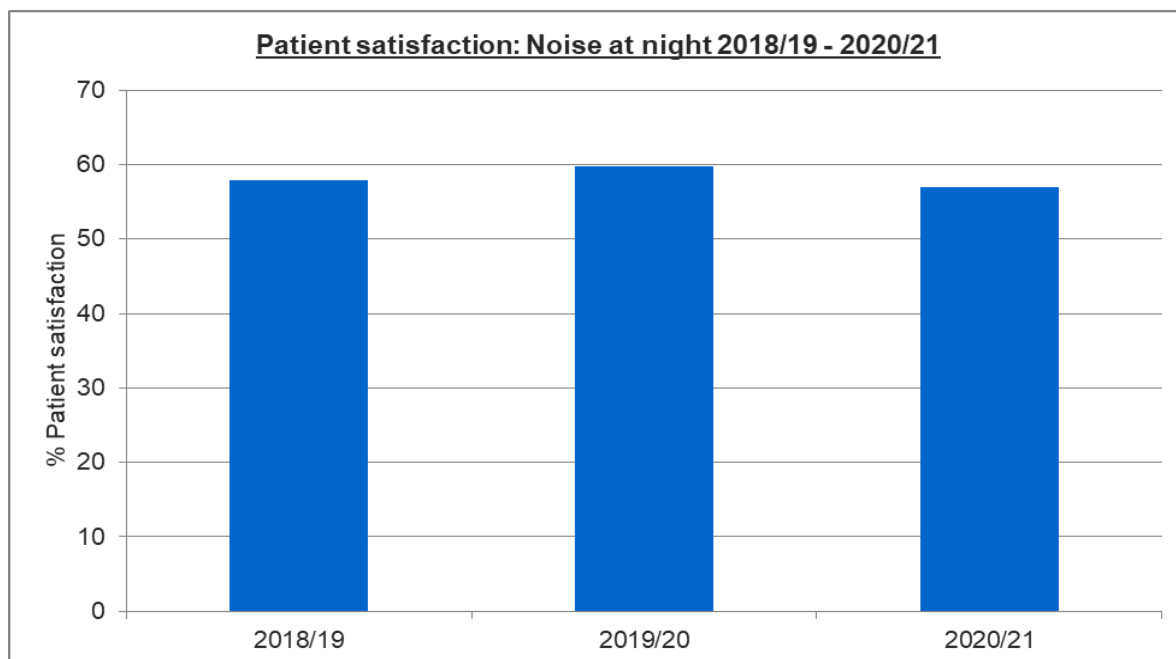
Outcome: Ongoing

Progress: *Continuing in 2021/22*

Sleep is important for healing; sleep deprivation is recognised as a major concern for patients in hospital and has been shown to lead to induced stress, increased pain sensitivity, high blood pressure and poor mental health. The two most recent National Inpatient Surveys carried out in 2017 and 2018 (published in 2018 and 2019 respectively) confirmed that noise at night, particularly from other patients, was a major area requiring improvement. National trends are similar, with the CQC reporting around 40% of patients are affected by noise from other patients

at night time, a figure which has been static for some time.

For 2019/20 we set ourselves a goal to improve noise at night satisfaction from 54% to 65% as measured by our inpatient real time patient experience surveys. We narrowly missed this target and therefore continued this programme of work in 2020/21, building on our positive successes and aiming to embed approaches put in place as business as usual.



We aimed to deliver and maintain patient satisfaction scores at 65% through 2020/21 however the volume of data was very limited due to the Covid-19 impact on patient experience volunteers not being able to conduct surveys with patients and they were paused for most of the year. For the very small number of surveys carried out, satisfaction in 2020/21 was 57%.

Improving staff engagement



True North goal: To be the best in the country for staff engagement, enabling staff to provide the best care

2020/21 achievement: True North Goal nearly achieved

NHS Staff Survey engagement score 7.2 (out of 10); ranking 21 of 128 – target to be the best in the country for staff engagement (top performing trust scored 7.6)

'Our People' determine the experience of their workplace and when individuals are highly engaged in their work they think and behave positively, are emotionally resourceful and have better health. This ultimately leads to delivering better outcomes for patients, increases staff productivity and satisfaction and compliments the Trust's Patient First strategy.

The national NHS Staff Survey is a way of assessing the quality of staff experience and is a

key indicator of how well staff are supported to provide care for patients.

In 2020 Western Sussex Hospitals received an overall staff engagement score of 7.2 out of 10; ranking the trust in the top 17% acute and acute community trusts in England and Wales. The national average score is 7.0.

Staff engagement programme

At Western Sussex Hospitals NHS Foundation Trust 'Our People' determine the experience of the workplace and when they are highly engaged in their work they think and behave positively, are emotionally resourceful and have better health. This ultimately leads to delivering better outcomes for patients, increases staff productivity and satisfaction and compliments the Trust's Patient First strategy.

Trust target: To be the best in the country for staff engagement in the National NHS Staff Survey

By when: March 2021

Outcome: 7.2 NHS Staff Survey engagement score – this places Western Sussex in the top 20% of acute NHS trusts

Progress: Close to target

The national NHS Staff Survey is a way of assessing the quality of staff experience and is a key indicator of how well staff are supported to provide care for patients. The survey findings are

grouped into 10 themes which provide an overview of staff experience:

1. Equality, diversity & inclusion
2. Health & wellbeing

3. Immediate Managers
4. Morale
5. Quality of care
6. Safe environment – Bullying & harassment
7. Safe environment – Violence
8. Safety culture
9. Staff engagement
10. Team working

Improvement in the Safe Environment categories (bullying and harassment and violence) is still required.

Staff Engagement Theme:

Staff engagement, as measured through the annual staff survey, was 7.2 (out of 10) in 2020. In particular staff advocacy about the trust as a place to work improved by 1% to 76% and as a place to receive care and treatment by 2% to 84%. Given the context within which the staff survey was conducted (Sep-Dec 2020), this is very encouraging. The national average score is 7.0.

Compared to the average theme scores for acute trusts, Western Sussex Hospitals’ scores were higher in four themes (immediate managers, morale, staff engagement and team working).

2020 Staff Survey Theme Results Overview:



Data source: 2020 NHS Staff Survey results – NHS Staff Survey Co-ordination Centre

2020/21 has required different approaches to staff engagement to be adopted. Our traditional Trust-wide face to face events (staff conference, thank you lunches, awards ceremonies) and leader gemba walks (visiting clinical and other areas), to name a few, had to be suspended. This also

extended to face to face training where staff participated in a local ‘pulse’ survey that mirrored the staff engagement questions contained in the national staff survey.

However, the introduction and extensive use of MS Teams across the organisation provided an opportunity to engage with staff more widely. Weekly Executive-led briefings were held throughout the year to update staff on the impact of the pandemic on the hospitals and how this was being managed. This was supplemented with preparations in readiness for the Trust's planned merger with Brighton and Sussex University Hospitals NHS Trust from 1 April 2021. The use of technology has enabled staff to engage on important topics and to post questions of importance to them. 'Live' attendance at the weekly briefings now exceeds circa 1,000 participants and provides a platform for staff unable to attend to catch up on the events at a later date.

A series of workshops and surveys with staff in the autumn informed the development of a set of refreshed organisational values for University Hospitals Sussex NHS Foundation Trust and the People Strategy for 2021/22.

Staff health, safety and wellbeing

The health, safety and wellbeing of staff have been a key component to overall staff engagement for a number of years. However during 2020/21, this has been fundamental to our ability to manage and respond to the coronavirus pandemic.

We have strengthened our health and wellbeing programme with a wide variety of interventions to support the emotional, physical and financial health of staff. This ranged from comfort packs, pop up shops for essential goods and hotel

accommodation at the outset of the pandemic through to additional counselling provision, mental health first aid training, emotional resilience support, online exercise and meditation classes and an employee assistance programme including debt management.

We have been very fortunate to have received national and local charity funds that have enabled us to improve the psychological support for staff and introduce health checks specifically for our BAME staff. Through the Project Wingman initiative, First Class lounges were established at our two main hospital sites, to enable staff to have a break with refreshments and access to a listening ear from highly skilled volunteers from the airline industry. Over 4,000 staff accessed this service and its popularity has led to its continuation, albeit on a scaled down basis.

Frontline clinical services particularly affected during the pandemic, have had access to our Listening Ear volunteers, trained through our staff mental health first aid programme. This has supplemented our counselling and chaplaincy services who have also been actively supporting the pastoral care of our staff.

At the outset of the pandemic a trust-wide workforce hub was established. The use of the Trust's electronic rostering systems enabled the capture of absence in real time enabling the workforce hub to assess the impact on skills and capacity and therefore manage the rapid and safe deployment of staff. At a trust wide level, this informed the decisions of the incident control command. The role of the hub was extended to

manage staff testing through the hospitals' testing pods. This provided same day testing facilities for staff and their families, immediate advice to manage and mitigate the risks and enabled the trust to manage immediate and future workforce capacity.

Throughout 2020/21 we have been undertaking and reviewing risk assessments for staff, volunteers, bank and agency workers with higher risk factors if exposed to Covid-19. This has been a dynamic process and enabled us to manage the safe deployment of staff at all times. During the peak of the pandemic circa 600 staff were absent from work, including 200 who were shielding.

Workplace assessments were completed for all areas of the Trust and appropriate safety measures taken in line with Infection, Prevention and Control guidance. This included the designation of clinical areas for Covid and non-Covid patients (red and green zones), the supply and issue of Personal and Protective Equipment (PPE), hand sanitizer and wipes, screens and barriers and ensuring the national public health messages were promoted and enforced.

Every member of staff was issued with a lateral flow kit to enable home self-testing and since December 2020, an extensive programme for the

roll out of a Covid-19 vaccination has been in place, with over 96% uptake. This roll-out followed the seasonal influenza programme that takes place annually.

In September 2020 we reviewed our staff appraisal processes and strengthened the staff welfare component to enable managers to focus on this aspect of work, signposting to other services where appropriate. This will continue to be a feature of appraisal as we return to business as usual and restore services.

Throughout 2020/21, the Trust Board, through its sub-committees, has been kept informed and updated on the health, safety and wellbeing of staff. This is a strategic risk for the Trust and how it is managed and mitigated is regularly reviewed through the Board Assurance Framework.

[Further improvements identified:](#)

The refreshed True North goal for the newly merged organisation has been agreed as: To be within the top quartile of acute Trusts for the National staff engagement score. Work is currently underway to identify the top contributing actions to support this goal.



First Class Service for NHS Staff



Part 3.2: Other information

Project Wingman — Pilots and cabin crew came together from June 2020 to give WSHFT staff a morale boost by opening first class Project Wingman lounges at Worthing and St Richard's. The airline specialists volunteering in the lounges are trained to communicate in stressful situations and have been available to support our staff whether they choose to talk to one of the crew in confidence or simply relax with a tea or coffee on their break.

Local quality indicators

Patient safety indicators						
	2020/21	2020/21 target	2019/20	2018/19	2017/18	2016/17
Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	85.3%	95%	85.4%	90.0%	94.80%	96.20%
Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	85.3%	95%	90.3%	89.3%	94.80%	97.10%
Safer Staffing: Average fill rate - care staff (day shifts)	83.9%	95%	90.5%	93.9%	93.10%	91.30%
Safer Staffing: Average fill rate - care staff (night shifts)	89.4%	95%	103.5%	106.6%	94.10%	92.30%
Care Hours Per Patient Day (CHPPD)	8.6	Tbc	7.2	7.1	6.6	6.5
Safety Thermometer: % of patients harm-free	n/a	n/a	94.7%	94.89%	94.93%	95.30%
Safety Thermometer: % of patients with no new harms	n/a	n/a	98.5%	98.5%	98.42%	98.50%
Total incidents (Trust data)	9588	9150	10552	10111	9150	9,938
Total moderate, severe or death incidents (Trust data)	169	153	110	174	176	162
Total serious incidents (SIRIs) (Trust data)	45	53	29	45	53	74
Number of outstanding CAS alerts	0	0	0	0	0	0
Total incidents involving drug/prescribing errors	852	1200	981	1149	1016	1,088
Moderate/severe incidents involving drug/prescribing errors	5	5	4	8	9	8
Number of hospital attributable MRSA cases	0	0	0	0	3	1
Number of hospital C.diff cases	38	64	34	31	35	45
Number of C. diff cases where a lapse in the quality of care was noted ^o	14	27	18	15	20	24
Number of hospital attributable MSSA bacteraemia cases	26	22	19	25		
Number of reportable MSSA bacteraemia cases	104	94	83	100	94	113
Number of reportable E.coli cases	367	751	418	341	400	417
Number of hospital attributable E.coli cases	50	60	60	61		
Full compliance with WHO Surgical Safety Checklist	100%	100%	100%	100%	100%	100%
NEVER events	3	0	1	3	2	3
~SSIs: Total hip replacement - All SSI = Inpatient & readmission, post-discharge confirmed and patient reported	1.1%	0.4%	0.7%	1.7%	1.50%	3.00%
~SSIs: Total knee replacement) - All SSI = Inpatient & readmission, post-discharge confirmed and patient reported	0.4%	0.3%	0.9%	1.3%	2.8%	3.20%
~SSIs: Large bowel surgery - All SSI = Inpatient & readmission, post-discharge confirmed and	12.2%	9%	8.4%	12.6%	11.50%	11.60%

Patient safety indicators						
	2020/21	2020/21 target	2019/20	2018/19	2017/18	2016/17
patient reported						
~SSIs: Breast surgery - All SSI = Inpatient & readmission, post-discharge confirmed and patient reported	0.0%	0.8%	0.3%	3.3%	5.70%	5.40%
All falls	1444	1452	1552	1546		
Falls resulting in harm (Trust data)	433	459	445	440	473	451
Falls resulting in severe harm or death (Trust data)	2	1	0	4	3	2
Grade 2+ pressure ulcers	374	240	338	317	356	258
VTE Assessment Compliance	96.9%	100%	95.9%	96.6%	94.10%	95.30%
~ These metrics and corresponding targets were updated in 2019/20; we previously reported All SSIs including post discharge, however as from April 2019 we now only include inpatient and readmission cases (i.e. post discharge cases are excluded). Data up to and including December 2020 as reported three months in arrears.						

Clinical effectiveness indicators						
	2020/21	2020/21 target	2019/20	2018/19	2017/18	2016/17
Trust crude mortality rate (non-elective)	3.28%	3.10%	2.91%	2.68%	3.10%	3.21%
Crude mortality rate (non-elective): 12 month rolling	2.94%	3.11%	2.71%	2.96%	3.11%	3.21%
Trust Hospital Standardised Mortality Ratio (HSMR) (Reported in arrears: 12 months to November 2019 is the latest available data.)	92.4	100	104.7	94.9	88.10	91.1
Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M) (Reported in arrears: data to September 2019)	1.01	1	1.01	0.98	0.95	0.97
% of Part 2 inpatient deaths reviewed	59.1%	100%	67.3%	79.6%	85.6%	
SMR for hip fracture (all diagnoses/procedures) (Reported in arrears: 12 months to December 2019 is the latest available data.)	76.9	100	101.5	105	88.54	93.6
Worthing SMR for hip fracture (all diagnoses/procedures) (Reported in arrears: 12 months to December 2019 is the latest available data.)	91.1	100	98.7	114	96.13	100.1
St Richard's SMR for hip fracture (all diagnoses/procedures) (Reported in arrears: 12 months to December 2019 is the latest available data.)	58.6	100	104.6	93.34	80.40	84.4
30 day mortality rate following hip fracture (Reported in arrears: 12 months to December 2019 is the latest available data.)	5.5%	5.70%	5.9%	6.7%	6.80%	6.40%
% patients with sepsis receiving antibiotic therapy within one hour	79.55%⁺	90%	79.7% [*]	79.0%		
Emergency readmissions within 30 days %	14.72%	13%	14.98%	14.54%	14.31%	14.20%
C-Section Rate	33.6%	27.80%	32.43%	29.14%	28.50%	28.60%
% Deliveries complicated by post-partum haemorrhage	0.4%	1%	0.88%	0.41%	0.40%	0.50%
Maternal deaths (MBRRACE-UK criteria)	0	0	1	0	0	0
% Admission of term babies to neonatal care	3.0%	5%	3.19%	3.15%	3.20%	3.30%

Clinical effectiveness indicators						
	2020/21	2020/21 target	2019/20	2018/19	2017/18	2016/17
% Emergency admissions staying over 72h screened for dementia	87.1%	90%	85.51%	86.32%	91.18%	93.20%
Induction of labour	36.8%	29.40%	33.00%	34.35%		
Normal delivery rate	29.0%	n/a	32.0%	32.67%		
Ward moves for patients flagged with dementia	2728	2257	2631	2506	2257	2,638
Night-time ward moves for patients flagged with dementia	256	500	256	495	505	555
% CT scans undertaken within 12 hours (reported one month in arrears)	96.0%	95%	97.9%	95.7%	95.28%	95.50%
% Stroke thrombolysis within 60 minutes of hospital arrival (reported one month in arrears)	57.2%	95%	52.9%	60.7%	71.88%	76.20%
% Swallow screen for stroke patients within 4 hours of admission (reported one month in arrears)	90.7%	95%	83.4%	88.6%	85.70%	85.80%
% of stroke patients admitted to stroke unit within 4 hours of admission (reported one month in arrears)	72.5%	90%	68.9%	73.2%	70.75%	73.50%
% high risk TIA patients seen within 24 hours (reported one month in arrears)	19.9%	60%	11.0%	15.0%	15.13%	44.10%
Patients recruited with CRN portfolio	2464	1500	1518	2183		
% inpatients with electronic discharge summaries produced	89.3%	94.20%	91.0%	91.4%	93.00%	94.20%
<p>+ Sepsis data for 2020/21 relates to April – June 2020: full year data not available due to operational pressures.</p> <p>* Sepsis data for 2019/20 relates to months April – August 2019 and January – March 2020: full year data not available due to operational pressures.</p>						

Patient experience indicators						
	2020/21	2020/21 target	2019/20	2018/19	2017/18	2016/17
Trust Friends and Family Recommend %: Inpatient*	97.1%	97%	97.2%	97.3%	96.75%	96.00%
Trust Friends and Family Recommend %: A&E*	89.9%	93%	93.1%	95.2%	85.78%	89.01%
Maternity Friends and Family Recommend %: Antenatal care (36 weeks)*	100%	97%	97.4%	97.1%	97.59%	96.70%
Maternity Friends and Family Recommend %: Delivery care*	96.2%	97%	97.9%	97.3%	97.89%	97.60%
Maternity Friends and Family Recommend %: Postnatal ward*	96.2%	97%	97.9%	97.3%	97.89%	97.60%
Maternity Friends and Family Recommend %: Postnatal community care*	100%	97%	100%	98.8%	98.66%	98.80%
Trust Friends and Family Recommend %: Outpatient*	98.8%	97%	97.3%	96.8%	96.96%	95.40%

Patient experience indicators						
	2020/21	2020/21 target	2019/20	2018/19	2017/18	2016/17
Trust Friends and Family Response Rate: Inpatient*	6.6%	40%	33.5%	40.9%	37.05%	34.30%
Trust Friends and Family Response Rate: A&E*	14.8%	23%	29.2%	24.8%	9.96%	12.50%
Maternity Friends and Family Response Rate: Delivery care*	3.9%	40%	53.1%	52.7%	52.00%	29.10%
Percentage of re-booked outpatient appointments	11.9%	7.8%	11.0%	11.5%	12.50%	8.90%
Clinics cancelled with less than 6 weeks' notice for annual/study leave	47	285	310	330	397	278
PALS contacts relating to appointment problems (% of total appts)	0.12%	0.08%	0.17%	0.17%	0.10%	0.08%
Reduce patients cancelled on the day of surgery for non-clinical reasons	70	336	299	265	354	361
Breaches of mixed sex accommodation arrangements	n/a	n/a	592	212	0	6
Compliance with MUST tool after 24 hours	80.5%	80%	81.3%	87.0%	85.21%	76.00%
Compliance with MUST tool after 7 days	97.2%	95%	97.7%	98.6%	98.87%	97.80%
Internal PLACE compliance: St Richard's Hospital (data to January 2020)	n/a	n/a	97%	96%	95%	94%
Internal PLACE compliance: Worthing Hospital (data to January 2020)	n/a	n/a	97%	97%	96%	95%
Number of complaints	373	456	534	416	438	585
Complaints where staff attitude or behaviour is an issue	29	43	61	42	42	59
Complaints where staff communication is an issue	57	39	54	19	25	54
Complaints about nursing	18	39	37	46	46	59
Local staff engagement score: I am able to make improvements happen in my area of work	n/a	n/a	69.5%	65.1%		
<p>Note 1: Complaints section relates to formal complaints only, does not include complaints received through PALS.</p> <p>Note 2: Friends and Family Indicators - We report year end unvalidated figures in the Quality Scorecard. The FFT results published in the main body of this report are the validated figures published a month in arrears by NHS England.</p> <p>Note 3: Breaches of mixed sex accommodation arrangements, Internal PLACE compliance and Local staff engagement score all suspended for 2020/21 due to the COVID-19 pandemic.</p> <p>*NHS England / Improvement temporarily suspended FFT data submission from March 2020 by all settings until further notice due to the COVID-19 pandemic; data presented herein is from the period April 2019-February 2020 for 2019/20 and from the period December 2020-March 2021 for 2020/21.</p>						

Single Oversight Framework indicators

Western Sussex Hospitals aims to meet all national targets and priorities. All Foundation Trusts report performance to NHS Improvement (NHSI) against a limited set of national measures

of access and outcome to facilitate assessment of their governance. As part of this Quality Report, we are required to report on the following national indicators:

Performance against the NHS Improvement Single Oversight Framework						
	2020/21	NHS Improvement threshold 2020/21	2019/20	2018/19	2017/18	2016/17
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	57.6%	92%	82.9%	82.3%	88.48%	89.90%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	91.8%	95%	89.8%	94.1%	92.86%	94.37%
All cancers: 62-day wait for first treatment from: Urgent GP referral for suspected cancer	69.3%	85%	80.9%	80.0%	88.69%	87.47%
All cancers: 62-day wait for first treatment from: NHS cancer screening service referral	64.3%	90%	87.1%	90.8%	94.90%	96.47%
<i>C.difficile</i> : variance from plan	<i>Already reported under section 2.3: Reporting against core indicators</i>					
Summary Hospital-level Mortality Indicator	<i>Already reported under section 2.3: Reporting against core indicators</i>					
Maximum 6-week wait for diagnostic procedures	48.9%	1%	1.67%	0.66%	0.93%	1.21%
VTE risk assessment	<i>Already reported under section 2.3: Reporting against core indicators</i>					

Annex 1 – Statement of Directors’ responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2020/21
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period 28th May 2020 to the 24th May 2021
 - papers relating to quality reported to the board over the period 28th May 2020 to the 24th May 2021
 - feedback from commissioners dated: *not applicable*
 - feedback from governors: *not applicable*
 - feedback from local Healthwatch organisations: *not applicable*
 - feedback from Overview and Scrutiny Committee dated: *not applicable*
 - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009: *not yet published*
 - the 2019 national patient survey 02/07/2020
 - the 2020 national staff survey 11/03/21
 - the Head of Internal Audit’s annual opinion of the trust’s control environment dated 23/04/2021
 - CQC inspection report dated 22/10/2019
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance

(which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board Date: 29th June 2021


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Chairman

Date: 29th June 2021


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Chief Executive

Annex 2 – Limited Assurance Report on Quality

Independent auditor's report to the Council of Governors of Western Sussex Hospitals NHS Foundation Trust on the Quality Report

In February 2021, NHS England and NHS Improvement issued an update to the NHS accounts timetable and year-end arrangements through the NHS foundation trust annual reporting manual for 2020/21 given the 'exceptional challenges' that have resulted from the Covid-19 pandemic:

"2020/21 quality report: there is no requirement for a foundation trust to prepare a quality report and include it in its annual report for 2020/21. There is no requirement for a foundation trust to commission external assurance on its quality report for 2020/21. The following paragraphs in the FT ARM are retained in case a foundation trust wishes to continue to prepare a quality account/report to the same timescales as the annual report for inclusion in the annual report, but this is not mandatory."

In confirmation, there is no limited assurance opinion report for Western Sussex Hospitals NHS Foundation Trust's 2020/21 Quality Report.

Glossary of terms and acronyms

A3

A3 is a structured problem solving and continuous improvement approach, first employed at Toyota and typically used by lean manufacturing practitioners. It provides a simple and strict approach systematically leading towards problem solving over structured approaches.

Active Hospital

A new initiative from Public Health England and Sport England to integrate physical activity interventions in to secondary care hospital settings to encourage patients to move more.

Audit Commission

Please note the Audit Commission closed 31st March 2015, however reference is made to it in a mandated statement. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme applied new methodology and there is no longer a standalone 'costing audit' with errors rates.

Care Quality Commission (CQC)

The independent regulator of all health and social care services in England.

Care bundle

Care bundles are small sets of evidence-based interventions which, when used together consistently by a single healthcare team, have been shown to significantly improve patient outcomes.

Clinical audit

The process by which clinical staff measure how well we perform certain tests and treatments against agreed standards. Plans for improvement are developed if required by the findings of an audit.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care by linking a proportion of providers' income to the achievement of agreed quality improvement goals.

COVID-19

An infectious viral disease caused by a newly discovered coronavirus. COVID-19 caused a global pandemic in 2020.

Crude mortality rate

The number of deaths in hospital as a percentage of the total number of patients discharged. We use the crude non-elective mortality rate as an immediate indicator of progress or to identify areas of concern and to sense check that improvements are real and not the result of changes in coding or recording.

Datix incident reporting system

An electronic, web based reporting incident reporting system used by many NHS organisations including University Hospitals Sussex.

Deconditioning

Frail older people in hospital are more at risk of losing muscle strength and mobility from prolonged hospital stays and therefore are at an increased risk of falls, confusion and demotivation.

Duty of Candour

Overview of CQC Regulation 20: Duty of candour

The aim of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

Friends and Family Test (FFT)

A feedback tool which offers patients of NHS-funded services the opportunity to provide feedback about the care and

treatment they have received. Patients are asked how likely they are to recommend the service they have used and provide further detail about their experience. NHS organisations monitor the number of patients who complete a survey by looking at FFT response rates.

GIRFT

The Getting It Right First Time (GIRFT) programme is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement. It is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.

Hospital acquired / Healthcare associated infections

Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an inpatient or outpatient.

Healthcare Safety Investigation Branch (HSIB)

HSIB offers an independent service for England, guiding and supporting NHS organisations on investigations, and also conducting safety investigations.

Hospital Standardised Mortality Ratio (HSMR)

A risk adjusted mortality tool produced by Dr Foster Intelligence reviewing in-hospital deaths from 56 diagnosis groups (medical conditions) with the highest mortality. A rate greater than 100 suggests a higher than average standardised mortality rate and a rate less than 100 a better than average mortality rate.

Human Factors

An established scientific discipline used by many safety critical industries especially the aviation industry. It aims to optimise human performance through better understanding of individual behaviour and staff interactions with each other and their environments; improving patient safety and clinical excellence.

Integrated Care System (ICS)

NHSI describe that from Sustainability and Transformation Partnerships (STPs) a partnership will evolve to form an integrated care system, a new type of even closer collaboration. In an integrated care system, NHS organisations, in partnership with local councils and others,

take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

LeDeR Programme

The Learning Disabilities Mortality Review (LeDeR) Programme is a world-first. It is the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities. People with learning disabilities, their families and carers have been central to developing and delivering the programme.

Local quality indicators

The local quality indicators were drawn from the WSHFT legacy Quality Scorecard which was reviewed by the WSHFT Board each month. They related to the three domains of quality: patient safety, clinical effectiveness, and patient experience. Quality indicators reported to the WSHFT Board were selected to provide a comprehensive picture of clinical quality in areas identified through the clinical quality strategy and priorities for quality improvement.

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)

MBRRACE-UK includes a national programme of work investigating maternal deaths, stillbirths and infant deaths. MBRRACE reporting criteria are different to those used in the "Identifying, Reporting, Investigating and Learning from Deaths in Care" section of this report; numbers herein are specific to inpatient deaths.

Mortality review

A process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care and identify learning, plans for improvement and pathway redesign where required.

MUST (Malnutrition Universal Screening Tool)

A screening tool to identify and treat adults at risk of malnutrition.

National Confidential Enquiries

These are similar to clinical audits but use in depth reviews of what occurred to highlight areas of less than good standard clinical practice, in order to develop new recommendations for the better care of patients. Most confidential enquiries relate to the investigation of deaths and whether or not better clinical care could have prevented a death. They are confidential because patient cases remain anonymous to protect confidentiality; reports of findings and learning are shared across the NHS to bring about system-wide improvement.

National Inpatient Survey

A CQC commissioned annual inpatient survey which is part of a national programme aimed at improving patients' experiences while in hospital. It includes measures that relate strongly to the care and compassion shown by individual staff and the organisation as a whole.

Neonatal death

The death of a baby born after 22 weeks gestation (completed weeks of pregnancy) who died between 0 and 27 days of age; we report inpatient neonatal deaths only in this report.

NHS Foundation Trust

Foundation trusts are a form 'public benefit corporation' – healthcare organisations that exist solely for the benefit of their patients but which operate in a similar way to a commercial business. They are subject to less central government control and are free to set their own strategy for improving and developing services in line with local priorities and needs, as well as to borrow money and invest surplus income in new services, equipment and innovations.

NHS Improvement (NHSI)

The organisation responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They hold providers to account and help the NHS to meet its short-term challenges and secure its future.

NHS Outcomes Framework

A set of indicators developed by the Department of Health to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing.

NHS Safety Thermometer

A point of care measurement tool for improvement that focused on the four most commonly occurring harms in healthcare: pressure ulcers, falls, urinary tract infections (in patients with a catheter) and venous thromboembolisms.

From the end of March 2020 national data collection for the Safety Thermometer ceased. NHS England / Improvement have not yet announced replacement data monitoring plans.

Patient First Improvement System (PFIS)

PFIS is the Lean management programme designed by the Trust to develop our people's ability to solve problems and improve performance. Further information can be found here: <https://www.uhsussex.nhs.uk/about/patient-first/>

Patienttrack

Our electronic advanced observation and assessment system that gives our nurses and doctors early warning if a sick patient's condition is deteriorating; this helps early and effective intervention to get things back on course.

Patient Reported Outcome Measures (PROMs) (core indicator)

PROMs provide a patient perspective (via before and after patient questionnaires) on the outcomes or quality of care following four types of surgery in the NHS (currently hip and knee replacements, groin hernia and varicose vein surgery).

Post-take ward round

The Royal College of Physicians recommends that all acute medical patients should be reviewed by a Consultant within 24 hours of admission: this review is known as a post-take ward round and is also an opportunity for teaching junior staff.

Readmissions (core indicator)

If a patient does not recover well, it is more likely that further hospital treatment will be required, which is the reason that hospital readmission are commonly used as an indicator of the success in helping patient recovery.

[Responsiveness to the personal needs of patients](#) (core indicator)

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

[Risk adjusted mortality tool](#)

In order to compare mortality rates between different NHS Trusts it is necessary to consider the mix of patients treated. For example, a trust with a very elderly, complex patient group might have a higher crude mortality rate than one that had younger or less acutely ill patients. To adjust for this it is necessary to standardise the mortality rate for trusts, thereby taking into account the patient mix. This is usually done by calculating an 'expected' mortality rate based on the age, diagnosis and procedures carried out on the actual patients treated by each trust.

[Sepsis](#)

A life threatening condition that arises when the body's response to an infection injures its own tissues and organs.

[Serious incident \(SI\)](#)

An incident where the consequences are so significant or the potential for learning so great, that additional resources are justified to produce a comprehensive response. They can affect patients directly but also include incidents which may indirectly impact on patient safety or an organisation's ability to deliver on-going healthcare.

[Seven Day Services](#)

The seven-day services programme is an NHS England programme designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. NHS provider organisations are required to ensure that they deliver 10 clinical standards relating to seven day services. The 10 clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define

what seven-day services should achieve, no matter when or where patients are admitted.

[Single Oversight Framework \(SOF\)](#)

NHS Improvement's monitoring system to oversee NHS providers' performance across five themes.

[Staff who would recommend the trust to their family or friends](#) (core indicator)

A question in the national NHS Staff Survey which assesses how likely staff are to recommend the Trust as a provider of care to their friends and family.

[Stillbirth](#)

When a baby is born dead after 24 weeks gestation (weeks of completed pregnancy).

[Structured judgement mortality review \(SJR\)](#)

A validated mortality review process in which trained clinicians review medical records in a critical manner to comment on the quality of healthcare in a way that allows any judgement to be reproducible.

[Sustainability and Transformation Partnership \(STP\)](#)

New partnerships between NHS and local councils across England which will develop proposals to improve health and care.

[Summary Hospital-level Mortality Indicator \(SHMI\)](#) (core indicator)

The SHMI is a risk adjusted mortality tool used to provide a ratio of the actual number of patients who die following hospitalisation at the Trust and the number who would be expected to die on the basis of average England figures. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

[Venous thromboembolism \(VTE\)](#) (core indicator)

A condition in which blood clots forms, such as deep vein thrombosis (most often in the deep veins of the leg) or pulmonary embolism (a clot in the lungs).



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