Croydon Health Services
NHS Trust

Annual Report and Financial Accounts

2018/19

www.croydonhealthservices.nhs.uk

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Welcome

Croydon Health Services NHS Trust had a remarkable year that included opening our major new Emergency Department and reshaping our local partnerships - creating new opportunities for seamless high-quality care across the borough.

The excellent Emergency Department is already providing more urgent care than before, to an even higher standard of comfort and clinical efficiency. Huge credit is due to our clinical teams who invested so much thought into its design – including a new Urgent Treatment Centre, two mental health liaison rooms and dementia-friendly features.

Now the population is ageing and demand on the NHS is growing - particularly because so many people now have long term health conditions - a new national NHS Long Term Plan was launched this year that is tailored to those challenges. It has a focus on bringing the NHS and other care services together to better enable people to stay independent and healthy.

Croydon Health Services NHS Trust (CHS) is very well positioned to fulfil this new Plan. We had already been making great progress with partner care organisations, who share our vision of helping people in Croydon lead longer and healthier lives.

In April 2017 we established an alliance called 'One Croydon' with Croydon Council, Croydon CCG, Age UK Croydon, South London and Maudsley NHS Foundation Trust and Croydon GP Collaborative, with the initial aim of supporting the health and wellbeing of people aged 65 or more. It brings hospital clinicians together with GPs, social workers, mental healthcare professionals and the voluntary sector to provide more seamless and interventional services that can better plan for individuals' needs.

In a short space of time it has already transformed the lives of people in the borough. For example, One Croydon's ongoing Living Independently For Everyone (LIFE) service helped 847 people avoid possible hospital admissions in its first year and helped many more to get home earlier after treatment.

Another One Croydon initiative, Integrated Care Networks, covers every corner of the borough. Our clinicians are working side-by-side with GPs and other care professionals to help manage long-term conditions and tackle more factors that can affect someone's' health, including social isolation. Working in partnership with Age UK Croydon, each network Personal Independence Co-ordinators (PICs) that can help older people with complex health and care needs to stay well. This year more than 600 older people in Croydon have benefited from this new way of working.

It is because of these successes that, together, we have now expanded One Croydon's remit to include people of all ages.

To strengthen the Alliance, in May 2018 we started discussions with Croydon Clinical Commissioning Group (CCG) about how we could work more closely together. I am very pleased to say that, by April 2019, we have already announced our first shared appointment at executive level – Elaine Clancy, who will work for both organisations as Joint Chief Nurse.

We believe there are more opportunities for aligning management and governance between our two organisations. Through closer alignment, we will be able to improve the health of local people by providing better quality, more joined-up care and working more efficiently by reducing duplication. We are already seeing considerable benefits from the shared roles and functions of, for example, our Joint Chief Pharmacist and our Integrated Safeguarding Team.

It is fantastic that the planners and the frontline staff delivering these evolving services have been so quickly recognised, as One Croydon won the Local Government Chronicle's prestigious annual Health & Social Care award.

There have also been many other successes in our Trust over the past year. Our maternity team continue to receive awards for their excellent and innovative service. Our cancer care is among the best in London. There are so many examples, all produced by our compassionate and skilful workforce of doctors, nurses, allied health professionals, porters, therapists, administrators and a hundred other different roles.

Most encouraging of all is seeing so many of those staff engaging fully with our new ways of working – creating a healthier Croydon for now and the future.

Mike Bell
Chair

Message from our Chief Executive

Since joining the Trust in October 2018, I have continually been impressed by the levels of kindness, expertise and professionalism at CHS. Our staff are proud of the services they provide and work hard to deliver excellent care for all in one of London's largest boroughs.

Over the past year it has been fantastic to see many of our staff and services get the recognition they deserve.

Our award winning midwives have been recognised nationally by the Royal College of Midwifery and more. A survey by the Care Quality Commission (CQC) also rated our maternity services the best in London for treating mums with dignity and respect during labour and the birth of their babies.

We have consistently performed within the capital's top five trusts for short waiting times to diagnose and treat patients with cancer. Throughout the year, the Trust was also better than the national average for our consultants seeing patients with 18 weeks. Our extensive and valued community services have set a strong collaborative pace in projects such as the One Croydon alliance and LIFE (Living Independently For Everyone), as well as striving to give parents and children the best start.

As a teaching trust, our clinicians are also training the next generation of doctors, nurses and other healthcare professionals. We have a successful track record of clinical innovation and this has grown in strength throughout the year. No other acute Trust in England matches our percentage increase in participation in clinical trials, and we are bringing the latest treatment, techniques and thinking to benefit people in our community first in Croydon.

Recent examples include using virtual reality to help the recovery of stroke victims and simple at-home tests to screen for bowel cancer.

The CQC also held a routine inspection of our services in the community and at Croydon University Hospital (CUH), rating us "good" on caring,

When combined with the results of the Trust's previous inspection in 2017/18, this latest report shows seven out of the nine core services inspected at CUH are now rated as "good". We do however have much more to do as the Trust overall is rated as "requires improvement" and we are committed to improving this going forward.

The Trust is continuing on its improvement journey and we have made real progress to act on the findings of the CQC – but there are many other areas where more work is required – one example being our response to the findings of the NHS staff survey. To improve our services for the people we care for, we must improve our support for staff. To help with this, we have set very clear objectives for the year alongside our longer term goals as well as our vision and values to ensure our progress continues at pace throughout the year ahead.

Like many NHS trusts, we face the challenges of increasing demand and rising expectations. An area where this is shown the most is in our Emergency Department (ED). Our four hour performance in ED has been below 95% but has begun to improve because of the decisive actions we are taking and the hard work of our teams in the ED and across the Trust as well as our partners right across Croydon.

Opened in December 2018, our new Emergency Department at CUH cost more than £21million to build and offers modern, high-quality facilities that are 30 per cent bigger than before. It now sees about 400 patients each day, supported by our three GP Hubs in the community that treat a further 300 patients daily for urgent minor injuries and illnesses. Together our ED and GP Hubs cared for 21% more patients this February than they did the previous February, when we were running a temporary Emergency Department.

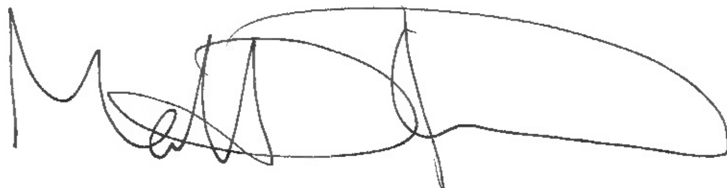
Collaboration is one of the pillars of the NHS Long Term Plan Our ambitious plans are in the same direction as these national developments

Our partnerships in the borough are changing lives by bringing health and care services closer together in the borough. For our patients, this means more coordinated care and for our staff this means greater opportunities to grow and develop in their careers.

We can now face tomorrow's healthcare challenges with a deeper collaborative approach that other boroughs may seek to replicate.

Our closer working with Croydon Clinical Commissioning Group will remove duplication and maximise resources. It means we can focus more time, energy and expertise on transforming our services, and fulfilling our twin ambitions of excellent care for all and better public health in future.

Matthew Kershaw
Interim Chief Executive



About Us

Croydon is a hugely diverse borough with a growing population and we play an important role in keeping our community well and healthy.

CHS employs more than 3,500 staff and provides integrated NHS services to care for people at home, in schools, and health clinics across the borough as well as at CUH and Purley War Memorial Hospital.

Our Trust provides more than 100 specialist services and more than 392,989 outpatient appointments every year. We also perform more than 28,000 procedures annually. The hospital is also home to the borough's only Emergency Department and 24/7 maternity services, including a labour ward, midwifery-led birth centre and the Crocus home birthing team.

Purley War Memorial Hospital (PWMH) in the south of the borough offers outpatient care, including diagnostic services, physiotherapy and ophthalmology services run by Moorfields Eye Hospital, alongside an onsite GP surgery.

Our experienced district nursing teams, Allied Health Professionals and community matrons look after people of all ages across Croydon and our Children's Hospital at Home cares for children with long-term conditions without them having to come to hospital.

Our emergency care doctors and nurses have also teamed up with local GPs to run a seamless network of urgent care services across the borough, including booked appointments with a GP available seven days a week.

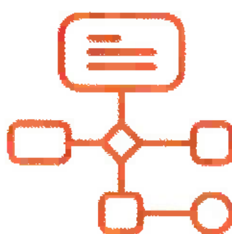
In 2018/19 we …

Community
The equivalent of **140** full time Adult Community Nurses managed more than **435,000** care contacts
Adult Therapy Services also managed more than **125,000** contacts to people in their homes and in our clinics

Maternity
delivered 3,444 babies
including **2.2%** home deliveries and
received 92.98% positive recommendations

Emergency
Looked after **131,933** attendances (urgent and emergency care),
including **30,393** emergency admissions
and **82,522** emergency attendances at GP hubs
and **95** blue-light ambulances every day

Planned care
provided **2,486** inpatient operations
25,992 day case procedures
and **392,989** outpatient appointments



Workflow
employed **3,680** staff
and had **420** volunteers

Income
had a total income during 2018/19 of **£318.8m**, an **8.8%** growth compared to the previous year

The Trust: overview of the year 2018-19

This section provides a month-by-month overview of news and events from around our Trust's two hospitals and our community services.

April 2018

- **Croydon Stars staff awards**
- **Listening into Action**
- **Awards and recognition for CHS**
- **Ending PJ paralysis**

The Croydon Stars

We held our annual Croydon Stars Awards Ceremony on 25 April at Selhurst Park, to recognise the great work of our staff and volunteers. Crystal Palace footballing legend Mark Bright joined our Chief Executive John Goulston and Trust Chair Mike Bell to present the awards to the following winners:

- Amazing Achievement - Mortuary Team
- Tremendous teamwork – Living Independently for Everyone (LIFE) team
- Incredible customer service - Sharan Gray, Wandle 1 ward
- Landmark leadership - Dr Chris Bell
- Listening into Action individual champion - Celsa Soares
- Volunteer of the year - Breastfeeding Peer Support team

Listening into Action - 2018 Pass it on Event

Our LiA Pass It On event showed just how dedicated and passionate our staff are about improving CHS. At the event on 25 April, the second cohort of LiA Ambassadors all picked different creative ways to showcase their achievements, including a quality street market place, video and presentations. The directorates also provided updates on their longer term improvement plans. Shagufta Ali from Pharmacy, Dianne Wilson from Estates & Facilities and Maria Johnson & Tara Terry from Cardiology won the prizes for best improvement showcases.

Awards and recognition for CHS

Vascular surgeon and one of the Trust's Clinical Directors, Stella Vig, won the national 'Silver Scalpel' award at The Association of Surgeons in Training (ASiT) awards on 7 April. The award was given in recognition of her fantastic leadership and support when training England's future surgeons and Stella was nominated by her surgical trainees.

Emmie Stewart-Parker who trained under Stella at Croydon in 2013/14, won the new *'Silver Suture'* award in recognition of the training courses she established which are now part of the annual induction programme for all new London surgical trainees.

Yvonne Battie, our Senior Emergency Services Clerk in the Emergency Department, won an ISTV (Information Sharing to Tackle Violence) Excellence award coordinated by the Mayor's Office for Policing And Crime (MOPAC). The two-year ISTV programme seeks to develop more effective data sharing between Community Safety Partnerships, health and other partners, using a new approach to collating and analysing anonymised Emergency Department data.

Our Macmillan Cancer Information and Support Service Manager, Benny Millier, also won a Volunteering Quality Standard award for her excellent work at the Macmillan Cancer Information and Support Centre at CUH.

The Trust was also shortlisted for the Quality of Care Award at the CHKS Top Hospitals Awards 2018. These awards are assessed entirely on public statistics about what hospitals have achieved including data such as lengths of stay, discharge rates, admissions and mortality.

Ending PJ paralysis

The Trust signed up in April to the national End PJ Paralysis campaign 70 day challenge aimed at boosting people's recovery. All of our adult wards signed up to the initiative that encourages, where possible, our patients to get up, dressed in their own clothes and moving before midday.

Evidence shows that for patients over 80, staying in bed for a week can create 10 years of muscle ageing, which can lead to a loss of independence. Helping patients to stay mobile while in hospital can reduce length of stay and risk of falling, while also improving their independence.

May 2018

- **Working together for a healthier Croydon**
- **Celebrating the achievements of our midwives and nurses**
- **Farewell to our lead chaplain Hilary Fife**
- **New CT scanner for CUH**

Working together for a healthier Croydon

On 23 May 2018, our board met with Croydon CCG to discuss how we could work more closely together to improve the health of people in the borough. We have a strong history of collaboration in Croydon, with partnerships already in place to improve our care and services for people aged over 65 years and children under five. Looking forward, we want to build on this to offer more coordinated care for people of all ages in the borough.

The two Boards discussed the priorities for the One Croydon alliance, including:

- How to build a proactive and preventative health and care system for people of all ages;

- Maintaining momentum the improvements already made to frail and elderly services; and
- Identifying new priorities to improve the health and mental wellbeing across all ages and communities in the borough.

We also discussed our quality improvements in many areas at CHS, including cancer waiting times that are consistently among the best in London. Further joint meetings have taken place throughout the year to look at opportunities for even closer working.

Celebrating the achievements of our nurses and midwives

As part of this year's celebration of International Nurses Day, we held a special awards ceremony on 11 May to recognise the care, compassion and professionalism of our nursing and midwifery colleagues across the Trust.

Nakita Martin won Healthcare Assistant of the Year, Linda Litchfield was Nurse of the Year and Yvonne Tapping was Midwife of the Year. Their awards were presented by NHS England's national Head of Safeguarding, Dr Kenny Gibson.

Retirement of our Chaplain Hilary Fife

On Wednesday 30 May, a service was held to mark the retirement of Hilary Fife. The service was led by the Bishop of Southwark and multi-faith leaders from across the borough who all spoke of Hilary's dedication, commitment and achievements during her career.

She was employed by the Trust for 22 years but worked for five years prior to this as a volunteer chaplain. During this time the chaplaincy team increased its services to include Bereavement Support Services and she raised money to refurbish the chapel at CUH. She also provided support for many thousands of patients, their families and our staff. Her legacy is a chaplaincy team which is leading in its field and an example of how such departments should be developed and provided in other NHS hospitals.

New CT Scanner in our Diagnostic Centre is fastest type in the NHS

Olympic gold medallist Tessa Sanderson came to the Trust on 24 May to open our new Aquilion ONE™ GENESIS Edition CT scanner which is part of our Diagnostic Centre upgrade this year.

It is the fastest type of CT scanner in the NHS and can produce high-resolution, accurate images of a heart in only 135 milliseconds – faster than a heartbeat. In particular it will help us manage NICE's requirement to do many more CT scans for people with Coronary Artery Disease (to reduce invasive coronary angiography.

June 2018

- **New pay deal for NHS staff**
- **Research and Development at CHS**

New pay deal for NHS staff

Following the Trade Union consultation, it was announced that the on 27 June 2018 the NHS Staff Council had accepted and ratified a proposed new pay deal for Agenda for Change staff. Pay was backdated pay from 1 April 2018.

Research and Development at CHS

On 20 June the Trust held its Annual Research and Development Day. The 56 clinical research projects showed how staff at CHS are working to improve healthcare and are enabling local people to access innovative new treatments. Awards were given across a range of categories including research, clinical service/service improvement, and audits.

Also this month, the National Institute for Health Research (NIHR) published new figures covering April 2017 to March 2018 that showed the number of research participants at CHS jumped 191% to 2,544 from 873 the previous year. This was the largest percentage increase of any acute trust across England and meant that more patients at Croydon had the opportunity to take part in research.

Inpatients said we continued to get better - although we had more to do

The annual national 2017 Inpatient Survey results, published on 13 June by the Care Quality Commission, revealed that care in our Trust continued to improve.

Our two areas of 'significant improvement' were in giving patients enough privacy when discussing conditions or treatments and also providing enough help for patients when they are eating meals. We also gradually improved across the vast majority of other areas, continuing a trend. Inpatients gave better scores in 80% (39 of 49) of the same questions now compared to 2013. By comparison, only 8% were lower - and only marginally. Overall, 78% of patients responding rated our care as seven or more out of 10 – an improvement from 69% in 2013.

However, we were below most trusts and the survey showed we were not improving as quickly as them. Relevant factors could be our especially large and diverse local population (considering the size of our Trust) and the fact that 83% of our 331 respondents were from A&E – a service where we were stretched and, at this time, in a temporary location.

A number of changes were introduced to help improve our patients' experience of care going forward, including work to improve discharges home, twice-monthly quality meetings, new electronic quality rounds, daily environmental checks and comfort packs for inpatients.

July 2018

- **NHS 70**
- **Trust's own pop up shop opened in Croydon**
- **CQC visit to community services**
- **Praise for ENT team**

NHS 70

On July 5, the NHS turned 70 and there were a whole range of activities across the Trust, in our hospitals and community clinics to mark the occasion.

Tea and cake were provided in the PGMC at CUH as well as cakes and strawberries out in the community, thanks to the generosity of our catering team, estates suppliers, Unison and charitable funds. Michael Fanning (Director of Nursing and Midwifery) went to Lennard Road for the cake cutting, where staff had also organised their own cake sale and dressed up in their nursing uniforms from many years ago. Radiology created a fascinating photo exhibition and teams in Nightingale House came together for a celebratory lunch.

Members of our senior team also joined colleagues from Croydon CCG, Croydon Council, HealthWatch Croydon, Croydon Voluntary Action and SLAM for a 70th birthday celebration at our pop up shop in the Whitgift Centre.

Pop up shop

Our first ever CHS pop up shop opened during July in the Whitgift Centre in central Croydon. We opened for three days a week for three weeks to showcase the services that we provide for the people across the borough.

Our recruitment team offered on the spot assessments and interviews to job applicants for a range of opportunities across the Trust. Our Patient Experience, Volunteering, Communications and Maternity teams were also regularly in the shop speaking with local people as were Croydon Works job brokerage team and SLAM. Our falls team even got out and about to give advice to people using walking aids in the shopping centre.

CQC visit to community services

During July the CQC held an unannounced inspection of our community services for children and young people and for adults. They also inspected core medical services at CUH.

In their report, which was published in September, inspectors awarded our medical care and community services overall ratings of "requires improvement". All our services were rated as "good" on caring and both medical services (including older

people's care) and community health services for adults were also judged "good" on being effective.

In total, combining the results of our previous inspection last year, this latest report meant seven out of the nine of the core services inspected at CUH were rated as "good". The Trust, however, remained on "requires improvement" overall.

The inspectors said Trust staff treated people with dignity, respect and kindness, and patients spoke positively about the care they had received. They also highlighted areas of outstanding practice including new research initiatives by our Speech and Language Therapy staff and community teams and the work of the Rainbow Health Centre which looks after homeless people and asylum seekers in the borough.

The CQC also set out a range of actions needed to address the issues raised and build upon work already underway. These included discharging patients earlier in the day when they are medically ready and not moving people late at night in the hospital because of capacity issues. They also highlighted how - like many trusts - we face challenges to recruit more clinical staff at a time when there is increased demand and limited supply.

Rupert Bear ward

As part of renovation work Rupert Bear ward at CUH moved to a new temporary home on the first floor of the Orange zone. This allowed renovations to take place and created a more welcoming environment for our young patients. The ward was also lucky enough to receive a £1,000 donation from friends of our multi-faith chaplaincy, an NGO called the Al Khair Foundation.

ENT praised for 'getting it right first time'

We were visited by NHS England's 'Getting It Right First Time' (GIRFT) team in June. The initiative looked at Hospital Episode Statistics to compare each of 122 Ear Nose Throat (ENT) departments across England. They called our service "stellar" and their ENT lead for GIRFT (an ENT surgeon from Nottingham) commended our team highly. We ranked in the top 10 per cent in almost every aspect, both for raw numbers and when adjusted for population and size of department.

Croydon NHS spearheads change in England's surgery teams

It was announced that clinicians who work alongside surgeons during operations could join the distinguished Royal College of Surgeons (RCS) as 'Associate Members'. The first ever person to join under this new arrangement was Matthew Smith who is Surgical First Assistant in the operating theatre for trauma and orthopaedic cases at CUH.

Launch of FFT by text

From 20 July the Trust launched a new initiative as part of the Friends and Family Test (FFT) so patients and service users could share their views by mobile. Patients

in our Emergency Department were the first to get this option and it has enabled more people to give us vital feedback in a convenient way.

August 2018

- **Reablement service rated good**
- **Trust rated top in SW London on cleanliness and maintenance**
- **Trust among the best in London on waiting times for treatment and suspected cancer.**

Reablement service rated good by the CQC

In August the CQC inspected Croydon's reablement services, including one of our new services run in partnership in the borough. Publishing the results on 5 October, CQC inspectors rated the Croydon community reablement service as "good" for all aspects of the service, including its safety, responsiveness and how well it was led. Feedback to CQC inspectors during the visit included comments from a service user's relative, who said: "The service is very good, I'd rate it outstanding."

The service is part of LIFE (Living Independently For Everyone) service. This was created by the One Croydon alliance in 2017, bringing together teams from health and social care as well as the voluntary sector. It provides coordinated short-term support to people and enables them to retain or regain their independence and continue living in their own home. It was set up to look after mainly over-65s with long-term conditions by tailoring their care to reduce the need for hospital stays.

Trust rated top in SW London for cleanliness and maintenance of buildings

In the annual Patient-Led Assessments of the Care Environment (PLACE), CHS achieved a score of 8.83 percent for cleanliness and 94.83 percent for the condition, appearance and maintenance of its buildings – the highest scores among South West London acute hospitals.

Against the measure of how well the Trust meets the needs of people with dementia, CHS scored 85.15 percent which was the highest in the South West London region. The Trust also scored an impressive 94.83 percent for how well equipped it is to meet the needs of people with a disability which was the highest score among London's 18 acute hospital trusts.

In the assessments, published by NHS Digital, also showed areas where the Trust could improve further. On food, the Trust achieved an average of 89.85 percent which was just below the national average of 90.2 percent. On privacy, dignity and wellbeing, CHS was rated at 80.44 percent which was below the average for England of 84.2 percent.

Trust among the best in London on waiting times for treatment and suspected cancer.

Data published by NHS England this month showed that in June 2018, 93.1 percent of patients who were referred to CHS for consultant-led elective (planned) care waited less than 18 weeks. This placed the Trust above the national average for the third month in a row and at third position among the capital's 18 acute trusts on Referral to Treatment Times (RTT).

The Trust was also at third position among London acute trusts on waiting times for people with suspected cancer with 98.32 percent of people seeing a specialist within two weeks. This was above the England average of 91.10 percent. CHS additionally performed well on the standard that all patients urgently referred by their GP should start cancer treatment within 62 days. During April, the CHS held the top position among London acute trusts for its 62 day performance, and was third in the capital during May and June.

September 2018

- **CHS support for national Organ Donation Week**

CHS support for national Organ Donation Week

CHS called on people to support Organ Donation Week (3-9 September) as figures revealed a fall the number of registered organ donors in the borough.

Over the past decade, 20 people at CUH have donated their organs, enabling 57 transplants. However figures from NHS Blood and Transplant showed that the number of people in the borough on the donor list had fallen from 103,798 in 2017 to 101,636 in 2018. In addition to urging more locals to register, the Trust highlighted the importance of people telling loved-ones if they wanted their organs to be donated.

October 2018

- **New Trust Chief Executive**
- **Innovative approach to stroke care**
- **New nurse recruitment campaign**
- **Red Bag scheme in Croydon**

New interim chief executive joins the Trust

Matthew Kershaw took up the post of interim Chief Executive on 1 October. With more than 25 years of NHS experience, he had previously held a number of senior leadership roles, most recently as Chief Executive of East Kent Hospitals University Foundation Trust where he led the Trust out of Quality Special Measures.

Prior to this, Matthew was Chief Executive of Brighton and Sussex University Hospitals NHS Trust for three years securing £500m capital to redevelop the Sussex County Hospital. He also worked nationally at the Department of Health, including developing the delivery plan for the 18-week waiting time target and being the first trust special administrator. His career has also seen him work with the Care Quality Commission, Health Education England, and the Kent Cancer Alliance, where he chaired the Kent Surrey and Sussex Clinical Research Network.

Immediately prior to joining CHS, Matthew was a Senior Fellow at The King's Fund, a health think-tank, where he played a key role in its work with health and care organisations to develop integrated care that better meets the needs of patients and service-users.

Innovative approach to stroke care

On 1 October 2018, ITV London News interviewed one of our stroke consultants, Dr Karen Kee, about a cutting-edge initiative we are trialling at CUH.

Dr Kee and her team are piloting the innovative use of virtual reality simulation to aid the recovery of their patients after a stroke. It is understood that CUH is the first Trust in London to use this technique and the only one in the country to be studying its benefits. ITV London spoke to one of our patients, Peter (aged 87), who experienced his stroke in July outside his home in Norbury. Using virtual reality is helping Peter regain his independence.

New 'Could You Be A Croydon Nurse?' campaign

To help fill the 200+ nursing vacancies across the Trust, we ran a nursing recruitment campaign to:

- Make potential employees aware of the nursing opportunities in our trust.
- Attract the right candidates to apply for our vacancies.
- Celebrate the Trust's support for staff.
- Bust some 'Croydon' myths by promoting the area as a vibrant, exciting place to be.

The campaign was seen by 42,000 people on Twitter and Facebook in just six weeks. More than 900 people also visited our recruitment microsite.

'Red bag' scheme rolled out across Croydon

The Red Bag scheme which is designed to make emergency hospital visits safer and speed up discharge was launched in Croydon. The bags for care home residents contain key information including medical conditions and personal belongings. Ensuring people arriving from care homes have it with them when they arrive at hospital gives staff the information they need to speed up clinical decisions. Evidence shows that use of the bags saved an average of 2.4 bed days. Croydon Clinical Commissioning Group began rolling it out across the borough in November including in CUH.

November 2018

- **Croydon Health and Care event**
- **New app to manage diabetes in pregnancy**

Croydon Health and Care event

The Croydon Health and Care event on 20 November offered a chance for local residents to share their views with ourselves, our partners from across the NHS as well as the local authority, the voluntary sector and local schools. The Trust's medical director, Dr Nnenna Osuji spoke at the event to discuss the importance of working collaboratively with our partners across Croydon to improve how well we look after people in our borough. She also spoke about the importance of self-empowerment and community involvement to enhance health and well-being in Croydon.

New app to help manage diabetes in pregnancy

A new app was launched to help NHS clinicians closely support Croydon women who develop 'gestational diabetes', which occurs in about 1-in-10 pregnancies in the borough. The free-to-download (for patients) app can connect wirelessly to a blood glucose monitor and means staff at CUH can monitor women and communicate with them easily. In trials the app was found to help avoid unnecessary clinic visits, reduce administration time and improve care. It is believed that good management of the condition can help prevent long term development of Type 2 diabetes.

December 2018

- **Opening of the new Emergency Department**
- **Gifts and visits from our community for the festive season**
- **Complete hepatitis service at CHS**
- **Dubai nurse recruitment success**

New Emergency Department

Our new Emergency Department, which offers modern, high-quality facilities for our community, was opened on 2 December. Designed by our doctors and nurses to create the best environment in which to care for patients, it is 30 percent bigger than our previous Emergency Department and has a dementia-friendly design. It has rooms with doors, rather than curtained cubicles, to increase privacy for patients. There are also separate paediatric areas for children and adolescents including an outdoor space and 14 paediatric patient rooms.

Two mental health liaison rooms offer private and appropriate spaces where nurses can assess people who need specialist care and there is a dedicated Children and Adolescent Mental Health Service (CAHMS). The department, which cost more than

£21million to construct, also includes a new Urgent Treatment Centre with six consultation rooms and a treatment room.

Our local media reported on the opening and our social media posts about it reached more than 10,000 people and had 4,600 engagements. We have also able to show the new facility to our local MPs, councillors and Croydon's Mayor.

Festive visits and gifts from our community

On 13 December, Crystal Palace footballers Patrick Van Aanholt and Scott Dann, alongside Palace Ladies Freya Holdaway and Ciara Watling visited CUH to hand out gifts to patients on Rupert Bear and the Acute Care of the Elderly wards. Children on our wards also received generous festive donations from the Sun on Sunday newspaper, London Ambulance, the Metropolitan Police and charities. Our older patients also benefited from a visit and gifts from the Lajna Women's Association, as well as carol singing organised by the Mayor of Croydon and our chaplaincy team.

Complete viral Hepatitis care opens in central Croydon for the first time

CUH began providing complete viral Hepatitis treatment for the first time so that Croydon's residents no longer needed to go outside the borough for treatment.

About 4,000 Croydon Residents have viral Hepatitis, which is higher than the national average. Many need treatment to be as convenient as possible because of the complexities associated with their infections. It is hoped the new service and expects it to significantly improve treatment rates.

Dubai nurse recruitment

As part of our ongoing nurse recruitment drive, our Deputy Director of Nursing and Lead Matron - Nursing Workforce, visited Dubai to encourage nurses in the region to #choosecroydon. After a rigorous selection process, including interviews and tests, 50 were offered roles in our nursing teams across the Trust.

January 2019

- **Positive results in the CQC Maternity Survey**
- **National award for CREATE project to enhance our stroke ward**
- **Director of Nursing steps down**

Positive results in CQC maternity survey

The CQC 2018 National Maternity Survey revealed that CHS is the highest of any London Trust in treating new mums with dignity and respect during their labour and birth of their babies.

The Trust received a score of 9.7 out of 10, fourth highest in the country and a significant increase in the number of new mums responding positively compared to the 2017 survey.

CHS also came fourth nationally when allowing women to choose a location for their antenatal appointments and scored higher than many other trusts in advising mothers of the need for a personal postnatal check-up 6-8 weeks after their child's birth.

Prize for CREATE project

The CREATE (Collaborative Rehabilitation Environments in Acute sTrokE) research project to enhance the Heathfield 1 ward at CUH and create a more stimulating environment for patients won a national UK Stroke Forum prize for 'Patient, Carer And Public Involvement'. Other innovations in the ward include patients getting more information and more opportunities to talk and even play together amid attractive wall murals. Heathfield 1 now provides a wealth of support to rehabilitate patients and help them get back their independence.

Director of Nursing steps down after five years at the Trust

Michael Fanning, the Trust's Director of Nursing, Midwifery and Allied Health Professionals announced at the end of January he would be leaving in April 2019 after five years at the Trust. During his time at CHS, Michael celebrated the professions of nursing, midwifery and therapists and introduced new roles to raise the profile of district nurses and therapists in providing holistic care for people in Croydon. He also championed dignity and compassion in care to improve people's experience of using services at the Trust.

February 2019

- **Home birth midwife wins regional Royal College of Midwives award**
- **Chaplaincy welcomes Bishop from Zimbabwe**
- **Stella Vig, consultant surgeon, shortlisted in Asian women of Achievement Awards**

Homebirth midwife wins regional Royal College of Midwives award

Kelly Sawyer, a midwife in the CHS homebirth team, was recognised as the RCM's London's region's 'Emma's Diary Mums' Midwife of the Year 2019'

Kelly was nominated by local mum Kasia DiMaria, whom she provided care for throughout her pregnancy, labour and postnatal period. The prestigious award is one of the Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the incredible work done by exceptional midwives across the country.

Zimbabwe Bishop visits CUH

CHS welcomed Bishop Ignatius Makumbe from Zimbabwe to see the positive work done by the Trust to provide the pastoral, spiritual and religious care to patients, relatives and staff. The visit provided Bishop Makumbe and colleagues with some help and guidance as they prepared to open a hospital to support the local community in Central Zimbabwe, a project which the CHS Lead Chaplain has supported since its early development.

Consultant surgeon Stella Vig shortlisted for award

Stella Vig, consultant surgeon at CHS, has been nominated for the Woman of the Year award at the 2019 Asian Women of Achievement awards. Highly respected by fellow clinicians at CHS and her vascular surgical colleagues across London and the UK, she has been recognised for being an inspirational leader, coach and mentor to many doctors in training each year at CUH, for being a fantastic clinical leader and an outstanding clinical professional. Stella will find out if she has been successful at the awards ceremony in April 2019.

March 2019

- **One Croydon alliance win HSJ award**
- **Recruitment success in Brighton**
- **Race equality workshop**
- **Pharmacy department praised by Health Education England in inspection**

One Croydon alliance win HSJ award

The One Croydon alliance was crowned winners of the Local Government Chronicle Health and Social Care award at the LGC Awards 2019. Shortlisted along with eight other Health and Social Care projects across the country, One Croydon were praised for their 'impressive scale and system-wide leadership' and quoted as having a 'real impact'.

The national recognition comes after an award win for the Rapid Response team as part of the Alliance last year and wide spread praise of the collaborative working across the borough.

Recruitment success in Brighton

Nursing Times Careers Fair played host to our nursing team for their annual careers fair down on the South Coast. Our three-strong team attended and met student and qualified nurses looking for roles across the South East. Despite the presence of a number of London trusts, our team spoke to nearly 300 prospective employees and offered roles to 63 nurses on the day.

Workforce Race and Equality Standard workshop

The Trust welcomed Yvonne Coghill, Director of Workforce Race Equality Standard Implementation at NHS England, for an engaging conversation about race equality across the CHS. Colleagues from all levels including senior executives and non-executive directors were invited to join the discussion about how CHS is performing in key areas.

Frank discussions were had and new ideas were suggested to make further improvements going forward which will benefit all staff in their understanding working well together around race equality issues in the Trust.

Pharmacy department praised by Health Education England in inspection

Health Education England (HEE) visited the Pharmacy department to inspect the quality of its training and education and their feedback was overwhelmingly positive. During the inspection HEE were highly complementary about the caring and supportive environment, the Pharmacy team's impressive record and the way they lead by example.

They interviewed all four pre-registration pharmacists, some year-one trainee technicians and other staff - and saw 'exemplary' work, some of which will be used by the HEE as examples of good practice.

Our Community

Croydon is home to more than 380,000 people making it the second largest London borough by population. Over the next 15 years the number of people living in the borough is set to rise to more than 430,000.

Within our population, we have the highest number of 0-17 year olds in London and the third highest number of people aged 65 and over. We are also a highly diverse borough with our communities speaking more than 100 languages between them and currently just over half of Croydon's population are Black, Asian and Minority Ethnic groups.

The borough also has some challenges around deprivation, with 10,261 people living in areas considered to be within the 10% most deprived in the whole country. Life expectancy also varies across Croydon, with men in some areas expected to live a decade longer than those in other parts of the borough.

Croydon also faces unique challenges from having the Home Office's UK Visa and Immigration division based in the borough, such as the highest number of Unaccompanied Asylum Seeking Children in London.

Given these and a range of other factors, Rachel Flowers, Director of Public Health for Croydon recently described the borough as "an outer London borough with inner London issues and a very large population."

As you will see in this report, we are working closely with our partners to help address these challenges and opportunities.

Why people choose us

Here are just some examples of why our services are valued for their quality, safety, accessibility and compassion.

Performance

We have successfully delivered against the incomplete national performance target for referring patients to treatment (RTT) during 2018/19. Performance has continued to improve on an upward trend since April 2018 ending the year on 92.22%. The Trust's performance has consistently been positioned around 11th out of the 24 London Trusts since November 2018.

Our cancer care has consistently maintained a high position within SW London and has generally been within the top five performing Trusts in London for the Cancer Waiting Time targets.

In September 2018 the Care Quality Commission rated our services "good" on caring. Both medical care and community health services for adults were also judged "good" on being effective. When combined with the previous inspection last year, the latest report also means seven out of the nine of the core services inspected at CUH are now rated as "good".

Maternity

In January 2019 the Care Quality Commission rated our maternity service the best in London – and fourth in England – for treating mums with respect and dignity during childbirth. During its last full inspection, in 2015, the CQC rated our maternity and gynaecology services as "Good".

Our maternity teams continue to win national and regional awards. In March 2019 Kelly Sawyer won London's the Emma's Diary Mums award for Midwife of the Year. In 2018 Memuna Sowe was announced Midwife Of The Year by the British Journal Of Midwifery and colleague Paulina Sporek won the Midwife Achievement Award at the London Maternity and Midwifery Festival. Our Crocus Home Birth team were finalists for the Team Of The Year at the Royal College of Midwifery Awards 2018.

To give women greater choice for their maternity care, CUH offers larger than average rooms with space for partners to stay overnight in the midwifery-led Birth Centre, including several with birthing pools. For women who need additional support in labour, the hospital's 11 delivery suite rooms are all en suite and have been designed to make women feel as comfortable and calm as possible.

Our Crocus Home Birth team has achieved the highest rate in South London for home birthing, which is the best and most comfortable method for mums at low risk of complications. In total 2.2% of the 3,444 deliveries by our midwives take place at home, who are working to increase this to our goal of 5%.

Emergency Care

The new Emergency Department cost more than £21million to construct and offers modern, high-quality facilities. It has been designed by our doctors and nurses to create the best environment in which to care for patients.

It now sees about 400 patients each day. Its three supporting GP Hubs in the community add another 300 patients to this, as they have urgent care GPs and nurses who can assess and treat minor injuries and illnesses.

This is a growing service. The Emergency Department and GP Hubs together cared for 21% more patients this February than they did the previous February, when the Hospital was running a temporary Emergency Department.

The Emergency Department is 30 percent bigger than our previous one and offers many benefits including a dementia-friendly design and rooms with doors, rather than curtained cubicles, to increase privacy for patients.

There are two separate paediatric waiting areas - one for children under 12 and the other for adolescents - plus an outdoor space and nine paediatric patient rooms where they can receive care.

There are also two mental health liaison rooms offering private and appropriate spaces where nurses can assess people who need specialist care, plus a dedicated Child and Adolescent Mental Health liaison room.

In addition the Emergency Department building includes a new Urgent Treatment Centre with six consultation rooms and a treatment room where people with more minor ailments can be looked after by qualified staff.

Other new services/facilities

Starting December 2018, CUH began providing complete viral Hepatitis treatment for the first time so that Croydon's residents do not have to go outside the borough for treatment. About 4,000 Croydon Residents have viral Hepatitis, which is higher than the national average meaning there is significant local need. Having this in the heart of Croydon is ideal for hepatitis patients - especially those who are vulnerable or injecting recreational drugs (needle-sharing accounts for more than half of Croydon's Hepatitis C cases).

We launched various mobile device apps over the past year, including ones for diabetes patients and atrial fibrillation patients. These help patients to self-manage and alert clinicians to patients' needs.

The free-to-download diabetes app supports the 400 Croydon women each year who start developing diabetes during pregnancy by putting their blood glucose monitor – and themselves – in monitored contact with our clinicians. 'Gestational diabetes' occurs in about 1-in-10 pregnancies in Croydon – a rate far higher than England's

national average of 1-in-17. Up to half of women diagnosed with it then develop Type 2 diabetes within five years of the birth, so early treatment and management is vital.

Two new portable devices are helping Croydon's heart patients who have a life-threatening and very common condition called atrial fibrillation (AF), which causes irregular heartbeats that can also be abnormally fast. Atrial fibrillation affects up to 1-in-50 people and many do not know they have it. Pocket-sized devices are taken home by patients at risk, who can grip it when they feel AF occurring. This gives vital of-the-moment information to our clinicians, aiding treatment. Another pocket-sized device is being carried by ten of our community nurses who, by combining it with an app, can quickly test for AF and are expected to identify thousands of cases earlier so that treatment can be provided quickly.

Significant restructure is occurring in our Scanning Department at CUH. In 2018 this included the installation of an Aquilion ONE™ GENESIS Edition CT, which is the fastest type of Computerised Tomography (CT) scanner used in the NHS and can produce high-resolution, accurate images of a heart in only 135 milliseconds – faster than a heartbeat. The scanner comes with a host of other improvements within an improved and modernised care environment. In particular it will help ensure the hospital can manage growing demand for scans of patients' hearts and blood circulation.

Research and Development

Our Trust has a university hospital, which means we can fund and run our teams of award-winning, pioneering researchers. In total we launched 56 research projects for the year 2018-19. This gives many of our patients access to special treatments many years before they become widely available.

In 2018 we were the declared England's top acute trust regarding the percentage increase in the number of patients taking part in research studies. The National Institute for Health Research (NIHR) reported that our number of public participants jumped 191%, from 873 to 2,544.

Research at our Heathfield 1 stroke ward was featured on ITV News in 2018 for its novel and effective use of virtual reality to assist stroke recovery. The ward is also one of four in England working with a project called CREATE to evolve their care environment for patients – resulting in a UK Stroke Forum award in 2019.

Our largest project, called NICE FIT, is anticipated to almost halve the number of invasive procedures on England's bowel cancer patients by improving the accuracy of tests for symptoms at GP surgeries. It has recruited more than 11,000 participants and is the UK's largest study into using faecal dipstick tests.

Community Services

We offer a wide range of community health services for all ages - from community midwives and health visitors looking after the very young to district nurses caring for older people in our community. Our community services are a crucial part of the

Trust's work to help people take greater control of their health and proactively manage long-term conditions without the need for hospital visits.

In Winter 2017 we launched Living Independently For Everyone (LIFE) and it is going from strength to strength, receiving in excess of 1,500 referrals over the last year. We work closely with our One Croydon partners (see Partnerships below) to create bespoke packages of care for over-65's who are well enough to leave hospital but who need a level of care to regain their independence. It means they can return home more quickly without any loss of care. This also helps to release our hospital beds for other patients when it is appropriate to do so - which is important during busy periods.

In August the CQC inspected Croydon's reablement services (a part of LIFE), including one of our new services run in partnership in the borough. Publishing the results on 5 October, CQC inspectors rated the Croydon community reablement service as "good" for all aspects of the service, including its safety, responsiveness and how well it was led.

In 2018 Memuna Sowe was announced Midwife Of The Year by the British Journal Of Midwifery for her work in our Homeless Health service. The team helps improve access to care for underrepresented women throughout their pregnancy to give their children and families the best start in life. Many of our services have won similar awards.

Other community services for children include specialist clinicians in our looked After Children Team, 58 Health Visitors looking after a cohort of 29,003 babies and children up to age five, an immunisation team who gave 26,975 injections this year, breastfeeding 'baby Cafes' and many other cherished services.

For adults, a workforce of 140 full time nursing staff managed more than 32,000 referrals – reflecting the increasing effort to ensure people remain well and independent outside of hospital.

Our specialist care has grown this year in many areas including community stroke rehabilitation, podiatry, falls prevention, respiration

Partnerships

We have a long and successful track record of collaboration in Croydon and the Trust is in a strong position to respond to the NHS Long Term plan.

In March 2019 our local alliance called One Croydon won the Local Government Chronicle's prestigious annual Health & Social Care award. See below for more about this Partnership.

This alliance is delivering real benefits to people in our borough. As a formal partnership between the local NHS, Croydon Council and Age UK Croydon, together we are focused on improving the health and wellbeing of people of all ages in the borough.

For our patients, this alliance means less duplication and fewer gaps between services. For example, confidential multi-agency meetings known as 'huddles' have been set-up between GPs, social workers, pharmacists and other healthcare professionals to proactively plan and review the care and support available for their patients.

The meetings form part of Croydon's six Integrated Community Networks made up of a GPs, community nurses, CCG pharmacists, social workers and Age UK Personal Independence Co-ordinators. Every GP practice in Croydon is now working as part of an integrated Community Network, and runs weekly 'huddles.'
For our staff, the alliance means more opportunities to grow and develop careers.

With our regulators at NHS England and NHS Improvement, the Trust is now developing a new partnership with Croydon Clinical Commissioning Group (CCG). This will combine expertise and reduce duplication to release time, energy and resources to support frontline clinicians and deliver more timely and coordinated care. For the first time, this also includes having a single shared budget to fund further improvements to local services. This would be an important step closer towards the full integration of the health and care system for Croydon.

We also have numerous partnerships with other charities, patient bodies and healthcare providers.

Vision and values

"Working in partnership to provide excellent care for all and improve the health and well-being of our population"

This is our renewed vision for the Trust.

Rooted in our community through our hospitals and clinics across the borough, we always strive to provide excellent care for all.

Croydon is a great place to live and work but some people in our borough face the challenges of poverty, housing or other environmental factors that can contribute towards poorer health and shorter lives.

Our local population is also growing rapidly in size. We have the youngest population of any London borough, with almost a third of our residents aged under 25 and, at the same time, people are living longer.

This means we have to do much more to prevent ill-health and help people in Croydon to stay well. We must do this at the same time as providing rapid access to diagnostic services and medical expertise when and where it is needed.

Collaboration is the key. Only by working well together with our partners in the borough, can we connect the services available to give people more coordinated and person-centred care which will deliver real benefits for our patients and service users in the years to come.

Our values

We want local people to feel confident in our care, and for our staff to feel proud to work here. Our values shape everything we do, every single day. They determine our behaviour and the experience of those we look after.

We will always be professional, compassionate, respectful and safe:

Professional
- Set ourselves very high standards and share best practice
- Keep our uniforms smart, and be professional and consistent in our approach
- Work in partnership to best support our community's needs
- Use resources wisely without compromising quality or safety

Compassionate
- Treat everyone as we would want to be treated ourselves
- Demonstrate kindness, dignity, empathy and compassion
- Make time for the people we are caring for, to understand their needs and wants
- Organise our services to give people the best possible experience of care

Respectful

- Be courteous and welcoming, and introduce ourselves
- Value the diversity and needs of everyone
- Always involve people in decisions about their care, listening to and respecting their wishes
- Appreciate the contribution that staff from all backgrounds bring to our services

Safe

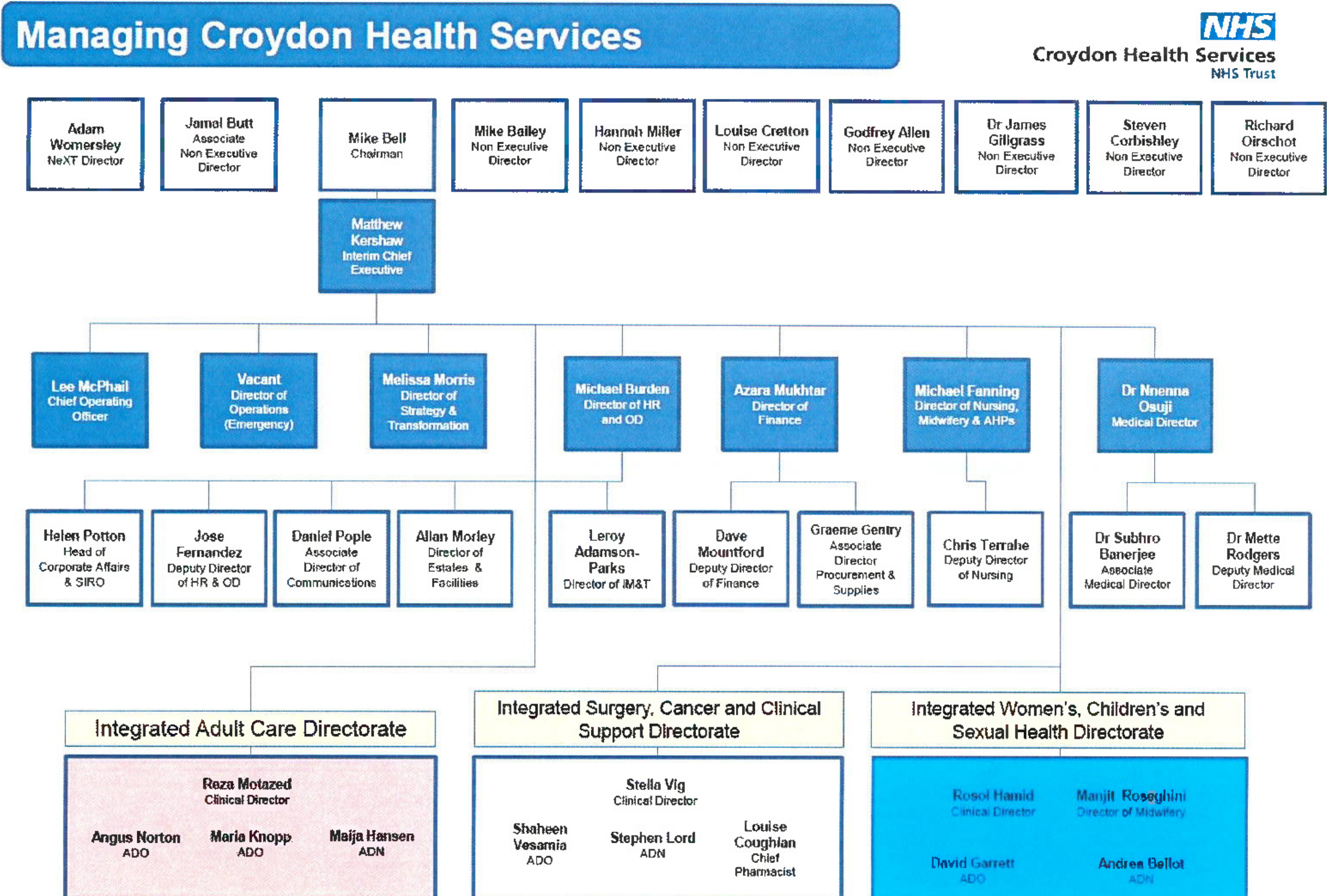
- Be open and honest in everything we do, sharing what we do well and admitting our mistakes, to constantly improve our care
- Protect the confidentiality of those in our care and show sensitivity to people around us
- Feel free to raise concerns so we are always learning
- Make time for training and development and support research so people always receive the highest standards of care

Annual priorities 2018/19

Objective	2018/19 Priorities	Progress
Quality	• Goal of achieving a good CQC rating - currently at Requires Improvement. • Improve quality such that areas of concern are addressed. In accordance with the Quality, Experience & Safety Programme (QESP).	• Of the Trust's nine acute core services, seven are now rated as 'Good'. • The CQC rates us 'Requires Improvement' overall. • We are working towards a Good rating. QESP developed into QIP and has already helped us deliver many of the CQC action plans, as well as preparing us for future CQC inspections. • Our Quality Team has been restructured. • A new Associate Director of Quality has been appointed.
Emergency Care	• A&E standard; achieve 90% and then 95% by March 2019. By delivering the Emergency Care Recovery Plan. • Goal is to move to the best segment on NHSI Emergency care ratings.	• During the year 85.36% of our Emergency Department patients were seen within four hours. • Opened a new Emergency Department in December. • We have implemented a range of High Impact changes to improve the performance of emergency care including: o Reducing the number of ambulance handover delays that were longer than 30 mins. o Improving the quality of data and analysis of the emergency care pathway and how it drives sustainable improvement. o Reducing the length of time that patients stay in the ED (aggregated patient delay). o Improving our discharge planning processes. o Redesigning the medical model of care, focusing on how our senior medical consultants work.

Finance 2018/19	• Maintain improve financial controls and delivery on savings (£19.2m) and additional net income (£6.3m) plans. • Delivering the Financial Recovery Plan. • Goal is to meet control total and receive Provider Sustainability Funding (PSF).	• £19.2m savings delivered although £7m of these were through non recurrent measures. £7.8m of income improvement was achieved in 2018/19. • The Trust met its £15.1m deficit control total, pre PSF and received £16.6m of PSF.
Sustainability	• Develop a strategic sustainability plan for Croydon Health & Care System. Deliver the Croydon Health and Care Plan. • Goal of return to surplus by 2019/20 and development of One Croydon Alliance into an Integrated Care System.	• If the Trust delivers its £13.2m deficit for 2019/20 it will receive £13.2m central funding which will result in a breakeven position for 2019/20.

Management Structure – 31 March 2019



Clinical Directorates

Integrated Surgery, Cancer and Clinical Support Directorate

Inpatient Pathways	• General Surgery • Trauma & Orthopaedics • Urology • Upper GI • Vascular • Breast • Surgical wards
Ambulatory Pathways	• Outpatients • Head & Neck • Dentistry • Clinical Haematology • Dermatology • Pathology • Palliative Care
Theatres & Anaesthetics	• Main Theatres & Recovery • Day Surgery & Recovery • Pre-assessment – Coulsdon 1 • Critical Care (ITU and HDU) • Surgical wards – Fairfield 1, Queens 1, Queens 2, Queens 3
Diagnostics & Clinical Support Services	• Diagnostic Imaging • Pharmacy • Neurophysiology
Cancer, Access & Performance	• Cancer • RTT • Access • Macmillan Nursing • Medical Records

Integrated Women's, Children's and Sexual Health Services Directorate

Obstetrics and Gynaecology	• Maternity Services – Labour ward, ante and post-natal wards (Hope and Mary) • Birthing Unit • SCBU • Community Midwifery Services • Crocus Homebirth Team • Gynae Outpatients • Colposcopy • Hysteroscopy Services • Endometriosis Services • Early Pregnancy Unit • Gynae Diagnostics • Fertility Services • IVF Unit • Continence Services • FGM Service
Public Health	• Sexual Health Services & Genitourinary Medicine • Contraception Services • Domiciliary Contraception Service • Sexual Health Outreach Service • HIV Team • Homeless Health Team • Health Visiting • School Nursing • Family Nurse Partnership • Breast Feeding Service • Sexual Health Advisers • Smoking Cessation Team • Enuresis Team • Immunisation Team
Children's Services	• Paediatric Emergency Department • Paediatric Urgent Care • Rupert Bear & Dolphin Wards • Paediatric Inpatients Paediatric Outpatients Service • Paediatric Surgery Paediatric Pre-assessment • Children's Community Nursing Service • Paediatric Asthma Nurse Specialist Service • Children's Therapies – Physio, Speech & Language Therapy, Occupational Therapy • Audiology • Community Paediatricians • Special School Services

Integrated Adult Care Directorate

Service	Includes

Emergency Care	• Emergency Department
	• Urgent Care Centre
	• Edgecome Unit:
	  o Rapid Assessment Medical Unit (RAMU)
	  o Acute Care of the Elderly Unit (ACE)
	  o Ambulatory Emergency Care Unit (AECU)
	• Acute Medical Unit (AMU)
	• CUCA – Out of Hours GP

Acute Specialist Medicine: Endoscopy, Gastroenterology, Diabetes & Renal Medicine	• Inpatient & Outpatient Services • Purley wards • Specialist Nurses
Acute Specialist Medicine: Cardiac & Respiratory Medicine	• Inpatient & Outpatient Services • Cardiac Cath Lab • Coronary Care Unit • Duppas wards • Specialist Nurses
Community & Therapies, Rheumatology & Musculoskeletal Services	• District Nursing • CICs • Community Matrons • Community Cardiac Nurse Specialists • CITMS • BHF Heart Failure • Health Visiting for the Elderly • Long Term Conditions
Learning Disability Team	• Learning Disability
Elderly Care, Neurology & Stroke	• Inpatient & Outpatient Services • Heathfield 1 • Wandle Wards • Specialist Nurses
Adult Therapy Services	• Podiatry • Dietetics • Community Pulmonary Rehabilitation Service • Adult Speech & Language Therapy (SALT)
Rehabilitative & Independent Living Services	• A&E Liaison Team • Community Neuro-rehabilitation • Neuro-psychology Service • Rehab Consultant • Community Stroke Team

Latest CQC Inspections

Overall rating	Requires Improvement

The Care Quality Commission (CQC) is the independent regulator for health and social care services in England. The CQC's duty is to ensure that hospitals meet government standards of safe, effective, caring, responsive and well led care.

The Trust is required to register with the CQC and comply with their fundamental standards of quality care. Our current registration status is "registered without conditions" which means that CHS is not subject to any CQC enforcement actions.

The CQC monitors the fundamental standards of care through inspections, patient feedback and other external sources of information. They inspect Trusts at a core service level and publish reports giving each service a rating which is then amalgamated into a Trust wide rating. The Trust was inspected by the CQC in June 2015 and a report was published on 7th October 2015 stating the Trust was given an overall rating of "Requires Improvement".

In October/November 2017 the CQC re-inspected the following core services: surgery, critical care, end of life care and outpatients. Of these, all but critical care improved to a rating of "Good". Critical care remained as "Requires improvement".
The CQC also looked for the first time at mental health provision in an acute setting and carried out a separate in-depth review of the well led domain in conjunction with NHS Improvement.

2018 inspection of community services

In 2018 the CQC inspected our community services (adult and children & young people) along with the medical care core service. Of the Trust's nine acute core services, seven are now rated as 'Good'. The Trust has retained a "Good" rating for the Caring domain, with the remaining domains of Safe, Effective, Responsive and Well Led given the rating of "Requires Improvement".

Following this inspection the Trust was given nine 'must do' actions to complete, with a further ten 'should do' recommendations. A comprehensive action plan has been drawn up to address these areas of improvement and is being monitored and reported on by the Trust's Quality Improvement Programme (QIP).

The CQC inspection schedule to date

Core service	2015 All core services inspected	2017 Surgery, Critical Care, End of Life Care & Outpatients	2018 Community Adults, Children & Young People and Medical Care
Urgent & emergency services	Good	Good	Good
Medical care	RI	RI	RI
Surgery	RI	Good	Good
Critical care	RI	RI	RI
Maternity	Good	Good	Good
Gynae	Good	Good	Good
Services for CYP	Good	Good	Good
End of life care	RI	Good	Good
OPD & diagnostics	RI	Good	Good
Community adults	RI	RI	RI
Community CYP	RI	RI	RI
Overall	**RI**	**RI**	**RI**

The current CQC ratings for all core services

Core service	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & emergency services	RI	Good	Good	Good	Good	**Good**
Medical care	RI	Good	Good	RI	RI	**RI**
Surgery	RI	Good	Good	Good	Good	**Good**
Critical care	RI	RI	RI	RI	Inadequate	**RI**
Maternity	RI	Good	Good	Good	Good	**Good**
Gynae	RI	Good	Good	Good	Good	**Good**
Services for CYP	RI	Good	Good	Good	Good	**Good**
End of life care	Good	RI	Good	Good	Good	**Good**
OPD & diagnostics	Good	n/a	Good	Good	RI	**Good**
Community adults	RI	Good	Good	RI	RI	**RI**
Community CYP	RI	RI	Good	RI	RI	**RI**
Overall	RI	RI	**Good**	RI	**RI**	RI

The Trust continues to work towards achieving a "Good" or "Outstanding" rating throughout the CQC inspection process to build on our previous achievements.

Reablement service rated good by CQC

In August the CQC inspected Croydon's reablement services, including one of our new services run in partnership in the borough. Publishing the results on 5 October, CQC inspectors rated the Croydon community reablement service as "good" for all aspects of the service, including its safety, responsiveness and how well it was led.

The service is part of LIFE (Living Independently For Everyone) service. This was created by the One Croydon alliance in 2017, bringing together teams from health and social care as well as the voluntary sector. It provides coordinated short-term support to people and enable them to retain or regain their independence and continue living in their own home. It was set up to look after mainly over-65s with long-term conditions by tailoring their care to reduce the need for hospital stays.

CQC maternity survey

The CQC 2018 National Maternity Survey revealed that CHS is the highest of any London Trust in treating new mums with dignity and respect during their labour and birth of their babies. The Trust received a score of 9.7 out of 10, fourth highest in the country and a significant increase in the number of new mums responding positively compared to the 2017 survey.

CHS also came fourth nationally when allowing women to choose a location for their antenatal appointments and scored higher than many other Trusts in advising mothers of the need for a personal postnatal check-up 6-8 weeks after their child's birth.

Compared to the 2017 results the maternity team also improved in the following areas:

- Encouraging skin to skin contact after birth (9.6 out of 10 compared to 8.7 in 2017)
- Involving women in decisions around care during labour and birth (9.0 out of 10 compared to 8.1 in 2017)

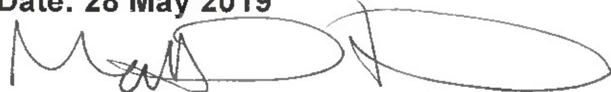
Overall, when compared to other Trusts, we were rated "about average" on most questions asked. However there were areas identified "worse than other Trusts". These include:

- Expectant mothers not being given enough time to ask questions and discuss their pregnancy at their antenatal appointments.
- Receiving the help needed when contacting a midwife during their care at home after the birth.
- Getting help from a member of staff within a reasonable time while in hospital.

Adjustments have been made to make improvements in those areas.

Performance report

Matthew Kershaw, Interim Chief Executive
Date: 28 May 2019



Overview

Partnering for better care

Since joining the Trust in October 2018, I have continually been impressed by the levels of kindness, expertise and professionalism at CHS.

Our ongoing work with One Croydon and closer alignment with Croydon CGG now set the stage for even better integrated care. We can face tomorrow's healthcare challenges with a deeper collaborative approach that other boroughs may seek to replicate.

Over the past year examples of our success also include:

- Seven out of the nine core services inspected at CUH are now rated as "good".
- The launch of our new Emergency Department.
- We have consistently performed within the capital's top trusts for short waiting times to diagnose and treat patients with cancer.
- Throughout the year, the Trust was also better than the national average for our consultants seeing patients with 18 weeks.
- No other acute Trust in England matches our percentage increase in participation in clinical trials.

Staff survey

The annual national NHS Staff Survey results were published in March. They are the most complete picture of the opinions and concerns of NHS staff throughout the country.

This year it revealed progress across England in areas including developing and training staff, while also reflecting the additional pressure caused by growing demand on NHS and other services. This is also reflected in the findings for Croydon.

Our Trust did 'significantly better' than the national average in two areas, which were identifying training needs and providing the right development. This is a big step forward and reflects our emphasis on finding the right opportunities for staff at our Trust. However our staff gave lower scores regarding career progression, highlighting that more work is needed to help staff with their development needs.

We equalled the national average on the vital question about being 'able to give the care I aspire to'. It was a good score although 2% lower than our strong result last the previous year.

It is very encouraging to see that more of our staff look forward to coming into work than the national average – 61% compared to 58% across all NHS Trusts. This is an improvement on last year too.

The number of staff that said the Trust had made adequate adjustments to help them carry out their work rose by 4% compared to last year. Similarly, fewer staff said they had experienced discrimination at work – something that we are working hard to remove entirely.

We have prided ourselves on having a strong safety culture at our Trust. A total of 94% of our staff said they know how to report unsafe clinical practice.

Our overall score for our Trust's 'safety culture' was also below the national average. In particular only two-thirds of our staff feel confident to raise concerns about unsafe clinical practice and only half feel confident that doing so would be acted upon. A fundamental part of our duty of care is that staff must be fully supported when they raise concerns about anything safety-related. Our Guardian of Safe Working (for junior doctors) and Local Freedom To Speak Up Guardians are available for staff to raise any concerns about care and we are reiterating our guarantees to staff that they can raise any concerns about care without fear of recrimination.

Out of 90 questions, we scored 'significantly worse' than other trusts in 31 and 'significantly better' in two. This means we ranked 15th out of the 16 Combined Acute Community Trusts.

As a result we have begun a new and engaging campaign with our 3,800 staff to ensure they are listened-to, informed, reassured and supported. It includes a strong emphasis on finding solutions to issues raised by the NHS Staff Survey, which include:

- 56% of staff said they would recommend our care to a friend or relative. This is 1% more than last year but still lower than the 69% national average.
- 76% of staff were satisfied with support from colleagues – almost 6% below the national average and 2% below last year.
- 21% of staff felt their health and wellbeing is supported, which is lower than the 27% national average and lower than our 32% score last year.
- Several indicators suggest staff sometimes experience discrimination from colleagues, from the public or even in their career progression.

All of these areas are very important to us. Behaviours like discrimination are not acceptable and will receive rigorous appropriate intervention. Other issues such as workplace pressure have an NHS-wide aspect, yet can still be improved locally – and we will work hard to do so.

The NHS Staff Survey was undertaken before our new Emergency Department was opened, which is now giving many staff an excellently equipped and 30% more spacious environment to work in.

Staff and public engagement

In direct response to the opportunities highlighted in NHS Staff Survey, we have refreshed our internal engagement strategy. Expanding on the work of our Listening into Action programme (which ended in 2018), staff now have even more opportunities to shape the workplace and share ideas.

A series of new engagement events has begun, attracting both staff and public, and a special mobile device App is under development. There will also be more local awards for staff so that excellence is recognised and shared, including a Croydon Star of the Month.

Public engagement is being increased and we ended the year with a detailed workshop evening, in which dozens of local community members explored how we can fulfil their expectations for future care – and how they can become more involved.

Volunteers

The Trust currently has 420 active volunteers who give their time to help in both the hospital and community. Volunteers carry out many valuable roles throughout the Trust and are highly valued. Some of the many roles they carry out include ward helpers, patient feeders, administrators, 'welcomers' to the Trust and support for the Chaplaincy team.

The Volunteer team run various volunteer initiatives to support patients:

- 'Lunch Club', which is an innovative programme enabling patients recovering from long-term conditions to eat lunch in CUH's Oasis Restaurant as part of their rehabilitation.
- Activity arts and crafts clubs in both the elderly care and stroke wards.
- Poetry club for the elderly.
- Knitting clubs that provide sensory items for the elderly and baby items for the Special Care baby Unit (SCBU).
- Volunteers who visit patients to direct them to smoking cessation services.
- Volunteers who call patients to help them attend appointments.
- Stroke exercise group on Saturdays.
- Assistance with feeding patients.
- Volunteers in the community.

We also have over 70 volunteer peer supporters helping in the Baby Cafes across the borough, supporting new mums with breast feeding.

PLACE assessments

In April 2018 CHS was rated top in South West London for the condition, appearance and maintenance of its buildings and second for cleanliness.

Every NHS patient should be cared for with compassion and dignity in a clean and safe environment. Patient Led Assessment in the Care Environment (PLACE) assessments provide a framework to review how the environment supports patient privacy and dignity, quality of food provided, cleanliness and general building maintenance. The inspectors are a mix of Trust members, external inspectors and patient representatives. The group is at liberty to visit any ward or department in which patient care is provided. The assessments take place every year and the results are reported publicly.

The annual PLACE audit looks at cleanliness, food, privacy, dignity, general building maintenance and how well the hospital environment is able to support the care of those with dementia or disabilities.

In 2018 assessments, published by NHS Digital on 16 August 2018, CHS achieved a score of 98.83% for cleanliness and 94.83% for the condition, appearance and maintenance of its buildings – the highest scores among South West London acute hospitals.

Against the measure of how well the Trust meets the needs of people with dementia, CHS scored 85.15% which was the highest in the South West London region. The Trust also scored an impressive 94.83% for how well equipped it is to meet the needs of people with a disability, which was the highest score amongst London's 18 acute hospital trusts.

The assessments also showed areas where the Trust can improve further. On food, the Trust achieved 89.85% which was just below the national average of 90.2%. On privacy, dignity and wellbeing, CHS was rated 80.44% which was below the average for England of 84.2%.

With a lot of older buildings within the Trust it was an excellent result to have achieved the best scores in South West London for how well we maintain our estate and for the cleanliness of our hospital environment.

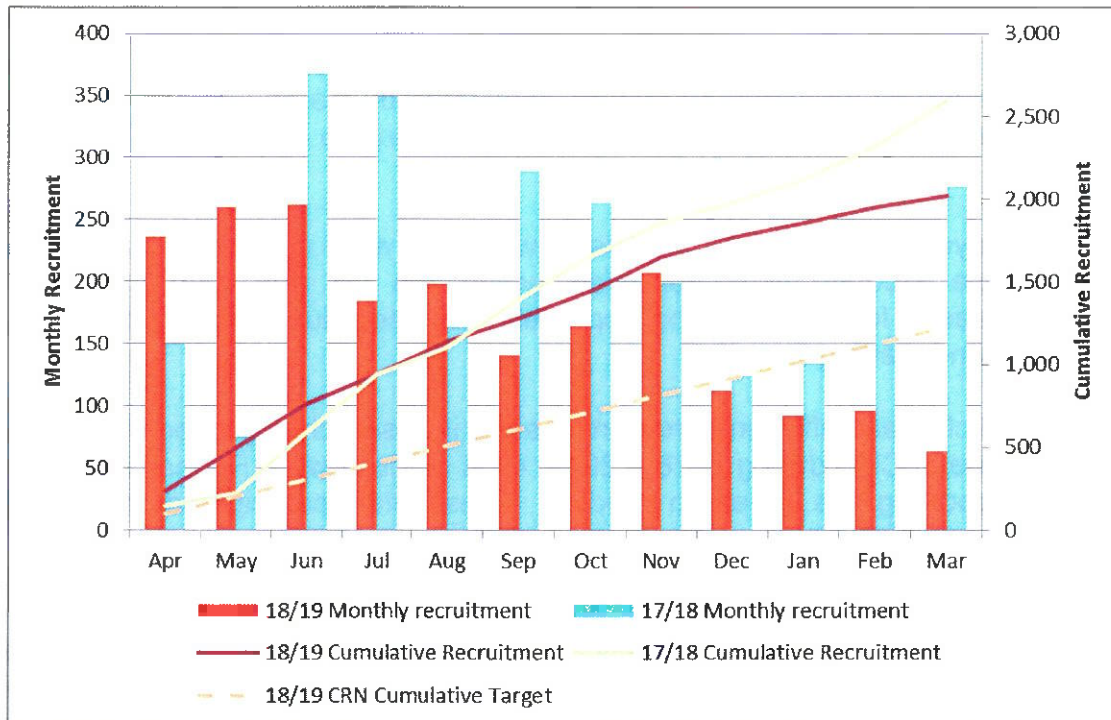
There is always room for improvement and so we will look closely at how we can enhance our scores on food, privacy, dignity and wellbeing in next year's assessments. The new Emergency Department, which opened after the PLACE review, has many significant improvements in the privacy and dignity it offers patients.

Research

In order to improve patient outcomes and transform health services, research has to be at its core. The organisation will greatly benefit from the outcomes of research when compared to organisations that do not, leading to better quality care and improved use of resources. 'Clinical research' refers to studies that have received a favourable opinion from a Research Ethics Committee.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment availabilities, and active participation in research can lead to successful patient outcomes.

All patients receiving NHS services provided or sub-contracted by CHS in Apr 2018 – Mar 2019 may be approached for research. Of those eligible, 2,015 patients were recruited to participate in research ethics committee approved studies. This figure is based on the Clinical Research Network (CRN) registered file. Compared to last financial year, this is a fall in recruitment of 22%. This drop in recruitment is in large part due to closure of one study that recruited a large number of patients during the 2017/18 year.



A comparison of recruitment over the 2018/19 financial year against that of 2017/18

The Trust continued to recruit over 2,000 patients into our research trials this financial year, following the last. This was due in part to several studies that were open at Croydon.

The first study is the NICE FIT trial, which examines for the presence of blood in patient stool samples and comparing these results to colonoscopy results. This is with the view of having a non-invasive test for cancer. The study recruited 705 patients over the 2018/19 year. With Croydon acting as the sponsor for this study we oversaw 12,522 patients recruited into the study from over 50 trusts across the UK. The study finished in March 2019, but there are 2 sub-studies that have extended their recruitment till December 2019.

This second study was the OPTIMAL study that closed in June 2018. The study investigated a computer system working with discharge advocates following up patients after discharge. It aimed to streamline their discharge process and reduce readmission into hospital before the 30 day window. The study could have the potential to save the Trust money by reducing penalties incurred when patients are readmitted within 30 days, as well as improving quality of patient care. From the preliminary analysis, the project only achieved a 2-3% reduction to readmissions, not the 5% that was aimed for. This lower than expected reduction could be due to a fall in the number readmissions compared to the previous year, the Trust also introduced a scheme with the aim to reduce the readmissions, this worked in parallel

to the study. There were aims to create a further study that would have expanded it to further trusts across the UK. However, due to the competitive environment, the grants submitted did not score high enough to get the funding.

The Obstetrics Department also contributed to the high recruitment number, through all the trials combined, this financial year they recruited 433 patients from 11 studies. This is testament to how close the research team works with clinicians to deliver recruitment to time and target.

In 2018-2019, 55 clinical research studies were being conducted in the Trust; 51 of which were funded by the CRN. 12 studies concluded by March 2019 of which 83% were completed as designed within the agreed time and to the agreed recruitment target.

In 2018-19 Croydon approved 14 studies of which 12 were supported by the CRN. 40% of eligible studies were approved within the 30 day time frame. The predominant reason for delays to the approvals has been due to contracting issues with sponsors and staffing issues.

There were 86 clinical staff members participating in research approved by research ethics committee at CHS during 2018 – 2019. 41% of these were Research Passport Personnel supporting the research studies. These staff participated in research covering 20 specialities.

An EU funded project called AEGLE completed its fourth year and finished in November 2018. This is a big data analytics programme that analysed anonymised patient data to try to improve the treatment of diabetes. We have diabetes data from Croydon and Epsom and St Helier, plus data from Northern Ireland. Analysis and testing of the software was carried out to visualise the data and create predictive models. From the models, we were able to make predictions on potential outcomes for patients suffering from diabetes.

In the last three years, 30 publications have resulted from our involvement in Research. Of these 30 publications 19 were directly from NIHR studies.

National Clinical Audits and National Confidential Enquiries

Participation in national clinical audits and National Confidential Enquiries enables us to benchmark the quality of the services that we provide against other NHS Trusts, and hence highlight best practice in providing high quality patient care and drive continuous improvement across our services. The Clinical Audit priorities are selected on the basis of national requirements, commissioning requirements and local evidence that has emerged from themes from incidents or complaints.

During 2018-19, the Trust participated in 60 national clinical audits and 3 National Confidential Enquiries. Out of the 60 national audits, 55 were in the NHS England Quality Account listed audits that the Trust was eligible to participate in, so representing 100% participation. Further details are outlined in the Quality Report.

Service and quality accreditations

The Trust has achieved or is working towards external accreditations and hosts external peer reviews. Some of those completed this year include:

- BSGE Endometriosis Centre for 2019 (British Society of Gynaecological Endoscopy) accreditation.
- British Society of Urogynaecology (5 year accreditation from May 2017).
- Sterile services department 93/42/EEC on medical devices and ISO 13485: 2016.
- JAG accreditation (valid until May 2021).
- Human Tissue Authority (HTA) in September 2018.
- ICNARC peer review of Critical Care.

Health and Safety

During 2018/19 there were no health and safety incidents that were investigated by the Health and Safety Executive.

Quality Improvement Programme (QIP)

Our priorities for 2019/20 were developed in discussion with our Clinical Directorates, Patient Safety and Mortality Committee, and our Quality Committee. We held a public survey on our priorities which was open to staff, patients, stakeholders and members of the public, along with our Commissioners, Croydon CCG (Croydon Clinical Commissioning Group), and Healthwatch.

We have kept those priorities from 2018/19 which remain key, or where we consider further improvement is required, for example creating a safety culture and listening to our patients. This will allow us to continue to make sustained improvement and build on the good work that we have achieved in the previous year.

Our quality priorities will form our local CQUINS (Commissioning for Quality and Innovation) and will be monitored and progressed via the Trust's Quality Improvement Programme (QIP) chaired by the Joint Chief Nurse.

In 2018 the CQC inspected our community services (adult and children & young people) along with the medical care core service. Of the Trust's nine acute core services, seven are now rated as 'Good'.

Following that inspection the Trust was given nine 'must do' actions to complete, with a further ten 'should do' recommendations. A comprehensive action plan has been drawn up to address these areas of improvement and is being monitored and reported on by the Trust's QIP.

C. difficile target

Our Infection Control Team met the national C. difficile target for the third year running - a testament to the diligence and engagement of our Infection Control Team.

CHS observed a reduction in the number of hospital onset infections (HOI) this year.

Total number of HOI C. difficile cases for the time period 1st April 2018 to 31st March 2019 is 13 against the Department of Health annual trajectory of ≤ 15.

There were several driving forces employed in achieving this target, including:

- Antimicrobial prescribing which stipulates that when, prescribing Tazocin, Co-amoxiclav, Carbapenems (e.g. Meropenem), staff should ensure shortest course possible is prescribed to reduce the risk of C. difficile.
- Introduction of a diarrhoea poster which stipulates when to send stool specimen for C. difficile testing.
- RCA meetings on new C. difficile cases within 24hrs of the lab result.
- Weekly Infection Control Team C.difficile case review meetings and follow up all inpatients with C.difficile infections/carrier.
- Enhanced Surveillance on wards with a period of increased incidence of C. difficile infection.
- Increased joint antibiotic ward rounds by the Consultant Microbiologist and Antimicrobial Pharmacist.
- Daily Intensive Treatment Unit ward rounds.
- Antibiotic guidelines have been updated in 2018 and submitted to the Medicine Management Committee for approval.

Antibiotic stewardship activities, which include antibiotic prescribing audits and targeted antibiotic ward rounds, are also in place to reduce usage of the high risk agents i.e. cephalosporins, co-amoxiclav and quinolones.

MRSA target

Total number of Hospital onset MRSA bacteraemia cases for the time period (April 2018 – March 2019) is one, against the DoH annual trajectory of zero.

To continue assurance of local effective prevention and control of MRSA and reduce MRSA transmission, the Trust MRSA guidelines advise the following:

- Routine MRSA screening for all adult emergency admissions as well as pre-operative MRSA screening for all elective and emergency surgical patients.
- All patients found to be MRSA positive should be started on anti-MRSA topical treatment.
- If patients are found to be MRSA positive, the presence of MRSA should be stated in the discharge summary.
- Those patients who are MRSA negative at admission but are considered at high risk for MRSA acquisition (i.e. all patients on ITU/HDU, SCBU, vascular wards, elderly care wards and those with indwelling devices or wounds (e.g. chronic ulcers, pressure sores, and surgical wounds) should be screened weekly for MRSA.
- There is also ongoing training of staff in relation to intravascular device management.
- Close surveillance of IV line care through weekly multi-disciplinary IV ward rounds was also implemented in 2018. An IV line Task and Finish group was set up in 2018 by the DIPC to further address this issue and implement an action plan to improve IV line care.

This includes training of staff on IV line care and documentation, improving education and training of HCAs inserting IV lines in ED, devising a wall poster on IV line care for clinical areas and re-introducing IV line training for junior doctors.

Influenza

The Trust treated a total of 853 laboratory confirmed influenza cases during the winter season beginning early December 2018 up to end of March 2019. This is a much higher number of cases compared to 2017/18 winter season with 454 lab confirmed influenza cases. The commonest circulating seasonal strain locally was Influenza A. Some of the isolates were typed and were showing to be Influenza A (H1N1) strain which is in keeping with the national picture. A few infections were due to Influenza B.

The rapid influenza/RSV test was implemented locally at CUH site on 19th December 2018. The test is carried out in CUH pathology reception with results available within two hours of sample collection. This has enabled early isolation of patients confirmed with flu and/or rapid discharge from the Emergency Department (ED) with a confirmed diagnosis.

Unlike last season, there have been a large number of young to middle aged adults in the non-high risk groups presenting to ED with severe flu symptoms during this winter season (365 cases in the age group 14 – 50yrs). Persistent fever, chest pain, palpitations, blackouts, vomiting and severe headache have been the symptoms that led to these patients presenting to ED or being referred by GPs to ED.

There were more hospital acquired infections than previous season. There were 43 hospital acquired infections. Secondary cases were also diagnosed in some instances where the index case was in a bay. In these situations the affected bay has to be restricted to only admit low risk patients. On occasions where it was not possible to move the index case straight away to a single room, the bay has had to be fully closed to admissions. The influx of flu cases has caused significant bed pressure. A few patients needed ITU/HDU care.

The Staff uptake for the influenza vaccine was 72%. There were a few confirmed influenza infections amongst staff, but this may not reflect the true numbers. Samples for lab confirmation of Influenza diagnosis are not routinely performed on staff members with flu symptoms.

Norovirus

There were 17 lab confirmed Norovirus diagnoses at CUH April 2018 – March 2019. This was due to 2 small unrelated outbreaks of Norovirus; one outbreak on a general medical ward and the second outbreak on a Care of the Elderly ward which predominantly manages stroke patients. The outbreaks were well managed and contained within the affected area. Both outbreaks were resolved within a week of onset.

GRE (Glycopeptide Resistant Enterococci)

Routine pre-admission and weekly screening of ITU/HDU patients has been in place for some years. Routine screening of this group of patients has enabled ITU/HDU to provide timely single room nursing or implement enhanced infection control precautions on the main ward.

There has been continuing low levels (0 – 2 per month) of ITU/HDU associated GRE colonisation diagnosed on the unit. There were no GRE blood stream infections since April 2018.

The Infection Control Team has worked closely with ITU/HDU staff to identify risk factors for GRE acquisition. Nursing practices, environmental cleaning standards and antibiotic prescribing are kept under review. Changes have been implemented to improve storage facilities and bed spaces to facilitate easy cleaning of the environment.

Gram Negative Bacteraemias

From April 2018 a government initiative extended the surveillance of bacteraemias caused by Gram-negative organisms to include Klebsiella species and Pseudomonas aeruginosa in addition to the existing E.coli data collation. This was with the intention of reducing gram negative bacteraemias by 50% by the financial year 2021. More detailed information has also been requested on the E. coli bacteraemias.

DoH Mandatory reporting of includes Klebsiella and Pseudomonas bacteraemias has been implemented by the Trust 1/4/17.

Achieving the 50% reduction by 2020/21 requires close working with the community based healthcare providers, care homes and GPs as majority of these bacteraemias are community onset/associated infections. Urinary tract infection is the predominant cause for these bacteraemias.

An internal quality improvement target has been set for 2018/19 aiming for <27 HOI E.coli bacteraemias.

The total number of HOI E.coli bacteraemias for 2018/19 up to date is 26 and the Trust has successfully achieved the set target.

The Infection Control Doctor (ICD) had been designated as the Trust lead for co-ordinating actions to achieve Gram negative Bacteraemia Target. An ADN has been designated to lead on catheter care.

The ICD has convened multidisciplinary meetings at the Trust and also attended meetings at the CCG to formulate action plans. The group are initially focusing on urinary catheter care as many of the bacteraemias are due to catheter associated urosepsis. A catheter care pathway protocol has also been produced and awaiting ratification by the Trust.

Urinary catheter care has been reviewed and arrangements are being implemented for more extensive education and audits in order to monitor practice, as well as improve catheter care.

A more enhanced catheter care audit tool has been in place since 2017. The audit tool has been implemented on all adult wards excluding maternity. This is a monthly audit carried out by the clinical area staff and information is recorded online on "RATE". The infection control nurses are also conducting independent monthly ad hoc catheter audits. The audit results have been reviewed to guide actions required to improve catheter care.

Mortality

The Trust has a robust process of retrospective case review of in-hospital deaths. The results of the reviews are securely recorded within the Datix Incident Module. The Mortality Review Group provides assurance to the Patient Safety & Mortality Committee that hospital deaths are subject to a mortality review by the development of a culture and practice of standard clinical audit of mortality.

According to the most recent Dr Foster report in Apr 19 for the rolling period Jan 18 to Dec 18:

- HSMR is 91.1 and is lower than expected.
- SMR is 92.7 and is lower than expected.
- There are no CUSUM alerts for the latest three month reporting period and there are no diagnosis groups within the HSMR bracket that are statistically significant.
- Two of the patient safety indicators relating to Mortality are within expected range - Death in low risk diagnosis groups- 61.4 and Deaths after surgery – 125.4.

Patient Safety Incidents

The Trust is committed to reporting of all incidents to support the processes of learning and improving care. There is particularly a strong commitment to increase reporting of incident from the community and in timely manner. Thus, CHS has taken a bold step to replace the Trust's web-based incident reporting system (Datix) with the Datix Cloud IQ which allows incident to be reported from anywhere including from mobile phone. Datix Cloud IQ project management process is underway for the full implementation of the Datix cloud IQ. The current web-based incident reporting system (Datix) continues to support intelligent incident, risk, mortality review and complaint data capturing, interrogation, analysis and investigation for quality patient care outcome.

The Trust's Datix system is electronically linked to the National Reporting and Learning System (NRLS), and patient safety incidents are uploaded to this central reporting and analysis centre. The Trust continued with the uploading of incidents to the central reporting and analysis centre. The use of Datix for mortality review has enabled better learning from deaths. Incident reported increased from 21613 in 2017/2018 to 29792 (27482 clinical incidents and 2,310 non-clinical incidents) in this year.

About 90% of the incidents resulted in no harm. Moderate harm continued to decrease year on year from 2.4% to 1.86%. Incidents with harm level above level 3 (moderate) constituted 0.3% of the total incidents for the year. In the year, a total 75 serious incidents were declared for investigation following review of the incidents and

in accordance with NHS serious incident framework in the year. The number represents a reduction compared to the number of incidents declared in in the previous year. The incidents were mainly related diagnosis problems, causes for concern about suboptimal care, security and violence and patient access/admission/ appointment issues. All the incidents were reviewed and 45 are still under investigation and 11 have been fully investigated and deescalated. The Trust continues emphasising learning from incident and closing the loop with auditing the effectiveness of the learning from the incidents.

All serious incidents are investigated by a panel comprising of multidisciplinary senior colleagues using the RCA methodology. Incident final reports are also subject to an internal quality assurance programme, with sign off by either the Medical Director or the Director of Nursing, Midwifery and Allied Health Professionals. This is prior to them being sent to the Clinical Commissioning Group for external scrutiny of the report and of the appropriateness of the actions before final closure of the Serious Incident.

There were no never events in the year. The Trust has a dedicated team working with the theatre staff in implementing scheduled WHO checklist audits to prevent a never event. The process has empowered all staff in theatres to speak up and ensure that WHO checklist process is properly carried out. Consequently two potential never events were avoided because of the WHO checklist practices.

Patient Experience and the Friends and Family Test (FFT)

Patient experience feedback has been a consistent challenge within the emergency department with response rates for the Friends and Family test often falling below the required 10% of patients using the emergency department.

In September 2018 the Trust commenced using a text message based test for Friends and Family. The response rate improved significantly from a mean of 9.2% to a mean of 22.8%. This is important as the confidence in the validity of the comments improves with the volume of responses.

As a consequence of the increase in response rate and in combination with the increase in waiting times over the winter period the proportion of responders willing to recommend our emergency department to friends and family has fallen. This is an important metric to monitor as part of our improvement work to improve the speed of care provided to patients throughout the emergency pathway.

The Trust continues to advertise the availability of the Friends & Family Test in patient facing areas and importantly, continues to offer a paper option to ensure that all patients/carers have the opportunity to provide their feedback.

Patient Advice and Liaison Service (PALS) and Complaints

The Patient Advice and Liaison Service (PALS) provides impartial advice and assistance in answering questions and resolving concerns that patients, their relatives, friends and carers might have. The Trust encourages concerns to be raised at ward and department level but in line with CQC best practice the Trust

widely advertises the PALS office through its web page, literature and public facing posters.

It is expected that each PALS contact has the potential to resolve the specific concern, preventing escalation to a formal complaint.

During 2018/19 the PALS team received 2714 cases. Of these 2439 (90%) were resolved and closed within 2 working days.

The PALS team is located and visible at the front entrance to CUH. The PALS team are visible in wards and departments as they try to resolve concerns and they use robust procedures to ensure that cases are resolved either at the time or within two working days.

Over the past year the profile of PALS has been raised and concerns are resolved much earlier. The PALS team is supported by volunteers who help to put the public at ease when they visit the department.

Complaints

During 2018/19 the complaints team received 622 formal complaints compared to 585 received during 2017/18.

The Trust has standards for acknowledging complaints (100% within 3 working days) and also that a final response is produced within the agreed timescale (target of 80%). The Trust is committed to achieving these targets and ensuring that all of our complainants receive an acknowledgement and a detailed response to their complaint within the timescale. The Trust achieved 95% compliance for acknowledging a complaint within 3 working days and 72% compliance in the provision of a final response.

In order to support the compliance with these standards the Trust introduced a new Quality, Experience and Safety team in March 2019.

Learning from complaints

During the year the Trust has reviewed the ways in which learning from complaints, incidents or PHSO outcomes can be shared across the organisation. There are systems in place to highlight key changes to practice or process via the following methods:

- The '3 Key Messages' initiative
- Patient Stories
- Clinical Governance meetings
- Croydon Cares initiative – front line nursing staff sharing learning from incidents and complaints
- Directorate Quality Boards
- Shift briefs
- Professional Forums

Each year the Trust welcomes our local PHSO Liaison Manager to provide a training event for key complaint handlers from within the Complaints Team and the directorates. In February 2019 the training focussed on:

- Getting it right first time
- Carrying out good local investigations
- Ensuring feedback and complaints are a part of every team meeting when discussing 'how are we doing'
- Learning from complaints

Duty of Candour

CHS has a Duty of Candour responsibility to patients and their families when an aspect the patient care processes results in moderate or severe harm under the CQC regulation 20. This involves healthcare professionals being open to service users, their next of kin, carers and advocates, when something goes wrong with their treatment or care causing moderate or severe harm. This ensures that we are open and honest about care and treatment and provides the opportunity for continuous improvement.

Duty of Candour process involves health professionals:

- Having a full conversation with patient or next of kin and giving true account of what has happened and answering any questions.
- Giving an apology and offer of appropriate support.
- Advising on investigation being conducted.
- Sharing the findings and learning.

CHS continued to demonstrate commitment to the Duty of Candour principles through the process established in the Trust. The Trust has a dedicated Senior Quality Facilitator within the Quality Experience and Safety (QES) team with specific responsibility of Duty of Candour and works with the directorates to ensure that duty of candour is completed in a timely manner.

The QES team reviews every reported incident that is graded moderate harm and above on either the day that the incident is reported, or the next working day and works with the responsible directorate or staff to confirm the assigned harm level. The QES team works with the relevant clinical staff to ensure the patient or family is told about the incident, and that an appropriate apology with a letter is given within 10 days of the incident being. CHS continues to offer the hospital's chaplaincy service in ensuring support is available to patients, next of kin and carers in situations where Duty of Candour is required. To ensure that staff have the requisite knowledge and confidence to perform duty of candour effectively and timely manner regular group and individual training sessions are delivered by the QES team.

The existing duty of Candour process within the QES team has an audit embedded in it to monitor complete compliance to the process. In addition, there is a yearly Duty of Candour audit to provide an assurance of the compliance of the CHS process to the CQC regulation 20. The executives monitor the Duty of Candour process through weekly reports from the QES team to Executive Review Group. There is also regular report on the duty of candour as part of the Integrated Quality and Performance Report (IQPR).

Croydon Stars

At our Annual Croydon Stars Awards, which took place in April last year, the Trust thanked members of staff and volunteers who went the extra mile. The awards categories included outstanding leadership, achievement, teamwork, and volunteering.

Counter Fraud

The Trust's Local Counter Fraud Services are provided by London Audit Consortium, of which Croydon Health Services NHS Trust is a core member.

The Trust's Anti-fraud, Bribery and Corruption Policy and Procedures sets out individual and collective roles and responsibilities, as well as details on how staff can report fraud, bribery and corruption and contains key contact information. The policy is fully up to date, having last been reviewed and issued in December 2018, and is available to all staff via the main Trust Intranet site, as well as on the dedicated Counter Fraud Intranet page.

The Trust's Local Counter Fraud Specialist (LCFS) is responsible for delivering a proactive annual work programme, the purpose of which is to minimise the risk of fraud, bribery and corruption within the organisation by raising levels of fraud awareness. This plan is fully compliant with the NHS Counter Fraud Authority's Counter Fraud Standards for Providers. Preventative measures include reviewing Trust polices to ensure they are fraud-proof by utilising intelligence, best practice and guidance from the NHS Counter Fraud Authority. Detection exercises are undertaken where a known area is at high risk of fraud and the National Fraud Initiative (NFI) data matching exercise is conducted bi-annually.

Fraud, bribery and corruption is also deterred by publicising proven cases of NHS fraud and staff are encouraged through the use of intranet briefings, presentations and fraud awareness literature to report suspicions of fraudulent activity. There is regular ongoing liaison between the LCFS and the Trust's Internal Audit team to discuss fraud risks identified by audit reviews. A Counter Fraud progress report is presented to each meeting of the Audit Committee, which also receives an annual report from the LCFS.

The LCFS has developed a Trust-wide fraud risk assessment in accordance with the NHS Standards for Providers based on local intelligence of reported fraud cases and statistical data provided by the NHS Counter Fraud Authority. This exercise sought to quantify the nature and extent of fraud risks within key Trust functions. The LCFS consulted with the relevant departments to establish how each potential fraud risk is monitored, so that appropriate measures, including additional or enhanced control mechanisms, could be taken to reduce them. This document has been considered by the Executive team and will be incorporated into the Trust's Risk Strategy.

Investigations into alleged or suspected instances of fraud, bribery and corruption are conducted in accordance with relevant legislation and are undertaken by an accredited LCFS in a professional, objective and fair manner. Referrals can be received from a number of sources, including anonymous calls from concerned

members of staff and the public. The resulting investigation report is provided to the Director of Finance, who is responsible for determining whether the matter should be considered for criminal prosecution.

Performance analysis

CHS Integrated Performance Overview

CHS provides integrated NHS services for the borough's growing population of more than 380,000, caring for adults and children at home, in schools and health clinics across the borough as well as at CUH and Purley War Memorial Hospital.

The Trust provides more than 100 specialist services and is home to the borough's only Emergency Department, which is supported by three GP Hubs that can provide urgent care for minor conditions. It has 24/7 maternity services, including a labour ward, midwifery-led birth centre and the Crocus home birthing team. Purley War Memorial Hospital (PWMH) in the south of the borough offers outpatient care, including diagnostic services, physiotherapy and ophthalmology services run by Moorfields Eye Hospital, alongside an onsite GP surgery.

Some key figures

92.75% RTT Waiting Times for Incomplete Pathways	27,991 Emergency Admissions	392,989 Planned Care Outpatient Appointments	34,810 Ambulance Arrivals	82,522 GP Hub Emergency Attendances
69% PDR Compliance (Census Point)	0 Never Events Reported	85.25% A&E 4 Hour Total Time In Department (All Types)	13 Cases of C. Difficile Reported	17,203 ED Breaches Reported
169,466 Beds Opened	25,992 Planned Care Day Cases	6 12 Hour Trolley Waits Reported	210 Subject Access Requests Made	90 Serious Incidents Reported
3.59% Delayed Transfers Of Care	434 60 Minute Ambulance Breaches	1 Hospital Acquired/Onset of MRSA Reported	131,933 Main A&E and UTC Emergency Attendances	168,350 Occupied Bed Days (General & Acute)

Referral to Treatment Waiting Times

The Trust has successfully delivered against the incomplete performance target for RTT during 2018/19. Performance has continued to improve on an upward trend since April 2018 ending the year on 92.22%. The Trust's performance has consistently been positioned around 11th out of the 24 London Trusts since November 2018. This continued improvement is representative of the significant work being delivered across the specialties to drive productivity and performance is expected to continue on this sustained and upward trend in 2019/20.

Type	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Open pathways	92.76%	92.9%	93.12%	93.19%	93.30%	93.01%	93.24%	93.31%	92.01%	92.02%	92.15%	92.22%

In 2018/19 there has been a strong focus on administrational and clinical education, root cause analysis, demand and capacity modelling and clinic and theatre utilisation. This has contributed to the reduction of long waiters and continued RTT compliance.

Long Waiters

The Trust has improved its approach to validating the Patient Transfer List (PTL) which has removed a large proportion of long waiting patients. There has been the opportunity for cross-speciality education through learning lessons from complex patient pathways and strengthening overall adherence to the access policy. Strategies are also being led to better manage waiting lists to ensure long waiters are flagged earlier and processes put in place to prioritise these patients. A live PTL has also been in use in since November 2018 which has greatly improved data quality in the system.

52+ week waiters

Zero 52+ week waiters have been reported in March 2019. The Trust has reported 36 breaches in total for 2018/19.

Specialty	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	TOTAL
Vascular										1	1		**2**
Gynaecology													**0**
ENT						1							**1**
Max Facs	2	2	2	4	2		2	4	5	2	1		**26**
Pain Management			1			1							**1**
Orthodontics						1							**2**
Dermatology				1					3				**4**
TOTAL	**2**	**2**	**3**	**5**	**2**	**3**	**2**	**4**	**8**	**3**	**2**	**0**	**36**

Cancer

It is recognised that detecting cancers early and beginning treatment swiftly is key to improving survival rates and clinical outcomes from cancer. Throughout the year, the Trust has worked with its clinical and operational workforce to optimise the clinical pathways for suspected cancers, ensuring that they are seen and treated quickly.

The Trust has consistently performed within the top Trusts in London during 18/19 and met the 62 day performance target 10 out of 12 months in 2018. This is exceptional performance by our teams, who have worked tirelessly to drive the Day 28 Faster Diagnosis Standard and 38 Day Inter Provider Trust targets in advance of the official go live dates.

We have consistently maintained a high position within SW London and have generally been within the top five performing Trusts in London for the Cancer Waiting Time targets. The Trust was one of the first in London to implement direct booking via eRS for the majority of its tumour sites with an exception of those pathways that go straight to test in 2018.

In the National Cancer Patient Survey, commissioned by NHS England, the Trust scored 8.6 out of 10 overall for care compared to the average for trusts across the country of 8.8. The survey also revealed that 87 per cent of Croydon patients said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist. This compares to 97 per cent last year, however still beating the national average of 86 per cent. Demonstrating the Trust's ongoing commitment to providing high quality cancer care to the people of Croydon, the survey also highlighted that:

- 79% of patients said that they were definitely involved as much as they wanted to be in decisions about their care and treatment (compared to 75% last year)
- 87% said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment (compared to 88% last year)
- 86% said that, overall, they were always treated with dignity and respect while they were in hospital (compared to 87% last year)

The Trust works in close partnership with the Macmillan cancer charity whose cancer centre, based at CUH provides invaluable support to many patients and their families, Macmillan has also supported funding for Macmillan Support Officer roles at the Trust to support patients who have been diagnosed with cancer and beyond.

The Trust also works closely with RM Partners who have also supported a number of research developments and grants during 18/19 – including our very promising NICE FIT study of bowel cancer testing that has more than 11,000 participants.

Macmillan

The Trust has recruited Macmillan Support Officers for Lower GI, Gynaecology, Breast and Lung to support patients and Cancer Nurse Specialists and be a direct point of contact for patients with a confirmed cancer diagnosis, as well as those on the Stratified Follow Up and Open Access Follow Up. The Trust will be going live in 2019 with electronic Health Needs Assessments via Macmillan.

Emergency Department

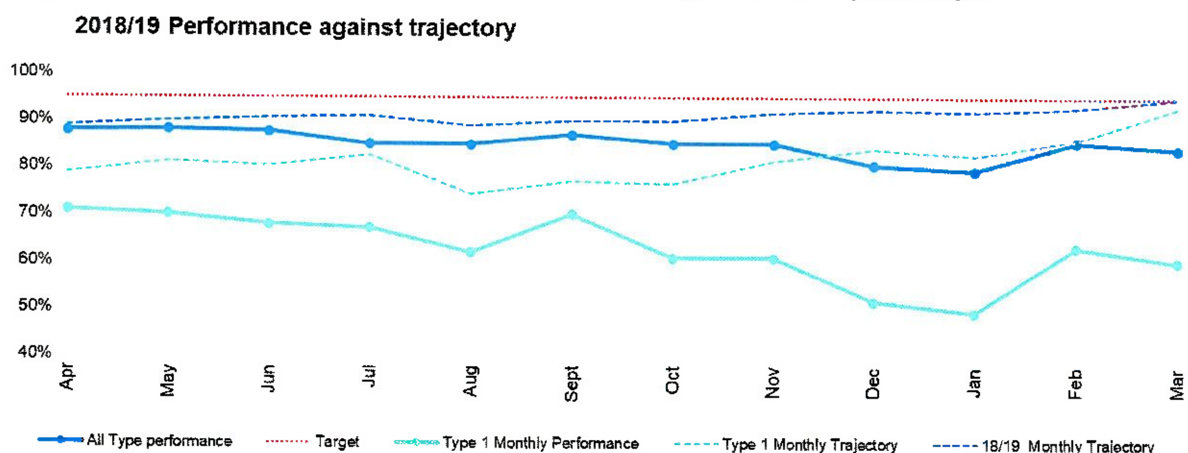
The Trust has undergone significant developments in its emergency provision during 2018/19, culminating in the opening of the new Emergency Department in December. It includes a special department catering for children under 16, offering them advice and treatment for a wide range of children's minor illnesses and injuries that would normally be provided in the community.

Like other London Trusts, our Emergency Department performance remained challenging during 2018/19 with 85.36% of patients seen within four hours. The number of attendances were high, with 74,731 attendances at the emergency GP Hubs, 35,121 ambulance arrivals and 27,991 emergency admissions during 2018/19.

To ensure quality of our emergency service the focus is still on the delivery of safe and responsive care to our service users, with clinical oversight and decision making within the department to help support safe practice at the cost of waiting times.

A&E Waiting times standard

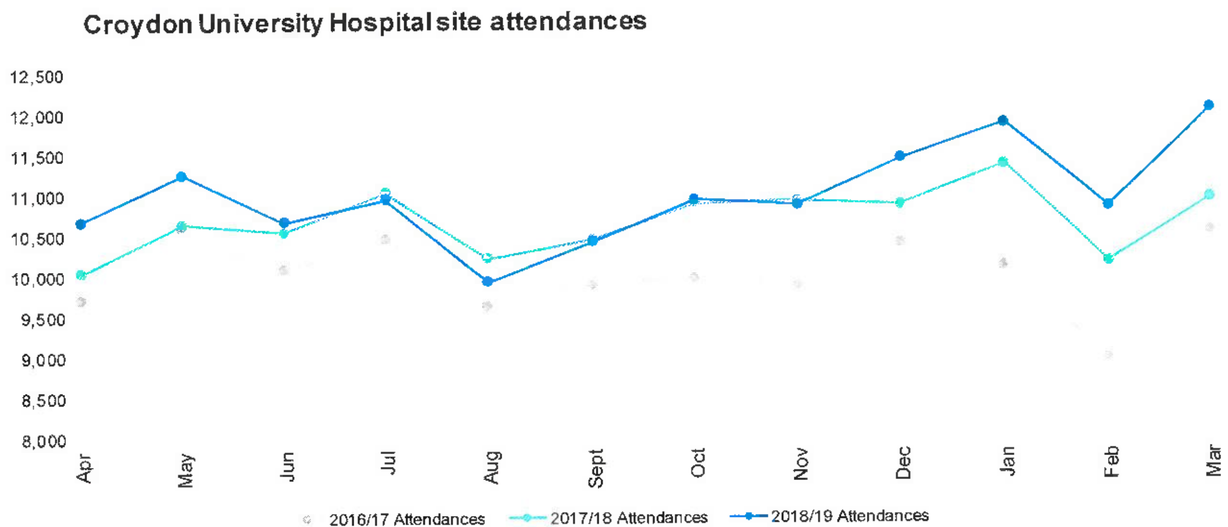
For the year 2018-19 the Trust agreed to work towards a performance trajectory of improvement towards achieving all types emergency care standard performance of 95% by March 2019. Throughout the year this trajectory has not been achieved despite considerable hard work across the emergency care pathways.



Similar to many other London trusts we have underperformed against the care standard, although starting the year well in April 2018, the Trust endured a much challenged winter in 2018-19 with type 1 care performance falling to 49% in January 2019. To support improvement four workstreams were established under the High Impact Improvement Programme for emergency pathways at CHS, encompassing emergency flow, medical model review, discharge process and operational management. At the year-end we are midway through the High Impact Improvement Programme.

Overall attendances to emergency and urgent care at CUH has continued to grow, reaching a peak in March 2019 above 12,000 attendances. Despite the summer and autumn months being relatively flat, activity has stepped up year on year over the winter. Average daily attendances in February 2019 was 405 per day compared to

the 366 in January 2018 which was the month with the highest average daily attendances in 2017-18



Integrated and Collaborative Healthcare

The establishment of One Croydon has been important step forward for our joint health engagement programmes and building on the inclusive process around designing health provisions to meet the complexities of users, working closely with colleagues who formed part of established clinical networks.

The integration of joint health delivery progressed during the year, bringing together clinicians and support staff from a range of healthcare providers enabling the delivery of more efficient and effective joint working across the region to ensure that its service users received supported discharges from Hospital to residential settings which equipped and empowered them to manage their physical, psychological and social care more independently through access to information and support when they required it.
Patient discharges from Hospital were also supported by the opening of a Therapy Led Ward at the Trust in September 2018 to prepare those who were medically fit for discharge, promoting self-care and self-management for those who required further physical or social support to regain independence before they were discharged. The Trust continues its partnership between the Council, Age UK and local NHS in improving the health and wellbeing of everyone's physical and mental health and wellbeing within the Borough.

Children's Community Services

As well as acute hospital services, the Trust offers a number of community-based services for its users across the Borough providing a full range of specialist healthcare Community Services to a growing population of more than 380,000 people. These are for both Adults and Children (aged 0-16) who reside and/or registered at the 57 GP practices within the London Borough of Croydon. In 2018/19, 3,207 babies were born at CUH with many others born out of the Borough but cared for by the Trusts Community Midwifery and Health Visiting Services. Health Visiting caseloads remained high within the Borough across 2018/19 in excess of 700 children each.

There is also a specialist group of Clinicians within the Looked After Children Team (LAC) who manage the healthcare of 488 Looked After Children living within Croydon. It has the highest number of looked after children in London.

All Children and Families within the Borough are supported by 58 Health Visitors, 36 Community Midwives and 13 Maternity Support workers. In addition to this, the Trust works closely with the local authority, NHS England and the Croydon Clinical Commissioning Group in providing healthcare services to all Children in schools across Croydon. These offer therapy and health screening services to Children and Families, delivering health improvement programmes for Healthy Weight, Healthy Mind and Childhood Immunisations.

In 2018/19 there were 45 young women who required interventions from The Family Nurse Partnership (FNP), supported throughout their pregnancies until their babies reached two years old. The service has the capacity to support 100 women who require these interventions for a number of reasons. Safeguarding of Children within the Borough is high on the Trusts patient safety agenda and in 2018/19 there were 54 Child Protection incidents reported by the Trust.

Performance of all Community Services is measured and monitored through a large number of key performance indicators (KPIs) to deliver quality care. We work closely with the local authority in providing healthcare services to all Children in schools across Croydon. In addition, CHS supported a number of homeless households in temporary accommodation in excess of 2,000 during 2018/19.

The health visiting teams look after a cohort of 29,003 babies and children up to age five. As well as providing a school nursing service to the schools in the borough of Croydon, we also have an immunisation team. This team gave 26,975 injections as directed by Public health England's immunization schedule. Also 8,641 children were seen and took part in the National Childhood measurement Programme. Both Health Visiting and School Nursing use digital resources as another strand to the service delivery model.

Adult Community Services

The Trust offers a number of community-based services for its Adult users across the Borough, including both our adult community nursing services and adult therapy services. Performance of all Community Services is measured and monitored through a large number of key performance indicators (KPIs) to deliver quality care, and we work closely with the local authority in providing healthcare services to all Children in schools across Croydon.

Growing demand for healthcare services meant that both of the Trusts sites experienced a significant growth in referrals during 2018/19 compared to previous years. However the organisation responded well in delivering timely care for patients and met waiting times standards for Cancer and 18 Week Referral to Treatment ensuring that patients received prompt care.

Adult Community Nursing delivers nursing care to the housebound over 18s in the Borough of Croydon. The care is provided through a locality based 24 hour integrated community nursing service a centrally based rapid response service and

other specialist teams. The combined contacts per year are in excess of 435,950 and 32,466 referrals with 140.53 WTE total workforce.

Adult therapy services include Podiatry, Dietetics, Speech and language Therapy, Neurorehab Team, Stroke Team, Domiciliary Physiotherapy, Falls service, Occupational Therapy Team, Learning Disability Team. They provided in excess of 125,000 contacts to those in their homes and in our clinics in the year.

The adult community Speech and Language therapy team were involved in a research project EVA Park Early Adopters Study with City University London - Eva Park is a virtual island, created with and for people with aphasia. Users of EVA Park are represented by avatars and can meet up for therapeutic activities, individual conversations or group discussions. Research has shown that therapies delivered in EVA Park can enhance functional communication (Marshall et al, 2016) and word retrieval (Marshall et al, 2018). This project released EVA Park to a number of speech and language therapists (SLTs), to then evaluate its use in 'routine' clinical practice. This project pilots the use of EVA Park in practice, before it is made widely available. It will help to ensure the success of its future general release.

The wheelchair service transferred over to Croydon Equipment Solutions and the Adult MSK physiotherapy service transferred over to Connect Health in year.

South West London funded an additional podiatry post from the Diabetes Network and with this increased capacity the service was able to demonstrate a decrease in hospital admissions and has resulted in an additional block of funding to continue into 19/20. The podiatry service provides 10 clinics per week to treat patients with foot ulcers, approximately 70 appointments per week in order to prevent hospital admissions.

Our Falls service have presented at the British Geriatric Society the positive impact their service has had on reducing falls, and the CCG have invested in the service, which will see the service expand in size.

UK Stroke Forum Community Stroke Rehabilitation team had a poster accepted for the Forum about using an integrated therapy outcome measure for Stroke (TOMS). This has subsequently been chosen to be printed in the new edition of the Therapy Outcome Measures manual. One of the team was successful in completing a train the trainer course and has subsequently delivered training to therapists from across South West London

We expanded our Community Stroke rehabilitation team with a new nurse post - enhancing the care and support patients who have had a Stroke and their families receive, especially in terms of continence, pressure care and medication management.
In addition, CHS supported a number of homeless households in temporary accommodation in excess of 2,000 during 2018/19.

The LIFE team provides enablement to facilitate early discharge and hospital avoidance through an integrated health and social care workforce and has received in excess of 1500 referrals over the last year.

Community Respiratory Services

The Croydon Respiratory Team have continued to grow and develop throughout the year. Its continued work on reducing COPD admissions has this year resulted in a 20% reduction in admissions and an overall 19.2% reduction in bed days from 2017/18 figures.

The team have also been working closely with primary care to improve the quality of spirometry and increase the number of COPD diagnoses.

In collaboration with the community education provider network lead nurse, £11K has been secured for Croydon primary care staff to attain a national qualification in delivering and interpreting spirometry (the qualification will be mandatory by March 2021.) This will put Croydon in a strong position to ensure high quality spirometry is being completed for patients in Croydon and put us ahead of other local boroughs in this area.

Trust Integrated Quality & Performance Management Framework

To support the delivery of national, local and contractual performance requirements across all clinical sites the Trust operates its regulatory and performance monitoring under an Integrated Quality and Performance Framework aligned with Trusts values, strategy and objectives to monitor and manage the delivery of quality care using the five NHS Improvement themes of Quality of Care, Operational Performance, Leadership and Improvement Capability, Strategic Change and Finance & Use of Resources. Trust performance is scrutinised through a range of daily, weekly and formal monthly review meetings at Clinical Business Unit, Divisional and Directorate level with transparency from Ward to Board using a system of Integrated Quality & Performance Reporting (IQPR) and adopting statistical process controls to inform debate and decision making in managing quality and performance, coupled with a strong quality improvement strategy which is to be progressed further in 2019/20.

NHS Improvement Single Oversight Framework

In addition, the Trusts monitors its performance with a self-assessment each month using NHS Improvements (NHSI) Single Oversight Framework (SOF) which measures all Trusts, nationally using five key elements of delivery, Safe, Effective, Responsive, Caring and Well-led plus the five NHSI Themes; Quality of Care, Operational Performance, Leadership and Improvement Capability, Strategic Change and Finance & Use of Resources. The Trusts' formal performance report to Committee and Boards is delivered using an Integrated Quality & Performance report introduced in quarter three of 2018/19 which is also framed around the Care Quality Commission and NHS Improvement domains and themes within the National Oversight Framework.

Performance Trends

The performance table shows how the Trust performed in 2018/19 against targets set at both national and local levels. These performance standards are used as a health check by our regulatory colleagues to monitor and measure our performance Delivery of these performance standards are reviewed both weekly and monthly and any trends over time are monitored and peer comparisons made using the published data from the Model Hospital, NHS England and NHS Digital.

Quality of Care (Safe Domain)

Quality of Care (Safe Domain)	Annual Performance 2018/19	Target/Tolerance
Clostridium Difficile Incidences (Trust tolerance is 16 for the year)	0	0
Incidents - Clinical	10	<= 5 Avg
Incidents - NonClinical	20,102	Trend
Incidents: Medication Errors	875	Trend
Incidents: Falls	349	Trend
Incidents: No of Falls Causing Harm	595	Trend
Incidents: Pressure Sores Hospital Acquired (Grades 3 & 4)	5	6
Incidents: Serious Untoward Incidents	42	Trend
Incidents: Serious Incidents No of A&E Black Breaches >60 Minutes that have been Validated and on Datix	409	0
Incidents: Never Events	0	0
Hand Hygiene Audit	93.49%	90.00%
Deaths in Low Risk Diagnoses Cases	5	0

Quality of Care (Caring Domain)

Quality of Care (Caring Domain)	Annual Performance 2018/19	Target/Tolerance
Cancelled Operations - Last Minute Cancellations	32	0
Cancelled Operations - Last Minute Cancellations (%)	0.46%	0.80%
Cancelled Operations not readmitted within 28 Days	7	0
Urgent Operations being Cancelled for the Second Time	0	0
FFT - Response Rate IP	20.04%	20.00%
FFT - Response Rate DC	23.57%	30.00%
FFT - % Recommend A&E	8.97%	30.00%
FFT - % Recommend IP	75.31%	90.00%
FFT - % Recommend DC	89.17%	90.00%
Dementia Screening - Case Finding	89.19%	90.00%
Dementia Screening - Diagnostic Assessment	84.20%	90.00%
Complaints Received	257	Trend
Timely Response to Complaints	82.55%	90.00%
Outpatient Cancellations by Hospital Cases	33,722	Trend
Outpatient Cancellations by Hospital %	18.81%	14.00%

Quality of Care (Effective Domain)

Quality of Care (Effective Domain)	Annual Performance 2018/19	Target/Tolerance
Emergency Readmissions On Day of Discharge	68	0
Emergency Re-Admission rate: Post Elective Spell within 30 days	2.27%	Trend
Emergency Re-Admission rate: Post Emergency Spell within 30 days	13.87%	Trend
Discharges <1pm % of total Discharges	15.83%	25.00%
Pre-2 pm Discharges (Emergency Admissions) % of all Discharges	22.06%	Trend
Weekend Discharges	18.78%	Trend
Average Length of Stay: Elective Spells	1.87	3.60
Average Length of Stay : Emergency Spells	7.14	5.00
Stroke who spend at least 90% of their time in hospital on a stroke unit	80.36%	90.0%
TIAs - Patients at higher risk of stroke	508	Trend
TIA Higher risk patients assessed and treated within 24 hours	96.26%	60.0%

Quality of Care (Responsive Domain)

Quality of Care (Responsive Domain)	Annual Performance 2018/19	Target/Tolerance
A&E <4 Hour Total Time in Department (All Types)	85.36%	90.00%
A&E <4 Hour Total Time in Department (Type 1)	63.31%	90.00%
A&E : 30 Minutes to Triage - Adults Ambulances & Walk-ins (% of total attendances)	76.87%	95.00%
A&E : 15 Minutes to Triage - Adults Ambulances & Walk-ins (% of total attendances)	58.45%	95.00%
A&E : 15 Minutes to Triage - Paediatrics Ambulances & Walk-ins (% of total attendances)	80.46%	95.00%
A&E : 12 Hour Trolley Waits	6	0
RTT: Admitted (Trustwide figures)	66.82%	90% (No longer Nat Std)
RTT: Non-Admitted (Trustwide figures)	87.65%	95% (No longer Nat Std)
RTT: Open Pathways (Trustwide figures)	92.80%	92.00%
RTT: All Types - Over 52 weeks	7	0
Delayed Transfers of Care %	3.65%	3.50%

Finance & Use of Resources (Including Contract Activity)

Finance and Use of Resources (Including Contract Activity)	Annual Performance 2018/19	Target/Tolerance
A&E Attendances (CHS Only)	73,326	Trend
Elective Daycase Spells	6,553	Trend
Elective Inpatient Spells	332	Trend
Non-Elective / Non-Emergency Inpatient Spells	234	Trend
Emergency Non Elective Inpatient Spells	15,479	Trend
Clinical Coding Depth (Mean Diagnosis/Spell)	11.33	Trend
Outpatient Attendances - First	35,451	Trend
Outpatient Attendances - Follow Up (inc Ward Attenadances)	73,021	Trend
Outpatient Procedures	450	Trend
Outpatient DNA Rate	10.07%	9.00%
Outpatient First to Follow-Up Ratio	1.70	TBC
Outpatient Consultant to Consultant Referral Rate	18.59%	14.00%

Finance report

Finance Overview

The Trust is assessed on its adjusted financial performance. On this basis the Trust has successfully achieved a 2018/19 surplus of £1.5m (post Provider Sustainability Fund (PSF)). This has improved the planned deficit of £2.8m by £4.3m. The Trust lost A & E PSF reward of £3.7m which was offset by a final additional PSF settlement from NHSI of £8m. This is the first time the Trust recorded a surplus (after technical adjustments for impairments and impact on capital grants and donations which are not included in financial performance) since suffering financial performance deficits for the last five years consecutively. The technical adjustments, which are not included in assessing financial performance, amounted to £34.5m deficit and has resulted in a Statement of Comprehensive Income of £33m deficit.

Circa two thirds of the Trust's overall budget is spent on staffing. The Trust has experienced difficulties in recruiting and retaining staff together with increased acuity requiring more staff input. The Trust has also significantly increased its elective activity which has required additional clinical staff to deliver. At the same time the national workforce market have become much more competitive with fewer EU staff applying for positions and all trusts effectively competing for a smaller number of expert clinicians. In 2018/19, we spent £2.9m more on temporary staff compared to £3.8m less than previous year in 2017/18. The Trust has plans to recruit overseas, non EU, staff in 2019/20 and 2020/21as well as focussing on UK recruitment and better retention rates. The aim will be to reduce the use of agency and locum staff through permanent recruitment and this is planned to reduce agency and locum expenditure by £6.2m in 2019/20. We also delivered around £19.2m of core Cost Improvement Plans (CIPs) and £7.8m of more productive elective activity and income.

We all want to see a sustainable CHS that can meet the health needs of our growing community. To do this, we have to work smarter within the existing resources we have.

The recurrent and improvements on expenditure and productivity overall have been achieved without impacting on quality and by applying new ways of working which need to be further developed and embedded in 2019/20.

All cost saving initiatives are quality assessed by the directorate clinicians as well as the Trust's most senior clinicians to ensure that our standards of safety and performance are maintained.

Our Accounts

The Trust prepares its accounts in accordance with International Financial Reporting Standards (IFRS). Two new accounting standards were introduced on 1 January 2018; IFRS 9 Financial Instruments and IFRS 15 Revenue from Contracts with Customers. There is no major impact on the financial statements except with additional disclosures for both IFRS 9 and IFRS15.

The Trust has the options to revalue the land and buildings using depreciated replacement cost (DRC) or modern equivalent asset (MEA). The Trust has adopted MEA valuation technique for 2018/19 and going forwards. This is a change in valuation methodology of the building asset compared to the one adopted in previous financial years. The basis of valuation for land is consistent with last financial year, but a different estimation technique has been applied in arriving at the valuation for both land and buildings. It requires appropriate disclosure in the Trust accounts to make clear an alternate site methodology has been adopted. The methodology adopted meets the requirements of International Accounting Standards (IAS) 16; Property, Plant and Equipment and does not deviate from the principles therein. Any impairment resulting from revaluation will be outside statutory Trust performance.

In 2018/19, the Trust successfully delivered its £15.1m deficit control total however it did not manage to achieve its A&E four hour wait target trajectories and the associated PSF benefit. The Trust reported a retained deficit of £15.1m pre PSF. The post PSF position is £6.5m deficit plus an additional £8.0m benefit by NHSI (taking full year PSF payment to £16.7m.) This results in a final £1.5m surplus post PSF.

The Trust targeted £19.2m of Cost Improvement Plans CIP in order to meets its £15.1m deficit control total. The Trust identified these savings including £7.0m non-recurrent CIPs. Income significantly over performed, particularly elective and A&E, which meant that a number of the pay and non-pay costs have increased as additional temporary staff were required to service the additional activity together with additional clinical supplies and services

Going Concern

The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in IAS1 "that the continuation of the provision of the service is the important determinant of the basis of preparation of the financial statements for public sector entities".

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

Profitability alone does not ensure the Going Concern status of an organisation. The critical factor that management use to determine the Going Concern status of CHS is whether we can maintain sufficient working balances to ensure our creditors are paid. Our Better Payment Practice figures showed improvement in volume terms in

our ability to pay suppliers within 30 days in 2018/19. There continues to be pressure on total value paid within 30 days.

The Trust met its control total of £15.1m deficit (pre PSF) and achieved an adjusted financial performance surplus of £1.5m (post PSF) in 2018/19.

In year the Trust has drawn down £12.07m revenue loans consist of £2.84m plan deficit, £3.67m missed A&E PSF targets and £5.56m PSF (performance targets) as advance to be repaid when the actual distribution is paid.

The Trust has a current loan of £56.1m which will due within one year and not later than two years. The Trust may not be able to repay the loans when due and in these cases, which will occur for the majority of trusts in deficit, NHS Improvement advises the Trust to seek extension from the Department of Health and Social Care (DHSC). The DHSC has never turned down one of these requests for extensions, although they may apply additional conditions and interest rates.

The 2019/20 plan does not require cash support from the DHSC provided the Trust meets its £13.2m deficit pre central support. The Trust has agreed to the £13.2m deficit, pre central support, and is therefore eligible for £4.3m Marginal Rate Emergency Threshold (MRET) funding. The remaining £8.9m of PSF and Financial Recovery Fund (FRF) monies are available on achievement of quarterly trajectories for the delivery of the £13.2m deficit. This should allow a breakeven position, with all central support monies otherwise further cash loans will be required. The Trust has requested access to further DHSC borrowing facilities to provide adequate liquidity headroom if needed.

The opening of new Emergency Department in 2018/19 signifies the continuation of provision of clinical services in the future. It is reasonable for the Directors of our Trust to consider the continuation of our provision of clinical services in the future as sufficient evidence of a going concern. Furthermore the trajectory of the Trust's deficits is on a downward trend, and the Trust met its 2018/19 control total.

The Trust has a reasonable expectation that adequate resources, from a cash perspective, will be available to continue in operation for at least 12 months from the date of signature of the 2018/19 accounts. This will be through a combination of its existing internal working capital and financial support offered by the DHSC, linked to an agreed financial recovery plan. Therefore the Trust will continue to adopt the going concern basis in preparing the accounts.

2019/20 Outlook

The Trust aim is to reduce 2018/19 deficit of £15.1m deficit outturn position (before PSF) to a £13.2m deficit position (before PSF, MRET & FRF) at the end of 2019/20.

Building on the work we are doing to more closely align the Trust and Croydon CCG (the CCG), the Trust and the CCG, as part of the local health system, have worked closely to create a joint plan for 2019/20. The contract is based on the outcome of these discussions. This plan builds upon the joint strategy, delivers the agreed joint and system control total and drives significant improvements in cost and quality.

The contract with the CCG will be a block (fixed amount of money irrespective of activity) contract with a small number of variable items and agreements around risk share. Historically, demand management was a CCG owned risk including delivery of demand management (QIPP), whilst cost control of delivery was a Trust owned risk including delivery of CIP and income growth. The resulting unaffordable activity costs and unfunded stranded costs worked against system wide benefit for patients. Through the co-production of 2019/20 plans and a joint control total, there is a shared understanding that the Trust the CCG are now shared owners of the risks. The whole system control total will be managed such that both risk and performance is shared and represented in the bottom line delivery for each organisation.

The plan has been discussed at length with partners within the CCG, across the South West London STP and with the Trust Board. The Trust and the CCG have worked hard to achieve a balanced system position. The Trust has also finalised its contracts with all other NHS commissioners and these will all vary with activity.

The Trust has set itself a challenging CIP target for 2019/20 of £14.3m which is 4.5% of expenditure outturn. A variety of QIPP relating to non-elective and elective activity have already been jointly modelled and agreed as part of the block contract arrangements. The Trust and the CCG will need to jointly agree further CIP and QIPP to ensure there is a system reduction in actual cost of delivery and that there are mitigation plans in place for any areas which fail to deliver in a timely way. A business and quality test will be undertaken on both CIPs and QIPPs jointly by the CCG and Trust to ensure both organisations have visibility of changes and agree with outcomes.

The CIP has been developed on a top down and bottom up basis, the CIP has been scrutinised in two Board Away days, to which CCG colleagues were invited, on the 14 February & 14 March 2019. A Cost and Quality Oversight Board (CQOB) has been established which is jointly chaired by the Trust Director of Finance and the CCG Chief Finance Officer. The Board also requires senior clinical presence from both organisations and operational presence from the Trust in order to be quorate. The CQOB will meet weekly in order to review new plans and monitor delivery against existing plans. A set of KPIs will be developed in early May for all existing plans. KPIs are already in place for key programmes.

Financial Review 2018/19

The table below sets out CHS's financial targets, and its performance against these, in the 2018/19 Financial Year:

Target	Performance	Target met?
Breakeven on revenue and operating costs	The Trust posted a reported deficit of £15.1m pre Provider Sustainability Fund (PSF) and £1.5m surplus post PSF.	No. Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 states: "Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account." The breakeven duty will be assumed to have been met if the breakeven cumulative net deficit is less than or equal to 0.5% of the turnover of the reporting year. The board is accountable for financial control and for ensuring that the Trust meets its statutory duty to break even.
Keep within the capital resource limit (CRL) of £11.952m (including £1.139m capital PDC)	The Trust remained within the CRL, and generated an underspend of £0.044m	Yes
Remain within the external financing limits (EFL) of £15.831m	The Trust remained within its EFL by £1.085m.	Yes
Keep within a Capital Cost Absorption Rate (CCAR) of 3.5%	The Trust kept within the 3.5% CCAR. This has resulted in dividend payments of £2.5m to the DHSC.	Yes

Where our money comes from

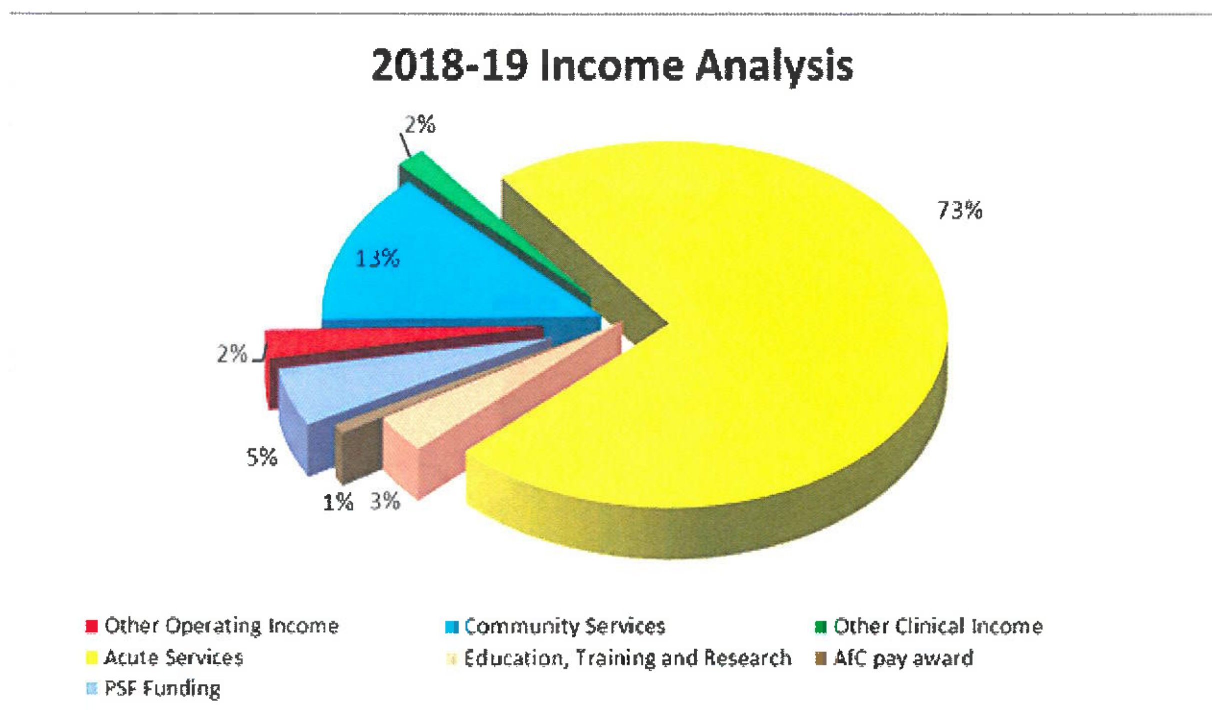
There was an 8.8% growth in the Trust's total income to £318.8m, due to significantly increased activity and over performance of £25.7m. This includes £16.6m of PSF payment.

The revenue generated from NHS and non NHS clinical activity is £284.0m. This principally comes from the following sources of income which are the CCGs for delivery of acute and community patient care activities, NHS England for specialised

services and local authorities for acute and community services. There are a number of other income sources such as the Education and Training income that pays for the training of doctors, nurses and other healthcare professionals – which, in doing so, supports the quality of the care we provide. The remainder of the Trust's income sources are not directly linked to patient care and include items such as catering, accommodation revenues and income for services provided to other third parties.

Income is classified as follows:

Revenue	£000	%
Acute Services	232,667	75%
Community Services	42,474	14%
Other Clinical Income	5,717	2%
Education, Training and Research	10,787	3%
AfC pay award	2,830	1%
PSF Funding	16,562	3%
Other Operating Income	7,807	3%



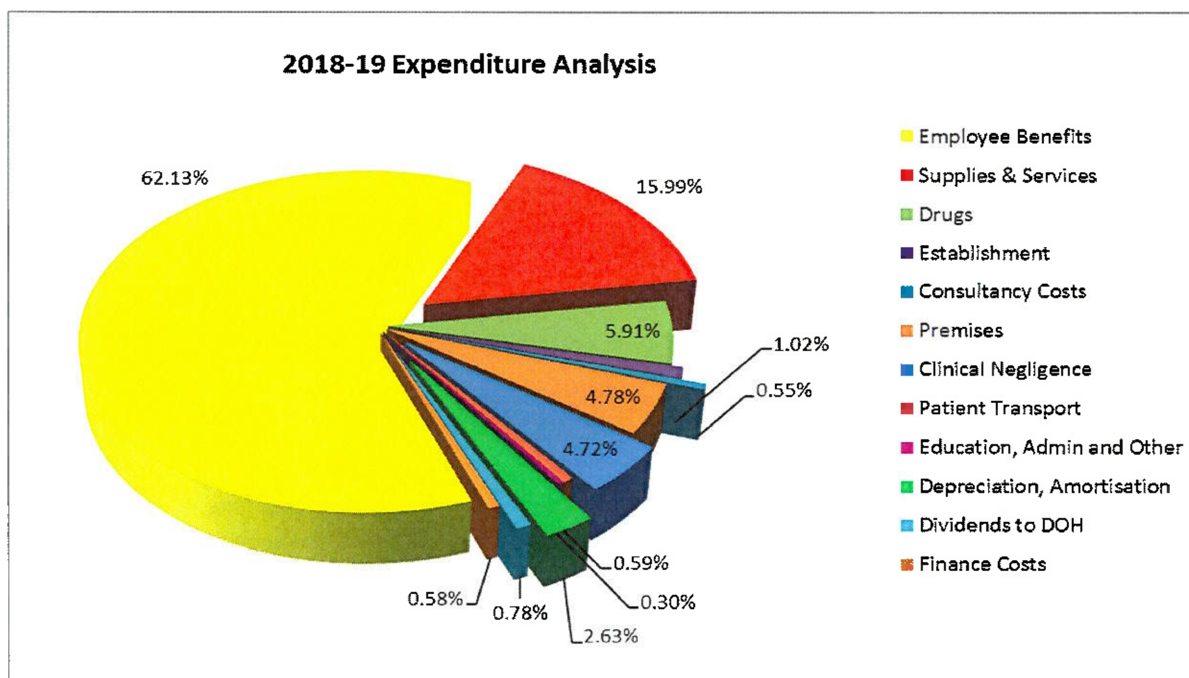
What we spend money on

Our Trust's total expenditure in the year was £319.6m - an increase of £4.1m (1.3%) from the previous financial year. The key drivers for the increase are pay, linked with escalation beds and enhanced care being above plan. Additional repatriation activity has contributed to increased pay. The Trust is looking to improve patient flow throughout the hospital and reduce costs as part of the 2019/20 CIP plan. A contributory factor has also been nursing and medical spend in emergency care. Other items such as the non-pay increase are due to higher IT and Estates costs, consultancy and professional fees.

Staff costs are the largest component of expenditure, accounting for 62% of operating expenses followed by supplies and services for clinical and drugs costs. As part of the efficiency scheme, the Trust has delivered £19.2m of Efficiency saving in 2018/19.

The spend is summarised as follows:

Expenditure	£000	%
Employee Benefits	198,541	62%
Supplies & Services Clinical/General	51,447	16%
Drugs	18,900	6%
Establishment & other	3,020	1%
Consultancy Costs	1,762	1%
Premises	15,182	5%
Clinical Negligence	15,097	5%
Patient Transport	1,889	1%
Education, Admin and Other	950	0%
Depreciation & Amortisation	8,398	3%
Dividends to DOH	2,508	1%
Finance Costs	1,864	1%



Getting best value for money

We made £19.2m core efficiency savings during the 2018/19 financial year, which equates to 6% saving against actual expenditure. These savings have been reinvested in patient care.

Capital investment

The Trust continues to make substantial capital investments in modern, innovative medical equipment to deliver excellent patient care, in IT systems to improve the efficiency and security of patient data and in our estates to enhance the environment for the benefit of patients, visitors and staff.

The capital programme is funded from a combination of the Trust's own internally generated resources, donations, Public Dividend Capital (PDC) funding from Department of Health and Social Care (DHSC) and loans from the DHSC.

In the 2018/19 year the Trust spent £14.0m (2017/18: £10.8m) of capital expenditure including £7.7m on the Emergency Department (ED), £1.9m on IT infrastructure, £1.4m on medical equipment and £3.0m on estates improvements.

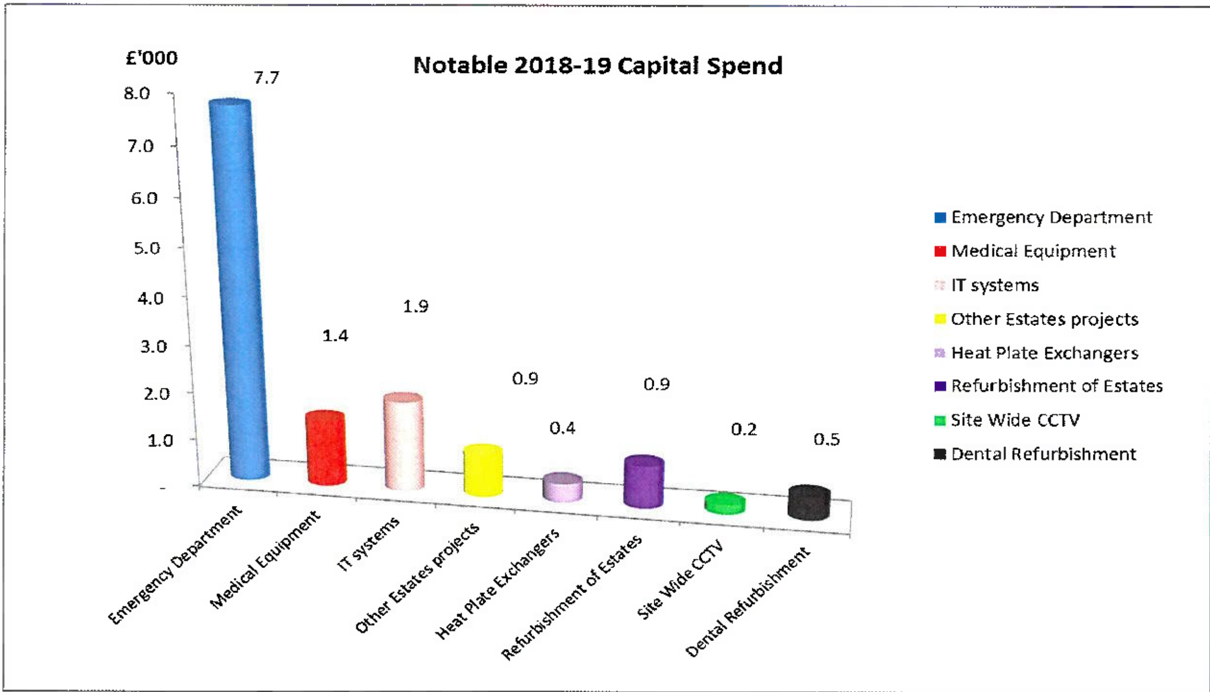
Most notably, the new emergency department at CUH has finally opened its doors to patients on the 2nd December 2018. The building covers an area of 3,080 m^2; it has 14 paediatric patient rooms, 28 Majors bays which are rooms, 8 bays in the Resus area and 6 patient rooms in the Urgent Treatment Centre offers modern, high-quality facilities and innovative care for patients. The new department means our community have access to some of the best emergency care facilities in London.

The Trust received £0.1m capital PDC funding from DHSC as part of modernising and enhancement of NHS digital Wi-Fi programme. The Trust also spent about £0.9m on IT rolling replacement for desktop equipment and back end infrastructure to enhance cyber security, receiving digital medical information, faster processing data that makes the back office runs more efficiently.

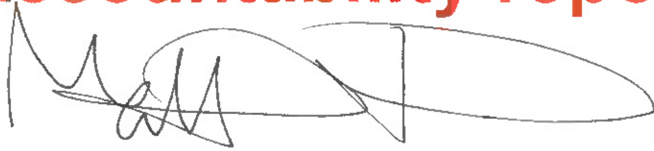
Investing in modern medical devices is essential to improve the diagnosis and treatment and care of patients. The Trust spent £1.4m on diagnostics equipment, operating tables and scopes and this has been managed efficiently to provide good quality care of patients at least cost.

The Trust adopted the "alternate modern equivalent asset" (MEA) valuation basis on its land and buildings as at 31 March 2019. An existing use value alternative was used which assumes the assets would be replaced with a modern equivalent, i.e. not a building of identical design - but with the same service provision as the existing asset. The alternative modern equivalent asset may well be smaller (reduced Gross Internal Area, than the existing asset which reflects the challenges Healthcare Providers face when utilising historical NHS Estate). This was a theoretical exercise as any new builds would require a business care prior to build. This resulted in an overall decrease in the value of the asset base by 31%.

The capital programme for 2019/20 continues with the on-going investment in patient care and well-being mostly from self-funded capital programme. These have been scored and prioritised based on patient safety and risk to develop a programme for the Trust for the coming year. Outside of the Trust's internally generated capital programme the Trust continues to work with the local Croydon Estates Board and other SWL organisations, as part of the SWL STP, to develop Outline Business Cases for Critical Care and Theatre refurbishments as part of the wider refreshed STP Estates Strategy for South West London.


£'000
Notable 2018-19 Capital Spend
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
-
7.7
1.4
1.9
0.9
0.4
0.9
0.2
0.5
Emergency Department
Medical Equipment
IT systems
Other Estates projects
Heat Plate Exchangers
Refurbishment of Estates
Site Wide CCTV
Dental Refurbishment

Accountability report



Matthew Kershaw, Interim Chief Executive
Date: 28 May 2019

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by the Secretary of State for Health and Social Care. The accountability report takes account of the Department of Health guidance for NHS Trusts in the manual for accounts as follows:

- The Corporate Governance report explains how the composition and organisation of the Trust's governance structures, which have been developed in line with good governance practices and support the Trust's objectives, and which provides assurance that the Trust's risks are appropriately identified and manage.
- The Remuneration and Staff report sets out the Trust's remuneration policy for Directors and Senior Managers, reports on how that policy has been implemented and sets out the amounts awarded to those individuals. It also details an analysis of staff numbers and costs and other relevant information relating to the workforce.
- The Trust's External Auditor also provides a report of its audit of the Annual Accounts, remuneration and staff report and annual report.

Directors' report and role of the Trust Board

The Trust Board run our two hospitals and community services across Croydon. The Board is responsible for determining the overall strategy and monitoring the performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within resources available.
The Trust Board holds four meetings in public. It is held to account for the delivery of services and use of public money by NHS Improvement and for the quality of services by the Care Quality Commission.

Leadership

The Board is led by the Chair who holds the Chief Executive as Accountable Officer to account. The Chief Executive is supported by the Executive Directors for ensuring that the Trust delivers high quality care for our community.

Non-executive Directors

Our non-executive directors work alongside other executive directors as equal members of the Board, sharing responsibility for the decisions made. Using their personal experience and expertise, they bring independent and external skills to the Board, to help lead improvements in healthcare for patients and service users. They also hold the executive team to account for strategy development.

Leadership effectiveness and appraisal

The Board met in public throughout the year with meetings held in April 2018, July 2018, October 2018 and January 2010. Attendance was monitored at all meetings and there were four authorised absences from Non-executive Directors, two authorised absences from Executive Directors.

The Audit Committee has overseen the continued development of the Assurance Map across areas of quality and planning and performance, identifying the current levels of assurance available at a specific point in time to the Audit Committee and Board of Directors re the Corporate Risk Register and Board Assurance Framework.

The Board Assurance Framework links the individual corporate risks identified on the Corporate Risk Register to the Trust's strategic objectives identifying any areas which require additional mitigation or controls being put in place. The Corporate Risk Register has been subject to a risk refresh across all directorates to identify any gaps and ensure that the Trust continues to effectively monitor risk.

The Cycle of Business for the Trust Board and each Board committee has been updated and the action trackers and decision logs continue to track completion of actions identified.

Board development days and seminars have been held to further develop strategic planning.

The Board's Register of Interests was maintained throughout 2018/19 and is included as a standing agenda item at each Trust Board meeting. The Chairs of each of the Board committees present written reports to the Board supplemented by verbal updates.

Further details of the CQC findings are outlined in the Performance section of this report.

Profiles of our Board

Mike Bell, Chair

Since joining CHS in 2013, Mike Bell has helped shape the Trust's vision and, alongside its senior management team, has seen the organisation deliver continued improvements in care and performance.

The Trust has formed new alliances with the local authority, commissioners, GPs, mental health services and the voluntary sector to make services more joined up for patients.

Mike has held a number of senior positions across the NHS, including chair of the London Mental Health & Employment Partnership and vice chair of NHS London.
He is the director of a consultancy company, MBARC Ltd, which works with central and local government and various NHS bodies on issues relating to both social exclusion and quality assurance.

Matthew Kershaw, Interim Chief Executive

Matthew Kershaw joined the Trust in October 2018 and has over 25 years of NHS experience.

Before joining CHS he was a Senior Fellow at The King's Fund, a health think-tank, where he has played a key role in its work with health and care organisations to develop integrated care that better meets the needs of patients and service-users. He has also held a number of senior leadership roles, most recently as Chief Executive of East Kent Hospitals University Foundation Trust where he led the Trust out of Quality Special Measures.

Prior to this, Matthew was Chief Executive of Brighton and Sussex University Hospitals NHS Trust for three years and building on work already progressed helped to secure and plan for the £500m capital investment to redevelop the Sussex County Hospital. He has worked nationally at the Department of Health, including developing the delivery plan for the 18-week waiting time target and being the first trust special administrator.

His career has also seen him work with the Care Quality Commission, Health Education England, and the Kent Cancer Alliance, where he chaired the Kent Surrey and Sussex Clinical Research Network.

Dr Nnenna Osuji, Deputy Chief Executive and Medical Director

With more than 20 years' experience within the NHS, Nnenna has been the Medical Director at CHS since September 2015 and prior to that was Associate Medical Director and Deputy Medical Director. The Medical Director is the most senior medical position at an NHS Trust, sitting on the Board to provide a clinician's voice on all management decisions.

Nnenna oversees the Trust's medical workforce providing professional leadership, support and accountability. Together with the Director of Nursing and Allied Health

Professionals, Nnenna leads on delivery of continuous quality and safety improvements at CHS. Nnenna also leads on promoting Research and Development and is the Caldicott guardian for the Trust, providing senior advice and direction on the ethical and correct use of information.

Nnenna joined the Trust as a Consultant Haematologist in 2005. She is an active member of the National Clinical Research Network for Cancer Chemotherapy and Pharmacy Advisory Service Committee. She was also an associate lecturer and consultant for the Mary Seacole Programme run by the NHS Leadership Academy, Open University and Hay Group, which develops leadership across the health service. She was appointed to the role of Deputy Chief Executive as part of changes to the senior management team in November 2018.

Michael Fanning, Director of Nursing, Midwifery and Allied Health Professionals

Michael Fanning joined the Trust as Interim Director of Nursing, Midwifery and Allied Health Professionals in December 2014.

A registered nurse since 1983, Michael brings with him more than 30 years' experience in the NHS, including eighteen months at the Department of Health and Social Care. He offers a wealth of experience as both a senior nurse leader and operational manager and has also worked as a Clinical Director in the commercial sector.

Michael was previously appointed as a panel member to the Nursing & Midwifery Council to hear fitness to practice hearings and he has also worked for several years as a volunteer counsellor for a charity in Oxford. Michael announced in January 2019 that he would be leaving the Trust in April 2019.

Azara Mukhtar, Director of Finance

Azara Mukhtar was instrumental in the Trust's exit from NHS Improvement's financial special measures after only seven months in February 2017. The Trust's recovery plan was carefully developed with close inclusion of senior clinicians.

A qualified accountant, Azara joined the NHS in 1995 and held a number of senior finance roles at NHS London, Barts and The London and Guy's & St Thomas'. Azara joined the CHS as our Director of Finance in 2013.

Michael Burden, Director of Human Resources and Organisational Development

Michael first joined the Trust in 2011 and has diverse experience of nursing and human resources management in healthcare.

He was trained as a general nurse at St Helier Hospital and then as a registered mental health nurse before moving into human resource management in a number of healthcare settings followed by a period at the Royal College of Nursing.

His HR team has worked hard to ensure staff feel supported and recognised – for example through our Croydon Stars Awards.

Dr James Gillgrass, Non-executive Director

Dr James Gillgrass became Non-Executive Director in January 2014 following a long medical career. He worked in various hospitals including CUH before becoming a GP in Croydon in 1983.

In addition to establishing a medical practice, Dr Gillgrass has held a number of leadership positions in local GP organisations including Chairman of the Croydon Local Medical Committee, Chief Executive of Surrey and Sussex Local Medical Committees and Chairman of the Practice Based Commissioning Group in Croydon. He was also the Surrey and Croydon representative on the British Medical Association's GP committee between 2004 and 2009.

James has chaired the Trust's Appointments Advisory Committee since March 2014, which has overseen the appointment of 13 consultants in 2016/17.

Godfrey Allen, Non-executive Director

Godfrey Allen joined CHS in January 2013 and chairs the Trust's Quality Committee. The Committee has oversight of the Quality Improvement Programme (QIP). Godfrey completes an executive walk-round of services every month to speak to patients, staff and visitors about our care.

He is a former Chief Executive in the public, private and charitable sectors and served as a non-executive director for Wandsworth PCT.

Richard Oirschot, Non-executive Director

Richard is a member of the Institute for Turnaround, a Fellow of the Institute of Chartered Accountants and a Licensed Insolvency Practitioner. He has a wealth of experience gained from over 25 years of turnaround, restructuring and recovery work across a broad range of business sectors.

Richard's career has included specialised lending at HSBC, a partnership at Smith and Williamson and roles with Hacker Young and PKF. He built a successful investment portfolio for Barclays Ventures, completing over 35 investments, working closely with Boards to implement restructures and turnaround strategies.

Now focusing on turnaround and Non-Executive Director (NED) assignments, Richard's current roles include: Insolvency Service - Non-executive board member; MHS Homes – member of the Finance, Risk and Audit committee.

Louise Cretton, Non-executive Director

Louise Cretton took up this position in 2014 and brings a wealth of knowledge about markets, research and strategy.

She has been a lecturer at undergraduate and post graduate levels and conducted various research projects for the NHS, including a pilot project aligning staff engagement with improving patient experience.

Louise is a member of The Market Research Society and sits on the Editorial Board of The International Journal of Market Research.

Louise chairs the Trust's Finance & Performance Committee to provide additional scrutiny and oversight, which supported the Trust's exit from Financial Special Measures and continued improvements in operational performance.

Mike Bailey, Non-executive Director

Mike Bailey took up this position in May 2015, having been an Associate Non-executive Director since July 2014.

Mike's role is to bring experience and expertise to ensure the training that doctors and other healthcare professionals receive at CHS delivers the best possible care to our patients, and supports the ongoing career development of our clinical staff.

He worked in the NHS for more than 40 years including 28 as a consultant urologist, and was the Medical Director at St George's and Epsom Hospital. Mike was also the joint Medical Director for the 'Better Services, Better Value' health service improvement programme that examined the configuration of the NHS in South West London from 2011 to 2014. He has previously been a council member of the British Association of Urological Surgeons.

Steven Corbishley, Non-executive Director

Steven joined the Trust in April 2013 and Chairs the Trust's Audit Committee.

A chartered accountant by trade, he has worked at the National Audit Office since 1987 and, during his career so far, has audited a wide range of central government departments and their arm's length bodies, including the Department of Health and Social Care.

He has also held senior non-executive roles at NHS South East London Joint Primary Care Trusts Boards and NHS Lewisham.

In his role as Chair of the Audit Committee, he has worked to strengthen our governance arrangements, embed risk management within the Trust, ensure sound financial reporting, and has supported the way the Trust navigated its way through Financial Special Measures.

Hannah Miller, Non-executive Director

A social worker by profession, Hannah Miller has managed a range of housing and social services across the borough.

Previously Hannah was the Executive Director Adult Services, Health & Housing, and the Deputy Chief Executive of Croydon Council.

She was awarded an OBE for services to the welfare of children in 2009. She is a Senior Associate at the Social Care Institute for Excellence and a NED at L&Q

Living, a care and support housing association. Hannah is a member of the Trust's Finance & Performance Committee, which played a significant part in the Trust's exit from Financial Special Measures. She also forms part of the Trust's Remuneration Committee which is responsible for determining the policy of executive pay.

Jamal Butt, Associate Non-executive Director

Jamal brings valued commercial and pharmacy experience, having spent more than 20 years in a variety of senior and commercial roles within Boots UK.

Trained at UCL, London School of Pharmacy and also at Oxford University Said Business School, he has experience and expertise in leading large healthcare transformation programmes across the UK, as well as an extensive network of relationships within the NHS and private organisations.

Over recent years, Jamal has headed up the UK Healthcare services wing at Celesio UK, which supports the creation of innovative integrated services across primary, secondary and social care and has also previously been Head of Pharmacy for Boots UK.

Jamal is currently the Commercial Director for MedAdvisor, one of the world's largest digital medicines management platforms, whose goal is to help people make the best use of their medication. Jamal also advises several digital start-up companies from Cambridge University.

Adam Womersley - NExT Non-Executive Director, CHS

Adam has over 13 years' experience working in the private sector in both Consumer Goods (FMCG) and Consumer Healthcare companies. Adam's current full-time role is Sales Director UK&I for Danone Alpro, working to bring health through food to as many people as possible in a sustainable way.

In June 2018, Adam joined CHS on a 12-month placement as a NExT Director. The scheme is designed to give individuals the senior skills and expertise necessary to make a contribution in the NHS as a Non-executive Director.

Attendance at Board meetings

The Trust Board met in public on four occasions as agreed and the table below sets out the level of attendance by Trust Board members:

		25 April 2018	25 July 2018	31 October 2018	30 January 2019
Michael Bell	Chairman	✔	✔	✔	X
James Gillgrass	Non-Executive Director	✔	✔	✔	✔
Louise Cretton	Non-Executive Director	✔	X	✔	✔
Hannah Miller	Non-Executive Director	✔	✔	✔	✔
Godfrey Allen	Non-Executive Director	✔	✔	✔	✔
Michael Bailey	Non-Executive Director	✔	✔	X	✔
Steven Corbishley	Non-Executive Director	✔	✔	X	X
Richard Oirschot	Non-Executive Director	✔	✔	✔	✔
John Goulston	Chief Executive	✔	✔	n/a	n/a
Matthew Kershaw	Interim Chief Executive	n/a	n/a	✔	✔
Dr Nnenna Osuji	Medical Director	✔	✔	✔	✔
Michael Fanning	Director of Nursing, Midwifery & AHPS	✔	✔	✔	✔
Azara Mukhtar	Director of Finance	✔	✔	X	✔
Michael Burden	Director of HR and OD	✔	✔	✔	✔

Committee structure

During the year the committee structure was reviewed to ensure that a number of areas including Quality, Performance and Finance were appropriately discussed and as a result a number of changes were put in place. Part of the focus of the review was to recognise that performance measurements relate to quality and as such should be reviewed and considered at the same time as that of quality issues.

In addition as part of the Trust Board's decision to work more closely with the Croydon Clinical Commissioning Group (CCG) the opportunity was taken to include CCG colleagues within the membership of the Quality Committee as part of a more aligned approach to Quality.

The Trust Board operates with the support of the following five committees:

Audit Committee: assists the Trust Board to deliver its responsibilities for the conduct of public business and the stewardship of funds under its control. The Committee provides independent assurance to the Board that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards of public business
- Public money is safeguarded and properly accounted for
- Financial statements are prepared to meet regulatory timescales and the Trust's Annual Statutory Accounts are reviewed before being presented to the Trust Board.
- Effective internal audit arrangements are in place to meet mandatory NHS Internal Audit Standards.
- The findings of External Audit are reviewed and the Committee provides a conduit through which their findings can be considered by the Board.

The Committee also receives the Board Assurance Framework, the Corporate Risk Register and the Assurance Map at every meeting and maintains oversight of the Trust's Counter Fraud arrangements.

In addition the Committee receives a regular update on Cyber Security and the plans in place to ensure that the Trust's IT systems remain robust and safe.

Finance, Investment and Transformation Committee (formerly the Finance and Performance Committee): oversees the Trust in its efforts to maximise its healthcare provision subject to financial constraints. The committee considers patient safety to be of paramount importance. The committee seeks to support the development of plans that will seek to transform the way in which the Trust delivers services that will achieve long term sustainability. The Committee's role is to provide challenge, critical review and assurance of the Trust's performance delivery and the quality of the services that it provides. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure:

- There is detailed consideration of the Trust's sustainability in respect of financial, investment and performance issues
- There is adequate information is available on key issues to enable clear decisions to be made Compliance with regulatory requirements e.g. NHS Improvement and the Care Quality Commission

- The achievement of the Trust's strategic aims and objectives
- The signing off of business cases;
- Appropriate oversight of the Capital Budget;
- Oversight of strategies and plans to transform and deliver services.

The Quality Committee (formerly the Quality and Clinical Governance Committee): is responsible for providing assurance to the Board on all aspects of quality including safety, patient experience, clinical effectiveness, research and development, medical revalidation and regulatory standards of care and on-going compliance with the Care Quality Commissions' recommendations following the inspection of its services in hospital and the community.

In addition as part of the integration agenda the committee seeks to provide assurance to the Governing Body of Croydon CCG in relation to the Trust's performance in relation to clinical care and patient experience against nationally and locally agreed standards.

The Committee ensures that appropriate systems are in place to ensure:

- The delivery and reporting of the Trust's Quality Account and the Quality priorities
- An effective review and scrutiny on all aspects of quality to ensure any aspects of concern are satisfactorily addressed
- Relevant independent reports and enquiries are responded to
- Monitoring of progress and completion of action plans as a result of Care Quality Commission Inspections and other external body assessments or accreditations
- Provide the forum where clinical matters between the Trust and the CCG can be addressed. This will include reviewing escalated events and exceptions to performance.

- **The Remuneration Committee:** is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for the termination of contracts and for approving any variations to pay. The Committee ensures that:
  - Appropriate performance management arrangements are in place for Executive Directors and works with the Chief Executive to relate performance judgements where necessary, to pay.

- **The Charitable Funds Committee:** is responsible for overseeing the management, investment and disbursement of the CHS Charitable Funds (Registered Charity No. 1054824). The Committee must ensure:
  - Compliance with statutory or other legal requirements or best practice required by the Charity Commission. This is a delegated duty carried out on behalf of CHS (the Trust), which is the sole corporate trustee of the charity.

Membership of committees

Audit Committee

- Steven Corbishley (Chair)
- Louise Cretton
- Godfrey Allen

Finance, Investment & Transformation Committee

- Louise Cretton (Chair)
- Matthew Kershaw*
- John Goulston**
- Richard Oirschot
- Hannah Miller
- Jamal Butt
- Azara Mukhtar
- Michael Burden
- Dr Nnenna Osuji
- Michael Fanning

Quality Committee

- Godfrey Allen (Chair)
- Mike Bailey
- James Gillgrass
- Dr Nnenna Osuji
- Michael Fanning
- Michael Burden
- Elaine Clancy (Croydon CCG)
- Dr Tom Chan (Croydon CCG)

Remuneration Committee

- Louise Cretton (Chair)
- Mike Bell, Trust Chairman
- Hannah Miller
- Jamal Butt
- Godfrey Allen
- Mike Bailey
- Steven Corbishley
- James Gillgrass
- Richard Oirschot

Charitable Funds Committee

- Mike Bailey (Chair)
- Azara Mukhtar

*Joined 1 October 2018
** Left 30 September 2018.

Declaration of Interests

Name	Role Type	Declaration Status YES/NO	Declaration Details
Godfrey Allen	Non-Executive Director	No	None
Dr Michael Bailey	Non-Executive Director	No	None
Mike Bell	Chairman	Yes	• MBARC Ltd holds a contract with NHS England which commissions services from CHS NHS Trust
Jayne Black	Deputy Chief Executive and Chief Operating Officer (resigned 19 April 2018)	No	None
Michael Burden	Director of Human Resources & Organisational Development	No	None
Jamal Butt	Associate Non-Executive Director	Yes	• Med Advisor UK - Commercial Director • Psyomics Ltd - Board Advisory Role • UCL - Academic Advisory Role • Medicbank Ltd - Board Advisory Role
Lisa Chesser	Director of Planning & Informatics (redundant 7 September 2018)	No	None
Steven Corbishley	Non-Executive Director	No	None
Louise Cretton	Non-Executive Director	Yes	• Pittards PLC- Non-Executive Director (shareholder) Surrey Club for Young People (Trustee of the Charity)

Michael Fanning	Director of Nursing, Midwifery and Allied Health Professionals	Yes	• Senior Clinical Fellow, Faculty of Health, social Care and Education, Kingston University
Dr James Gillgrass	Non-Executive Director	Yes	• Trustee Croydon Post-graduate Medical Centre • Member Whitgift Foundation Care Committee • Daughter is Associate Director of Primary Care Transformation at Wandsworth CCG.
Matthew Kershaw	Interim Chief Executive (1 October 2018 to present)	Yes	• Visiting Senior Fellow - Kings Fund
John Goulston	Chief Executive (Retired 30 September 2018)	Yes	• Member of the One Croydon Alliance Board (Croydon Health and Care Transformation Board) • Acute Provider Lead South West London Health & Care Partnership (STP) • Member of the SWL Acute Provider Collaboration Board
Hannah Miller	Non-Executive Director	Yes	• Director - Hannah Miller Ltd • Non-Executive Director - L&Q Living • Non-Executive Director - Hesley Group Ltd • Independent Chair-Adult and Children Safeguarding Boards, London Borough of Hounslow
Azara Mukhtar	Director of Finance	No	None
Richard Oirschot	Non-Executive Director	Yes	• Director of R Oirschot Ltd • Non –Executive Board member of the Insolvency Service
Dr Nnenna Osuji	Medical Director	Yes	• Board Of Trustees - Norbury Manor Academy • Council Member - Faculty of Medical Leadership and Management
Melissa Morris	Director of Operations (Planned) -1 April 2018 to 30	No	None

	November 2018 Acting Director of Business Development, Strategy & Performance - (1 December 2018 to present)		
Samantha Goldberg	Director of Operations (Emergency) (resigned 3 February 2019)	No	None
Adam Womersley	NeXT Non-Executive Director (Not Remunerated) (appointed 28 June 2018)	Yes	• Sales Director- Danone (Alpro) • Shareholder of Danone.

Statutory statement on Modern Slavery

Modern Slavery Act 2015: Annual Statutory Statement 2018/19

CHS is aware of its responsibility towards patients, employees and the community which it serves. The Trust supports the Government's objectives to combat modern slavery and human trafficking and understands the significant role the NHS has to play in supporting victims.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015. The statement is subject to Board approval in July 2018. It acknowledges steps taken by the Trust in the last financial year and the plans for continued compliance.

Who We Are

CHS is an organisation providing acute and community health services across the largest London Borough, with a population of more than 380,000 residents. The Trust employs over 3,900 staff and has a dedicated team of 420 volunteers. More than a third of our staff work within our community services, alongside our partners in primary care and social services, to care for people in and out of hospital. The Trust runs two hospital sites covering both north and south of the borough: CUH is our main hospital and includes one of busiest Accident & Emergency Departments in South London. Our community services include nursing, health visiting, home therapies, school nursing, homeless health, sexual health and Children's Hospital At Home.

Further details as to our services can be found on our Website.

Policies and initiatives

The Trust provides a programme of advice and training on slavery and human trafficking in respect of adults and children. Through our Safeguarding Team, front line staff can access guidance and advice to ensure they are aware of and be able to respond to potential incidents of modern slavery within care settings. There are Trust wide policies for safeguarding adults and children which were ratified in July 2017. Flow charts are available throughout the wards to help staff identify and escalate concerns. During our CQC inspection in October/November 2017, inspectors confirmed that staff spoken to knew how to recognise abuse and how to report it. Although compliance with safeguarding adults level 2 and 3 training programme is not fully compliant, the Trust has action plans in place and compliance is monitored by our Human Resources Department.

People

The Trust's recruitment process ensures that we check the identity of new employees and their right to work in the UK. The Trust follows NHS Agenda for Change Terms and Conditions which provides staff with fair pay rates and contractual terms. Our Dignity at Work, ABC, Grievance and Freedom to Speak Up policies provide additional platforms for employees to raise concerns about poor working practices.

Procurement & Supply Chain

CHS also acknowledges that slavery and human trafficking can be less visible through procurement and other contractual supply chains. The Trust expects all its suppliers of goods and services to adhere to ethical values and comply with the requirements of the Modern Slavery Act 2015. The Trust has introduced evidence gathering questions in its tendering processes for contractual relationships to ensure that we only engage with those businesses which can provide the assurances of compliance. When procuring goods and services, the Trust additionally applies the NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement) – both of which requires suppliers to comply with this Act.

Mike Bell on behalf of the Board of Directors:
Dated: 28 May 2019

Corporate Governance report

Annual Governance Statement 2018/19

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of CHS, 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 CHS for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

While executive directors are full time employees who manage the daily running of the Trust, the entire Trust Board takes collective responsibility for setting the strategic direction and for holding the executive to account for the Trust's performance. The Trust Board is also accountable for upholding high standards of governance and probity. The Executive Director for Human Resources and Organisational Development has executive responsibility for the system of risk management which is led on his behalf by the Company Secretary.

The Trust Board approved framework for risk consists of the:

- Risk Management Strategy which seeks to ensure that appropriate systems of internal controls are in place to oversee, monitor and manage risk within the Trust.
- Risk registers which document risks at every level of the Trust alongside actions to control, mitigate or resolve each risk.
- The Board Assurance Framework which focuses on assurance and links the high level risks to each of the Trust's objectives.

- The Assurance Map which identifies where assurance is provided and the strength of the level of assurance provided.
- The Risk Assurance and Policy Group monitors risk and undertakes a programme of deep dives across all the directorates with appropriate challenge and scrutiny.
- The Audit Committee receives and discusses the Corporate Risk Register, Board Assurance Framework and Assurance Map and undertakes a number of deep dives into areas of concern.
- The Public Trust Board meeting receives and discusses the Corporate Risk Register, Board Assurance Framework and Assurance Map

Together these support the development of an organisational culture whereby effective risk management is an integral part of providing healthcare and day to day decision making.

The Board Assurance Framework and the Assurance Map provide a high level assurance process which enables the Trust to focus on those risks which will impact upon its strategic objectives and the ways in which assurance is given that these risks are mitigated or managed to an acceptable level. Responsibility for maintaining the framework rests with the Trust Company Secretary.

As part of good risk management practice the Trust has undertaken an annual review of the Corporate Risk Register and has worked with all directorates to ensure that their risk registers reflect all risks and that the cause and effect of risks are fully understood.

Training is undertaken on a Trust wide basis including basic risk management identification and understanding of a working and effective risk register. The Trust uses Datix, a digital solution to manage and record incidents and risks and appropriate training is provided.

Discussions at the Risk Assurance and Policy Group enable directorates to discuss the risks faced by the Trust and learn from other Directorates. The use of cause and effect enables members to understand the links between risks and manage them appropriately.

The risk and control framework

The Trust Board and its Committees

The Trust Board is accountable through the Chairman and Chief Executive to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. The Trust Board at 31 March 2019 consisted of the Chairman, seven Non-Executive Directors, an Interim Chief Executive, Medical Director, Director of Nursing, Midwives and Allied Health Professionals, Director of Finance and a Director of Human Resources and Organisational Development as outlined below.

The membership of the Trust Board is balanced and appropriate and members possess a wide range of skills and ring experience gained from NHS organisations,

other public bodies and the private sector. The Trust Board has the capability and experience necessary to deliver the Trust's operating plan and the governance structure for the Trust is appropriate to assure the Trust Board of this delivery. During the year membership of the Trust Board has changed as follows:

- Following the resignation of Jayne Black on 19 April 2018 the fifth voting member of the Board moved to Michael Burden, Director of Human Resources and Organisational Development on an interim basis.
- Following the retirement of John Goulston, Matthew Kershaw was appointed interim Chief Executive as at 1 October 2018.
- Dr Nnenna Osuji was appointed Deputy Chief Executive as well as continuing in her role as Medical Director on 1 November 2018

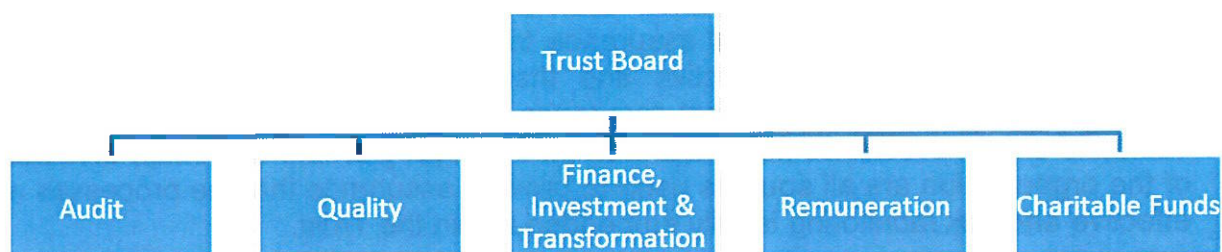
The Trust Board met in public on four occasions as agreed and the table below sets out the level of attendance by Trust Board members:

		25 April 2018	25 July 2018	31 October 2018	30 January 2019
Michael Bell	Chairman	✔	✔	✔	x
James Gillgrass	Non-Executive Director	✔	✔	✔	✔
Louise Cretton	Non-Executive Director	✔	x	✔	✔
Hannah Miller	Non-Executive Director	✔	✔	✔	✔
Godfrey Allen	Non-Executive Director	✔	✔	✔	✔
Michael Bailey	Non-Executive Director	✔	✔	x	✔
Steven Corbishley	Non-Executive Director	✔	✔	x	x
Richard Oirschot	Non-Executive Director	✔	✔	✔	✔
John Goulston	Chief Executive	✔	✔	n/a	n/a
Matthew Kershaw	Interim Chief Executive	n/a	n/a	✔	✔
Dr Nnenna Osuji	Medical Director	✔	✔	✔	✔
Michael Fanning	Director of Nursing, Midwifery & AHPS	✔	✔	✔	✔
Azara Mukhtar	Director of Finance	✔	✔	x	✔
Michael Burden	Director of HR and OD	✔	✔	✔	✔

The Trust Board also met in private on 11 occasions and the table below sets out the level of attendance by Trust Board members:

		25 April 2018	23 May 2018	27 June 2018	25 July 2018	26 Sept 2018	31 Oct 2018	28 Nov 2018	19 Dec 2018	30 Jan 2019	27 Feb 2019	27 March 2019
Michael Bell	Chairman	✔	✔	✔	✔	✔	✔	✔	✔	X	✔	✔
James Gillgrass	Non-Executive Director	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Louise Cretton	Non-Executive Director	✔	✔	✔	X	✔	✔	✔	✔	✔	X	✔
Hannah Miller	Non-Executive Director	✔	✔	✔	✔	✔	✔	✔	✔	✔	X	X
Godfrey Allen	Non-Executive Director	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Michael Bailey	Non-Executive Director	✔	✔	✔	✔	✔	X	✔	✔	✔	✔	✔
Steven Corbishley	Non-Executive Director	✔	✔	X	✔	✔	✔	✔	✔	✔	X	X
Richard Oirschot	Non-Executive Director	✔	✔	✔	✔	✔	✔	✔	✔	✔	X	✔
John Goulston	Chief Executive	✔	✔	✔	✔	✔	n/a	n/a	n/a	n/a	n/a	n/a
Matthew Kershaw	Interim Chief Executive	n/a	n/a	n/a	n/a	n/a	✔	✔	✔	✔	✔	✔
Dr Nnenna Osuji	Medical Director	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Michael Fanning	Director of Nursing, Midwifery & AHPS	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	X
Azara Mukhtar	Director of Finance	✔	✔	✔	✔	✔	X	✔	✔	✔	✔	✔
Michael Burden	Director of HR and OD	✔	✔	✔	✔	X	✔	✔	✔	✔	✔	X

The Trust Board has five committees that directly report to it as follows:



During the year the Trust Board reviewed the governance structure and made some changes. Recognising the need for additional focus and scrutiny on investment and transformation the Finance and Performance Committee's terms of reference were reviewed and amended to include additional focus upon these areas and the name of the Committee was changed to Finance, Investment & Transformation Committee to align with this new remit.
At the same time it was recognised that performance was an inherent element of the quality agenda and changes were made to the Quality and Clinical Governance Committee's terms of reference to reflect this and recognition that clinical governance formed a part of the quality agenda and was not separate to it. Recognising that Quality was the overarching element the name of the Committee was changed to Quality Committee.

As part of the Trust's integration agenda two members of Croydon Clinical Commissioning Group (CCCG) were invited to become members of the Quality Committee to enable more robust and effective quality discussions to take place for the benefit of the people of Croydon. As the year has progressed integration has progressed further and in March 2019 the Trust held its first Finance, Investment and Transformation Committee in Common with CCCG which recommended to the Trust Board the approval of a Joint Control Total for both organisations further recognising the need for both organisations to have one plan delivering one control total wherein both organisations share both the risks and the benefits to enable a more integrated approach to healthcare.

The Audit Committee received at each of its meetings the Corporate Risk Register, Board Assurance Framework and Assurance Map and discussed these documents providing challenge where appropriate. It also undertook a number of deep dives during the year on key areas identified. In particular the Audit Committee received a regular deep dive in relation to Cyber Security recognising the importance and significance of this to the Trust.

Risk Management Process

The Risk Management Strategy describes the approach the Trust will take to identifying, managing and mitigating risk. Each directorate maintains a risk register which sets out risks identified across the directorate to ensure that risks are identified by all staff including clinical staff. The Strategy sets out how risks are scored and how risks are escalated ensuring that risks are managed and controlled with appropriate oversight at the appropriate level. Risks are escalated for inclusion on the Corporate Risk Register where the level of risk is identified to have a significant

impact on the Corporate Objectives and thereby the running of the Trust. These would be risks that score 15 or above on the risk matrix.

The Committees provide internal assurance to the Trust Board that the mitigations and controls in place are effective and that the risks are well managed. The Assurance Map provides additional assurance indicating where the Trust Board can seek and obtain assurance from. The Internal Audit programme and external reviews of the organisation are all sources used to provide assurance that the processes are effective and risk monitoring is fully embedded within the Trust.

Risks can be identified through many sources including proactive risk assessments, strategic planning, performance data, patient and public feedback, incident reporting, clinical benchmarking and external stakeholders including the Care Quality Commission (CQC), NHS Improvement and Dr Foster Intelligence. There are clear examples of risk being identified at all levels of the Trust showing that risk is "ward to Board" and vice versa.
Risks to the Trust's strategic objectives are identified and tracked in the Board Assurance Framework which includes details of mitigations and controls in place and the current level of risk after the controls are already in place. The Board Assurance Framework also identifies the need for further actions and the effectiveness of actions and controls.

During the year the following risks were identified on the Corporate Risk Register:

Risk Description	Risk Mitigation and Control
If the Trust was to be targeted by a cyber-attack or hack, this could lead to an outage of critical clinical systems and confidential data	The Trust has implemented a revised governance structure including a Task and Finish Group to identify, review and monitor delivery of security and legal standards as set out in NHS Digital's Data Security and Protection Toolkit. This group reports to the IT Steering Group. The Trust has developed a Cyber Security Action plan which is monitored by the Cyber Security Board which is attended by a Non-Executive Director and chaired by the IT Director.
If the Trust does not take action to update its IT security and controls it will not meet mandated or minimum legal standards.	Following the risk being identified it was incorporated and managed as part of the cyber risk.
Lack of IT equipment and access to network in community which could lead to delays in inputting patient care data and increase the workload of community staff.	Following the risk being identified additional funding was secured which reduced the level of risk and the risk was only on the Corporate Risk Register for less than a month.
Difficulty in attracting, recruiting and retaining high calibre and skilled workforce. In addition during the year risks were specifically	The Trust has implemented a number of controls including a comprehensive Workforce Strategy and has undertaken an overseas recruitment exercise for hard to recruit to nursing posts. The Trust has developed effective succession plans

identified in relation to specific staff groups including community maternity and midwifery staffing, which could lead to inconsistent patient care, poor patient experience and have an adverse impact on staff morale.	across together with a robust rotation and secondment policy. The Trust is also developing a number of different ways of engaging and communicating with staff to better understand any issues or concerns.
Capacity to deliver adequate level of Health Visitor service at all levels including mandated contacts including new birth visit which could lead to poor patient experience and the Trust not achieving the relevant KPIs.	The Trust put in place a recruitment and a retention strategy specifically targeted towards Health Visitors which included targeting students who were due to complete their training and offering bespoke continuous professional training and a development programme embedded within the service. The work undertaken has enabled the level of risk to reduce and is no longer on the Corporate Risk Register.
If the Croydon health and social care system is unable to work together to create a sustainable plan for all the organisations within it, there is a risk that one or more organisations will not be able to demonstrate financially sustainable plans resulting in actions being taken by their regulator.	The Trust has submitted an Operating Plan to NHSI in line with the agreed Pre-central funding deficit of £13.2m for 2019/20 and a breakeven position after central funding. This requires the delivery of £14.3m CIPs and an increase in elective, day case and outpatient activity. For 2019/20 the Trust has agreed a joint control total and a risk share with CCCG. The Joint control total incentivises the correct behaviours to ensure system sustainability across the 2 organisations. Work is underway to further incorporate social care and other partners via the One Croydon Alliance. The operating plan is challenging and there are currently risks to identifying and delivering the CIP target recurrently. To mitigate this risk, the Trust and CCCG have aligned planning assumptions and operating plans for 2019/20 to ensure both parties are working to the same plans with no system disincentives. In addition, a joint PMO between the Trust and Croydon CCG is being developed in April to ensure governance and monitoring is in place. Furthermore accountability is being strengthened by setting up a Weekly Cost and Quality Oversight Board (CQOB) jointly chaired by Trust DoF and CCCG CFO with clinical and operational input to review all CIPs, QIPPs, activity and productivity to drive delivery, monitor progress on activity, income and expenditure.
If the Trust is unable to manage the level of emergency demand, it may fail to meet the agreed type 1 and type 3 trajectory agreed	The Trust has implemented a High Impact Improvement Programme which has four key workstreams, each led by an Executive Director and an Operational Lead with dedicated Programme Management Office resource. The four workstreams

and set by the system Accident & Emergency Delivery Board of 90% in September 2018 and 95% in March 2019.This will have an impact on patient wait times and experience and hospital reputation.	relate to: • Emergency Department flow and process • Discharge Planning • Emergency Care flow and medical model of care • 24/7 Operational management. Each work stream includes a plan of delivery with clear measurement of the impact of the change and its effect on minimising breaches of the four hour standard. This is identified as a significant issue for 2019/20.
Environment in ITU/HDU identified as not being fit for purpose due to close proximity of patients which contributes to an infection control hazard and lack of storage space.	The Trust has undertaken a number of mitigations to ensure that there is enhanced environmental and near patient cleaning and hand hygiene and is part of a mitigations plan to include increased infection control measures.
Lack of CUH / System capacity to adequately care for Mental Health Patients which could lead to poor patient experience, reduced outcomes and an adverse impact on staff morale.	In line with most health economies system capacity for mental health has proved challenging over the year. The Trust has seconded a Head of Nursing for mental health to provide greater oversight and scrutiny and a monthly report is now presented to Executive Management Board, Quality Committee and Finance, Investment & Transformation Committee with concerns escalated to the Trust Board as appropriate. In addition our new Emergency Department has improved facilities for mental health patients. Over the year, due to the effectiveness of the mitigations in place the risk has reduced and is no longer on the Corporate Risk Register.

The identification of the key risks faced by the Trust is an important process and one that the Trust is undertaking as part of an ongoing risk refresh which has and will include discussions with directorates, the Executive Management Board and the Board sub-committees. This will then form a discussion paper for a risk workshop with the Trust Board with the expectation that these risks will link into the four strategic priorities that the Trust has namely high quality patient care, supporting staff, sustainable finances and improving health for all. Once this work is complete it will be shared with the organisation and will form part of the Board Assurance Framework process.

Potential Significant Issues for 2019/20

Whilst the risk refresh is ongoing the Trust has identified the following three significant issues that it is likely to face for 2019/20.

1. Ability to achieve agreed A&E 4 hour performance.

   The Trust is not currently achieving the national standard to see and admit, or treat and discharge 95% of patients that present to A&E within four hours. The key drivers of this under performance are rising demand, increasing acuity, staffing shortages, increasing numbers of long staying patients and high levels of inpatient bed occupancy. The Trust is currently working towards a revised A&E performance trajectory which aims to deliver 90% by the end of March 2020.

   The Trust has implemented a High Impact Improvement Programme which has four key workstreams, each led by an Executive Director and an Operational Lead with dedicated Programme Management Office resource. The four workstreams relate to:
   - Emergency Department flow and process
   - Discharge Planning
   - Emergency Care flow and medical model of care
   - 24/7 Operational management.

   Each workstream includes a plan of delivery with clear measurement of the impact of the change and its effect on minimising breaches of the four hour standard.
2. Difficulty in attracting, recruiting and retaining high calibre and skilled workforce.
   The Trust has high vacancy levels particularly in respect of band 5 nurses and other specialist areas. The Trust has a robust Workforce Strategy in place which will address the issues identified whilst recognising that our workforce is the Trust's greatest asset.
3. Inability to deliver the Cost Improvement Programme and thereby achieve the joint control total.

   The Trust has a very challenging Cost Improvement Programme (CIP) needed to achieve the joint control total agreed with the CCG.

   To enable delivery of the joint control total the Trust has developed integrated working with the CCG including joint planning and shared risk thereby enabling the early identification of any areas of concern and a joint approach to resolving the issues for the benefit of both organisations and thereby the residents of Croydon.

Workforce

The Trust recognises that its workforce is not only its greatest asset in terms of delivering sustainable change but also is the primary driver of future costs, and cost control. Our workforce plans have therefore been designed to consider specific local pressures, local integrated care and the NHS 10 year plan.

The Trust needs to employ more staff in certain areas and improve how it retains, manages and develops its existing workforce as well as ensure that our workforce requirements continue to be at the levels to accommodate safe and effective service delivery needs. The Trust has a vital role to play in providing high quality patient care and improving the health and wellbeing of the local community. A workforce that represents the local community is fundamental in creating the inclusive environment in which the Trust can continue to ensure the highest standards of health care provision and commissioning are achieved through the calibre and commitment of its workforce, both individually and collectively in teams. To do this, the Trust must have the right numbers of staff with the appropriate skills and experience to deliver services.

The Trust also needs to take into account the results of the staff survey and in particular a number of key themes. These themes include lack of communication, not feeling supported by management, lack of recognition, senior management not being visible in clinical areas and staff not understanding how their roles relate to overall Trust priorities. All of these themes will impact on the retention of our staff and also the Trust's ability to recruit staff and our workforce plans seek to address these areas.

The overriding outcome is to ensure that our approach to workforce planning ensures that we are recruiting the right numbers of staff with the right skills and behaviours to meet the needs of our patients, recognising that the way we deliver services will change through the lifetime of the Plan.

The Trust has developed a comprehensive Workforce Strategy with four key aims:

1. To recruit and retain the best staff with the right range of skills, experience and qualities to meet the demands of an integrated care organisation based on high quality services.
2. To develop and promote a range of employment models, policies and excellent practice that support the values and vision of the Trust, including a greater emphasis on flexible employment, excellent HR Management practice, high performing employees, quality, personal ownership and accountability.
3. To become an employer of choice by improving the quality of the work experience and enhance employee well-being.
4. To underpin the above with strong, inspirational leadership and performance management.

Our strategic aims are fully integrated with delivery of performance and quality standards and targets and are monitored via various sub committees of the Board. Specific workforce agendas are discussed at the Trusts People and Organisational Development Committee which regularly reviews the wider workforce issues on a bi-monthly basis, before seeking final ratification from the Trust Board.

The Trust has an integrated performance dashboard at Trust Board level. This has been developed to align the Trusts overarching scorecard metrics with those in the quality report as well as the finance and HR reports at each level within the organisation. This triangulated reporting uses key indicators: Friends and Family Test (patients and staff), workforce turnover, sickness absence, vacancy rate temporary costs, stability index, staff core skills training and appraisal compliance.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC), the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive car that meet fundamental standards. The CQC has not taken any enforcement action against the Trust.

Disclosures

Register of Interests

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance and is fully compliant for Board members. However, the Trust was subject to a Quality Inspection on 23 and 24 October by NHS Counter Fraud Authority Services which identified that there was limited evidence of registers being actively managed, reminders being sent to staff nor a complete and comprehensive register provided with nil returns. This did not relate to Trust Board members whose interests were appropriately managed but related to the wider staff and in particular all band 7 staff and above. Following the outcome of the assessment an action plan has been put in place and a digital solution to manage the declarations will be in place from April 2019.

Fit and Proper Persons

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Condition 4 of the Provider Licence the Trust has an effective system in place to assess all Board Directors as being Fit and Proper Persons to be Directors of the Trust. The process is also used for other senior members of the Trust including deputies.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

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

Sustainability

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

Information governance

The Trust successfully completed submission of the new Data Security and Protection toolkit completing 34 of the 40 mandatory assertions. The remaining six assertions relate to IT systems and their management. An improvement plan was submitted to NHS Digital to review covering the six remaining assertions. The plan has been approved and the Trust's status is "Standards not fully met (plan agreed)" which is considered sufficient assurance. The Trust has agreed to complete the remaining assertions by the end of September wherein it will achieve a status of "Standards Met". As part of the Internal Audit programme, the auditors undertook a review of the toolkit and the Trust received a Reasonable Assurance report.

Data Protection and Security incidents

The Trust continues to promote and encourage data protection incident reporting to support and build secure systems and processes. The Trust self-reports breaches categorised as potentially capable of causing harm (level 2 incidents) using the toolkit reporting facility and these breaches are captured in the table below:

Description of breaches	Number of incidents
Lost or stolen paperwork	3
Data posted or faxed to the incorrect recipient	3

Two incidents were reported to the Information Commissioner Office (ICO) relating to a stolen computer (resulting in no further action from the ICO) and a stolen medical device. The latter incident occurred at the end of the reporting period where the medical device (also a computer) was stolen from a locked room. The incident has been notified to the ICO and the Trust is currently responding to a number of questions and will await the outcome from the ICO. The Trust will work to implement any advice and lessons learned from the incident.

Freedom of Information Act Requests

The Trust self-reported to the Information Commissioner on the 28 September 2018 that due to a number of reasons the Trust was not complying with the Freedom of Information (FOI) Act. A total of 439 FOI requests were identified as having breached and not responded to over a period of approximately 9 months. A robust plan was put in place to complete all outstanding requests whilst at the same time responding to current requests in a timely manner. The backlog was completed in January 2019. Currently over 80% of FOI requests are responded to within time and the Trust is moving towards a 90% response rate during 2019/20.

Annual Quality Account

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

The formulation of the Quality Account has been led by the Quality, Safety & Experience Manager (Compliance & Audit), on behalf of the Director of Nursing, Midwifery and Allied Health Professionals, to meet all relevant Department of Health and Social Care requirements. It provides a retrospective of the year's identified quality priorities, overall quality progress and performance, the quality priorities for the coming year and how the Trust is working to improve quality of care under the headings of safety, effectiveness and experience.

The quality account includes a section on mandated topics, e.g. clinical audits and reports against the achievement of national standards. This includes elective waiting time performance data e.g. Referral time to Treatment (RTT) and Cancer.

During 2018 there was an external assurance process undertaken by the Intensive Support Team (IST) who completed an end to end review of the RTT elective waiting list to ensure the quality and accuracy of the data. The review looked at how the data was processed through the Trust's systems, to ensure compliance with national guidance, through to the final presentation of the data to the Operational Teams. The NHS Improvement Elective Care Support Team provided feedback following the review which was incorporated into a specific Trust action plan which is monitored and reported monthly and an update included as part of the RTT paper. One of the subsequent improvements was the resultant new 'live' Patient Tracking List (PTL) which supports live validation of data to ensure accuracy as well as productivity. The PTL is monitored and discussed weekly at specific PTL meetings. The performance is reported each month to the Executive Management Board, Quality Committee, Performance Meetings and Trust Board.

The progress of preparation and finalisation of the Quality Account is monitored closely by the Executive Management Board, the Quality Committee (attended by the CCG) and the Audit Committee. Prior to publication the Quality Account is reviewed and signed off by the Executive Management Board, the Quality Committee, the Audit Committee and the Trust Board.

Modern Slavery Act 2018/19 Annual Statement

The Trust is committed to ensuring that no modern slavery or human trafficking takes place in any part of its business or supply chain. The Trust is fully aware of the responsibilities we bear towards our service users, employees and local communities. Are have a zero tolerance for slavery and human trafficking and staff are expected to report concerns about slavery and human trafficking and management will act upon them. The Trust also expects those companies that the Trust does business with to adhere to these same principles. The Annual Statement is discussed at Executive Management Board prior to sign off by the Trust Board.

Emergency Preparedness

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS Emergency Planning Guidance 2005

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

The Trust agreed a control total of £15.1m deficit before Provider Sustainability Fund (PSF) funding of £12.2m, resulting in a post PSF control total of £2.8m deficit. Earning PSF was based on a combination of meeting quarterly control total and A&E trajectories. The plan was predicated on £7.8m of additional elective activity the delivery of £19.2m of Cost improvement Plans (CIPs). The Trust is assessed on its adjusted financial performance. On this basis the Trust has successfully achieved a 2018/19 surplus of £1.5m (post Provider Sustainability Fund (PSF)). This has improved the planned deficit of £2.8m by £4.3m. The Trust lost A & E PSF reward of £3.7m which was offset by a final additional PSF settlement from NHSI of £8m. This is the first time the Trust recorded a surplus (after technical adjustments for impairments and impact on capital grants and donations which are not included in financial performance) since incurring financial performance deficits for the last five years consecutively. The Trust overperformed on additional elective activity, which required additional expenditure, and this helped to mitigate the shortfall on the CIPs which were also bolstered by non-recurrent income and expenditure reductions.

During 2018/19 the recommendations from both the independent review of why the Trust had missed its 2017/18 control total and the internal audit review of the 2017/18 Cash Releasing Efficiency Savings were implemented. The reports were presented to the Audit Committee together with progress on recommendations implementation with the majority of these being in place before the start of the 2018/19 and the remainder implemented by the end of quarter one. Internal Audit reviewed the CIP controls, delivery and governance and gave reasonable assurance as opposed to limited assurance in 2017/18 in recognition of the changes made in 2018/19. Internal Audit complete a review of budget setting every year and the assessment of the controls and governance were once again rated as reasonable in 2018/19. One of key changes was the implementation of timely mitigation actions when the plan was seen not to be delivering.

The Trust started to work closer together with Croydon CCG (CCCG) during the summer of 2018 and held a number of board to board meetings and explored the concepts of closer alignment. In the autumn of 2018 the Trust and CCCG Chairman and Chief Executive and Accountable Officer asked the Trust Director of Finance (DoF) and CCCG Chief Finance Officer (CFO) to develop a joint control total for 2019/20 and to align the 2018/19 financial positions. The DoF and CFO had already been holding meetings with the Trust and CCCG Chairs of their respective Finance Committees for over a year so that both parties could understand each other's respective finance positions.

The DoF and CFO began working with their senior managers and those across contracting and information in joint forums from November 2018 onwards. This joint working and analysis allowed a year end deal on 2018/19 to be agreed in mid-January 2019, earlier than ever before, and allowed both organisations to concentrate on developing a joint activity and financial plan for 2019/20. The plans were presented to the respective finance committees in March and both organisations recommended acceptance of their respective control totals. A

Finance Committee in Common was convened where both organisations recommended acceptance of a joint control total. The papers for the Finance Committee in Common explained both the Trust and CCCG financial plans together with their CIPs and Quality Innovation Productivity & Prevention (QIPPs), contracting arrangements, risk shares and risks and mitigations to delivery of the control totals. The Trust Board received all of the papers together with the Trust Finance Investment and Transformation Committee recommendations together with those from the Finance Committee in Common and formally accepted the Trust control total and the joint control total.

The Trust has accepted a pre Marginal Rate Emergency Threshold (MRET), Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) control total of £13.2m deficit. If the Trust meets its quarterly control total trajectories it will receive up to £13.2m of support funding resulting in a post MRET, PSF and FRF control total of breakeven. CCCG has accepted a £3.5m surplus control total. This means the Trust and CCCG have agreed a joint control total of £9.7m deficit pre MRET, PSF and FRF and a post MRET, PSF and FRF of £3.5m surplus. The financial governance and monitoring systems to support delivery of the control totals will be finalised in April 2019 and will include weekly monitoring of KPIs covering market repatriation activity and CIP and QIPP delivery. This will be supported by a joint PMO and Transformation resource. A monthly Finance Committee in Common will be established to govern the Finances of both organisations.

Contracts were signed in the last week of March 2019 and therefore the final budget setting paper will be presented to the May 2019 Finance Committee and Board for approval. Budgets will incorporate the output of the directorate agreed activity, expenditure and workforce less the agreed CIP targets and including repatriation targets by specialty.

Review of effectiveness

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

In support of this:

- The Head of Internal Audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. Internal audits carried out have provided assurance from substantial assurance through to limited assurance and management have

accepted and taken action to address recommendations made.

- The Trust Board, the Audit Committee, Executive Management Board, Directorate Performance Reviews and the Risk Assurance & Policy Group reviews risks to the delivery of the Trust's performance objectives through periodic monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety, quality and workforce.
- The Board Assurance Framework, Corporate Risk Register and Assurance Map provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives which are regularly reviewed. Internal audit has rated the framework as providing reasonable assurance.
- The Audit Committee oversees the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust Board it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate. The Committee regularly receives reports on internal control and risk management matters from the internal and external auditors.
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- NHS Improvement's Single Oversight Framework provides a structure for overseeing Trusts and identifying potential support needs. The framework looks at five these: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability (well led). Trusts are then rated from one to four according to these themes with a four being those who need the most support. The Trust is currently rated as a three within the framework reflecting the Trust's financial and operational challenges as outlined in this Governance Statement.
- Noting that I have not been the Accountable Officer for the entire period of the Annual Governance Statement, a copy has been shared with my predecessor who was content that it was an accurate reflection of the Trust, its processes and the challenges faced whilst he was the Accountable Officer. In addition when I joined the Trust, and prior to my commencement with the Trust, I received a thorough handover from my predecessor and a full induction programme with staff and key stakeholders including CCCG to enable me to fully understand any issues, concerns or risks that the Trust was facing. Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; patient led assessments of the care environment.

I can confirm, having taking all appropriate steps to be aware of potential steps to be aware of potential breaches or failure to comply, that arrangements are in place for the discharge of statutory functions have been checked for any irregularities and that they are legally compliant.

Conclusion

The Trust Board is committed to continuous improvement of its governance arrangements to ensure that systems are in place that ensure risks are correctly identified and managed and that serious incidents and incidence of non-compliance with standards and regulatory requirements are escalated and are

subject to prompt and effective remedial action so that the patients, staff, public and stakeholders of CHS can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

I consider that any significant issues are detailed in the body of the Annual Governance Statement above and that actions to address each of these areas are in place.

Matthew Kershaw, Interim Chief Executive
Date: 28 May 2019

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Matthew Kershaw, Interim Chief Executive
Date: 28 May 2019

Statement of directors' responsibilities in respect of the accounts

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

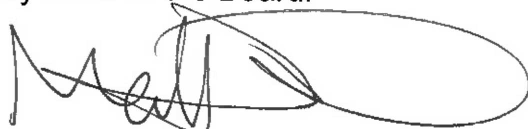
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

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

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

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

By order of the Board.



Matthew Kershaw
Interim Chief Executive
28 May 2019

Azara Mukhtar
Finance Director
28 May 2019

Independent auditor's report to the Directors of Croydon Health Services NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Croydon Health Services NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including 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 Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements which indicates the Trust has submitted a financial plan for 2019/20 to NHS Improvement which delivers a break-even position, assuming receipt of Provider Sustainability Fund income of £13.2 million and delivery of a £14.3 million savings programme. As stated in note 1.1.2, the delivery of the 2019/20 plan does not require cash support from the Department of Health and Social Care (DHSC) provided that the breakeven target is met, otherwise further cash loans will be required. The Trust has requested access to DHSC borrowing facilities but, as at the date of our report, this access has not been confirmed.

The Trust has a revenue loan of £55.89 million that will mature within one year and not later than two years. The Trust will need to write to DHSC to either request a new loan to repay the old or extend the maturity. These events or conditions, along with the other matters as set forth in note 1.1.2, indicate that a material uncertainty exists

that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.
- We have nothing to report in respect of the above matters except on 28 May 2019 we referred a matter to the Secretary of State:
- under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2019
- under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the Trust setting a deficit budget for the year ending 31 March 2020 and the resultant ongoing breach of the Trust's breakeven duty for the three-year period ending 31 March 2020.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement

when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects, Croydon Health Services NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust reported an adjusted financial performance surplus of £1.5 million in 2018/19. However, this was only delivered because of gains on disposals of assets and other one-off transactions. The Trust estimates that it had an underlying deficit of £25.3 million at 31 March 2019.
- The Trust's financial plan for 2019/20 budgets for a deficit of £13.2 million, prior to the receipt of Provider Sustainability Fund (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Fund (FRF) income. Should this deficit target be achieved, NHS Improvement will provide the Trust with PSF, MRET and FRF income totalling £13.2 million to enable the Trust to report an in-year break-even position. This funding will not be given to the Trust if it does not meet its deficit target. In order to meet its deficit target, the Trust must deliver challenging cost savings of £14.3 million, not all of which had not been identified at 31 March 2019.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget and developing savings plans. This matter is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

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 be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Croydon Health Services NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Grady

Paul Grady Paul Grady
Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor London

28 May 2019

Sustainability Report

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive and sustainable effect on the communities we serve. We must also be prepared for events such as heatwaves, cold snaps and flooding, which are expected to increase as a result of climate change.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to exceed this target by reducing our direct (scope 1 & 2) carbon emissions from 2013/14 levels by 30% by 2019/20.

Overall strategy

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. We consider sustainability in areas such as procurement and the impact of our suppliers.

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). Our Estates team and Sustainability Manger (Trust Sustainability Lead) have drafted a SDMP which is the process of being approved by the board. This reflects the Trust's vision for how we can adapt services to be more resilient to our changing climate, in particular developing new models of care with sustainability 'built in'. Examples being new GP hubs that provide more coordinated care and support and improved access to point of delivery teams.

We have developed and implemented several policies and protocols in partnership with other local agencies to account for potential future changes in heat waves, extreme temperatures and prolonged periods of cold, floods, droughts or other conditions.

We are also performing ongoing reviews of many other aspects of sustainability such as waste water, staff commuting distances and efficiency of the Trust utility systems.

Collaboration

We are working with other South West London Trusts to improve collaboration on sustainability and leverage collective purchasing power in areas such as utilities. An example is the collective procurement of water and water metering services which we completed over the last year. We have worked with Croydon Council on reducing our collective climate tax liability and we also plan to expand collaboration with the wider community on social and sustainability matters. Current community schemes include our One Croydon collaboration with Age UK to improve care of over 65's in the community. This has resulted in 62% fewer patients requiring care packages six weeks after hospital discharge.

promote the benefits of sustainability and wellbeing to our staff. These campaigns are backed up by staff surveys to measure the effects of the wellbeing and sustainability campaigns. We currently train our staff on a variety of sustainability, and safeguarding adults topics which include modern slavery. More details on out sustainable employment practices can be found on the policy section of our website.

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. For commissioned services here is the sustainability comparator for our CCGs; please note this is published a year in arrears.

Measuring performance

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (SDAT). We completed this earlier this year and scored 45%. Our performance areas are shown below and include starting to contribute to: clean water sanitation, affordable and clean energy, reduced inequalities and climate action.

Current performance

These are key measurements of our sustainability:

- Our direct carbon emissions (from energy) have gone down by 18.5% (to 10,602 tCO_2e) since 2013, whilst over the same period floor space has increased by 3% (new ED department) and the number of staff has increased by 4%. Direct emissions do not include areas such as travel, waste or procurement. The Trust has plans to reduce its direct emissions in the coming year to meet the target, which it has not yet met.
- Procurement makes up 76% of our overall carbon footprint and account for emissions estimated at 38,338 tCO_2e per annum. We consider the social impact of our procurement and where possible look to support the local economy and ensure that we procure ethically. We plan to investigate our two largest procurement categories, health care commissioning and pharmaceuticals, to develop plans to reduce the carbon footprint of these areas.
- Our total Trust electrical load has fallen by 9% from the site peak demand in 16/17. This has been achieved through a variety of energy saving projects including lighting upgrades.
- We measure the environmental impact of our travel. Staff commute emissions (estimated) have increased 28%, business travel emissions have reduced to 90% and patient transport emissions have reduced to 51% compared to what they were in 2013/14. We aim to improve its knowledge of lengths and type of

staff commuting in the coming year as we recognise that the national survey may not accurately reflect our staff commute profile given our South London location. This will enable us to better model emissions due to staff commuting and implement programs to reduce the environmental impact of staff commuting.

- We recognise the importance of reducing waste and in particular waste sent to landfill. Last year 1,707 tonnes of waste was created and 26% was recycled. We are currently undergoing a complete review of waste management with the aim of reducing cost and increasing recycling rates. We are also investigating alternative waste disposal methods to further reduce the environmental and carbon impact of its waste. Additionally we are looking to reduce incoming packaging waste delivered to site.
- We recognise clean water is a finite resource. Its use must be reduced and optimised. The Trust used 6% more water in 2018/19 than in 2017/18. In the coming year we plan to install half hourly meters to allow us to better understand our water use and to develop further ideas to reduce our water use.

A more detailed Sustainability Report, including graphs, is available at www.croydonhealthservices.nhs.uk/corporate-publications.

Remuneration and Staff report

Remuneration policy

The Chairman and Non-executive Directors form the Remuneration Committee, which is a sub-committee of the Trust Board. The committee determines the rates of pay and contracts of the Executive Directors against a Department of Health and Social Care framework.

During 2018/19, the committee was chaired by Non- Executive Director Louise Cretton.

Other members during the 2018/19 year were:

- Michael Bell
- Steven Corbishley
- Godfrey Allen
- Michael Bailey
- Dr James Gillgrass
- Jamal Butt
- Richard Oirschot
- Hannah Miller

The committee also monitors and evaluates the performance of the Executive Directors. This approach is consistent with the overall performance management ethos of the Trust, and ensures linkage to national targets and local priorities.

The committee's role is to ensure that the Executives are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance and to the provisions of any national arrangements for such staff where appropriate. Annual data comparison will continue to be made with other Trusts of a similar size to ensure that CHS continues to pay what is generally considered to be the market rate. No part of the Chief Executive's or Director's remuneration is subject to their performance (in other words they do not attract any kind of performance bonus).

My role as Interim Chief Executive is on a fixed term contract terminating on the 31st December 2019. The other Voting Directors are substantive and have notice periods of three months.

Matthew Kershaw
Interim Chief Executive
Date: 28 May 2019

Salary and pensions of senior managers (audited)

2018-19 Name & Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) Total (a to e) (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston, Chief Executive (retired 30 September 2018)	90 to 95	0.00	0.00	0.00	0.00	90 to 95
Matthew Kershaw, Interim Chief Executive (appointed 1 October 2018)	105 to 110	0.00	0.00	0.00	0.00	105 to 110
Azara Mukhtar, Director of Finance	125 to 130	0.00	0.00	0.00	15 to 17.5	140 to 145
Jayne Black, Deputy Chief Executive & Chief Operating Officer (resigned 19 April 2018)	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Michael Burden, Director of Human Resources & Organisational Development	120 to 125	0.00	0.00	0.00	0.00	120 to 125
Dr Nnenna Osuji, Medical Director	200 to 205	0.00	0.00	0.00	47.5 to 50	250 to 255
Michael Fanning, Director of Nursing, Midwifery and Allied Health Professionals	115 to 120	0.00	0.00	0.00	0.00	115 to 120
Lisa Chesser, Director of Planning & Informatics (redundant 7 September 2018)	105 to 110	0.00	0.00	0.00	0.00	105 to 110

Melissa Morris, Director of Operations (Planned)– (1 April 2018 to 30 November 2018), Acting Director of Business Development, Strategy & Performance - (1 December 2018 to present)	90 to 95	0.00	0.00	0.00	45 to 47.5	135 to 140
Sam Goldberg, Director of Operations (Emergency) (resigned 3 February 2019)	85 to 90	0.00	0.00	0.00	0.00	85 to 90
Michael Bell, Chairman	40 to 45	0.00	0.00	0.00	0.00	40 to 45
Godfrey Allen, Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Dr James Gillgrass, Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Steven Corbishley, Non-Executive Director (not remunerated)	NA	NA	NA	NA	NA	NA
Louise Cretton, Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Jamal Butt, Associate Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Mike Bailey, Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Hannah Miller, Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Richard Oirschot , Non-Executive Director	5 to 10	0.00	0.00	0.00	0.00	5 to 10
Adam Womersley, Non-Executive Director (not remunerated) (appointed 28 June 2018)	NA	NA	NA	NA	NA	NA

Note: All pension related benefits: where the calculation results in a negative figure the return will show zero as per DHSC Group Accounting Manual guidance.

2017-18						
Name & Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) Total (a to e) (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston, Chief Executive	180 to 185	0	0	0	-17.5 to 0	160 to 165
Azara Mukhtar, Director of Finance	125 to 130	0	0	0	5.0 to 7.5	130 to 135
Jayne Black, Deputy Chief Executive & Chief Operating Officer	125 to 130	0	0	0	-15.0 to 0	115 to 120
Michael Burden, Director of Human Resources & Organisational Development	110 to 115	0	0	0	-17.5 to 0	90 to 95
Dr Nnenna Osuji, Medical Director	200 to 205	0	0	0	27.5 to 30.0	230 to 235
Michael Fanning, Director of Nursing, Midwifery and Allied Health Professionals	110 to 115	0	0	0	-17.5 to 0	95 to 100
Lisa Chesser, Director of Planning & Informatics	105 to 110	0	0	0	20 to 22.5	130 to 135
Michael Bell, Chairman	40 to 45	0	0	0	0	40 to 45
Godfrey Allen, Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Dr James Gillgrass, Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Steven Corbishley, Non-Executive Director (not remunerated)	NA	NA	NA	NA	NA	NA
Louise Cretton, Non-Executive Director	5 to 10	0	0	0	0	5 to 10

Jamal Butt, Associate Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Mike Bailey, Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Hannah Miller, Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Richard Oirschot , Non-Executive Director (Appointed 1st September 2017)	0 to 5	0	0	0	0	0 to 5

Pension benefits 2018/19

Name	Title	Real increase / (decrease) in pension at pension (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase/ (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's Contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston	Chief Executive	-5.0 to -2.5	-2.5 to 0	60 to 65	190 to 195	1,506	-1,540	0	13
Azara Mukhtar	Director of Finance	0 to 2.5	-2.5 to 0	40 to 45	95 to 100	626	104	744	19
Dr Nnenna Osuji	Medical Director	2.5 to 5	0 to 2.5	50 to 55	115 to 120	737	149	902	27
Jayne Black	Deputy Chief Executive and Chief Operating Officer	-2.5 to 0	-5.0 to -2.5	50 to 55	150 to 155	1,063	84	1,171	1
Michael Burden	Director of Human Resources & Organisation Development	0 to 2.5	0 to 2.5	50 to 55	155 to 160	1,128	112	1,265	15

Lisa Chesser	**Director of Planning & Informatics**	-5.0 to -2.5	0 to 2.5	10 to 15	0 to 5	179	-29	154	6
Michael Fanning	**Director of Nursing, Midwifery and Allied Health Professionals**	0 to 2.5	0 to 2.5	50 to 55	150 to 155	1,042	113	1,179	17
Melissa Morris	**Director of Operations (Planned) and Acting Director of Business Development, Strategy & Performance**	2.5 to 5.0	2.5 to 5.0	15 to 20	25 to 30	142	59	204	12

Pension benefits 2017/18

Name	Title	Real increase / (decrease) in pension at pension (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Cash Equivalent Transfer Value at 31 March 2018	Real increase/ (decrease) in Cash Equivalent Transfer Value	Employer's Contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston	Chief Executive	0 to 2.5	0 to 2.5	60 to 65	190 to 195	1,388	1,506	78	26
Azara Mukhtar	Director of Finance	0 to 2.5	-5.0 to -2.5	35 to 40	95 to 100	564	626	46	18
Dr Nnenna Osuji	Medical Director	2.5 to 5	-2.5 to 0	45 to 50	115 to 120	675	737	42	27
Jayne Black	Deputy Chief Executive and Chief Operating Officer	0 to 2.5	0 to 2.5	50 to 55	150 to 155	976	1,063	59	18
Michael Burden	Director of Human Resources & Organisation Development	-2.5 to 0	-2.5 to 0	50 to 55	150 to 155	1,048	1,128	50	16

Lisa Chesser	Director of Planning & Informatics	0 to 2.5	0 to 2.5	10 to 15	0 to 5	147	179	28	16
Michael Fanning	Director of Nursing, Midwifery and Allied Health Professionals	0 to 2.5	0 to 2.5	50 to 55	150 to 155	960	1,042	54	17

Pay multiples

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 calculation is based in the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. This is shown in the table below:

	2018/19	2017/18
Band of Highest Paid Director's Total Remuneration	£210k to £215k	£200k to £205k
Median Total Remuneration of all staff	£25,478	£24,816
Remuneration Ratio	8.44	8.21
Number of employees who received remuneration in excess of the highest paid director	0	0
Remuneration for these staff ranged from:	NA	NA

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

Numbers of Senior Staff (by band)

The Trust employs the following senior staff in the organisation:

Band	2018-19 Headcount	2018-19 WTE	2017-18 Headcount	2017-18 WTE
Associate Specialist	13	12	13	12
Band 8A	143	134	141	135
Band 8B	44	44	41	41
Band 8C	20	18	25	24
Band 8D	16	16	16	16
Band 9	3	3	3	3
Consultant	208	192	187	175
Specialty Doctor	30	22	28	23
Staff Grade Practitioner	4	3	3	3
Very Senior Manager	6	6	8	8
Total	**487**	**450**	**465**	**440**

Staff costs

	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	129,242		129,242	127,495
Social security costs	14,379	336	14,715	14,237
Apprenticeship levy	675	0	675	654
Employer's contributions to NHS pensions	16,282	118	16,400	16,097
Temporary staff		38,385	38,385	34,580
Total gross staff costs	**160,578**	**38,839**	**199,417**	**193,063**
Of which Costs capitalised as part of assets	77	799	876	884

Staff numbers

The Trust employs a total of 3,912 permanent and temporary staff in the following staff groups.

Staff grouping	2018-19 WTE	2017-18 WTE
Administration & Estates Staff	459	485
Healthcare Assistants & Other Support Staff	1,169	1,153
Medical and Dental	517	506
Nursing and Midwifery Registered	1,348	1,310
Scientific, therapeutic and technical staff	419	433
Grand Total	**3,912**	**3,887**

Staff composition

Trust Total	2018-19 %	2017-18 %
Female	79	80
Male	21	20
Grand Total	**100**	**100**

Directors (Board level)	2018-19 Headcount	2018-19 %	2017-18 Headcount	2017-18 %
Female Executive	3	50%	4	57%
Male Executive	3	50%	3	43%
Female Non-Executive	2	20%	2	17%
Male Non-Executive	8	80%	10	83%
Total Female	5	31%	6	32%
Total Male	11	69%	13	68%
Trust Total	16		19	

Ethnic Origin	2018-19 Headcount
Asian or Asian British	555
Black or Black British	849
Chinese	37
Filipino	7
Mixed	124
Other ethnic group	159
Unknown	583
White	1,361
Trust Total	3,675

Trust-wide			
Category	BME	White	Unknown
Trust Workforce	47%	37%	16%

At Board Level			
Category	BME	White	Unknown
Directors	33%	50%	17%
Non Execs and Chair	20%	70%	10%

Sickness absence data

Staff Sickness Absence	2018-19 Number	2017-18 Number
Total Days Lost	29,999	29,069
Total Staff Years (average number)	3,326	3,357
Average working Days Lost (total day lost/staff years)	9.02	8.70

Staff disability policies

The Trust is an Employment Service disability symbol user (often referred to as Two Ticks) and has undertaken to implement the symbol's commitments, in letter and in spirit, across its HR policies for recruitment & selection and sickness & attendance management.
These include:

- To interview all applicants with a disability who meet the essential criteria for a post and to consider them on their abilities.
- To take action to ensure that all employees have attained the appropriate level of disability awareness, in order for the Trust to meet its commitments under the symbol.
- To ensure that reasonable adjustments are considered at all stages of the recruitment and selection process, in order to accommodate the particular needs of any disabled person, as defined in the Disability Discrimination Act 1995 and Disability Discrimination (Amendment) Act 2005."
- Make all reasonable adaptations and changes to the workplace/job to accommodate employees who are deemed disabled.

Reasonable adjustments might include but not limited to:

- Making adjustments to premises, duties, working hours
- Arranging training (and allowing time for the training)
- Acquiring or modifying equipment

Expenditure on consultancy

- The Trust spent £1.76m on consultancy. Consultants were hired to undertake work in relation to financial support on 2018/19 outturn, Cost Improvement Plan delivery, setting the 2019/20 Budgets, supporting year end agreement and greater collaborative working with Croydon CCG as well as supporting planning for 2019/20.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Departments and their arm's length bodies must publish information in relation to the number of off payroll engagements; more than £245 per day and more than six month that are/were in place within their organisation.

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months	2018-19 Number	2017-18 Number
Number of existing engagements as of 31 March 2018	11	42
Of which, the number that have existed:		
For less than one year at the time of reporting	5	12
For between one and two years at the time of reporting	3	19
For between 2 and 3 years at the time of reporting	0	5
For between 3 and 4 years at the time of reporting	1	4
For 4 or more years at the time of reporting	2	2

New Off-payroll engagements

All new off-payroll engagements or those that reached six months in duration, between 1 April 2018 and March 2019, for more than £245 per day and that last for longer than six months.

	2018-19 Number	2017-18 Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	9	10
Of which No. assessed as caught by IR35	0	1
No. assessed as not caught by IR35	9	9
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0	10
No. of engagements that saw a change to IR35 status following the consistency review	0	0

Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	10

Exit packages

	2018/19						2017/18					
	Compulsory Redundancies		Other Departure		Total		Compulsory Redundancies		Other Departure		Total	
	Number	£000	Number	£000	Number	£000	Number	£000	Number	£000	Number	£000
Exit package cost band (including any special payment element)												
<£10,000	2	13	0	0	2	13	0	0	0	0	0	0
£10,000 - £25,000	1	19	0	0	1	19	0	0	0	0	0	0
£25,001 - 50,000	2	67	0	0	2	67	0	0	0	0	0	0
£50,001 - £100,000	3	215	0	0	3	215	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0	0	0	0	0
Total by type	**8**	**314**	**0**	**0**	**8**	**314**	**0**	**0**	**0**	**0**	**0**	**0**

Exit packages: other (non-compulsory) departure payments- note

	2018/19		2017/18	
	Payment agreed		Payment agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	0	0	0	0
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Annual Accounts for the year ended 31 March 2019

Summary of 2018/19 financial performance

The table below sets out the Trust's Financial Targets, and its performance against these, in the 2018/19 Financial Year:

Target	Performance	Target met?
Breakeven on revenue and operating costs	The Trust posted a reported deficit of £15.1m pre Provider Sustainability Fund (PSF) and £1.5m surplus post PSF after technical adjustments for impairments and impact on capital grants and donations.	✓
Keep within the capital resource limit (CRL) of £11.952m (including £1.139m capital PDC)	The Trust remained within the CRL, and generated an underspend of £0.044m	✓
Remain within the external financing limit (EFL) of £15.831m	The Trust remained within its EFL by £1.085m	✓
Keep within a Capital Cost Absorption Rate (CCAR) of 3.5%	The Trust kept within the 3.5% CCAR. This has resulted in dividend payments of £2.508m to the Department of Health and Social Care.	✓

Further copies of these accounts can be obtained from:

PA to the Director of Finance
Croydon Health Services NHS Trust
530 London Road
Croydon
CR7 7YE
Tel: 020 8401 3563

Statement of Comprehensive Income for year ended 31 March 2019

	Note	2018/19	2017/18
		£000	£000
Operating income from patient care activities	3	284,017	271,264
Other operating income	4	34,827	21,852
Operating expenses	6, 8	(349,750)	(308,727)
Operating deficit from continuing operations		**(30,906)**	**(15,611)**
Finance income	11	84	36
Finance expenses	12	(1,864)	(1,705)
PDC dividends payable		(2,508)	(4,125)
Net finance costs		**(4,288)**	**(5,794)**
Other gains	13	2,210	0
Deficit for the year from continuing operations		**(32,984)**	**(21,405)**
Deficit for the year		**(32,984)**	**(21,405)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(44,468)	6,085
Revaluations	15	505	4,777
Total comprehensive expense for the period		**(76,947)**	**(10,543)**
Adjusted financial performance (control total basis):			
Deficit for the period		(32,984)	(21,405)
Remove net impairments not scoring to the Departmental expenditure limit		34,564	(911)
Remove I&E impact of capital grants and donations		(73)	165
Adjusted financial performance surplus / (deficit)		**1,507**	**(22,151)**

The items shown in Other Comprehensive Income and in the Adjusted Financial performance are:

a. The total of impairments charged to revaluation reserves due to adoption of modern equivalent asset (MEA) and completion of new Emergency Department (ED) building.

b. The negative impact on the deficit for the financial year, as a result of change in accounting estimation for valuation of lands and buildings i.e. adoption of MEA technique. Impairments are specifically excluded from measurement of the Trust's financial performance.

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	487	710
Property, plant and equipment	15	169,626	243,971
Receivables	20	1,008	727
Total non-current assets		**171,121**	**245,408**
Current assets			
Inventories	19	2,662	2,750
Receivables	20	33,516	20,661
Cash and cash equivalents	21	5,832	4,433
Total current assets		**42,010**	**27,844**
Current liabilities			
Trade and other payables	22	(38,887)	(38,582)
Borrowings	24	(57,024)	(27,218)
Provisions	26	(5,445)	(2,016)
Other liabilities	23	(1,042)	(939)
Total current liabilities		**(102,398)**	**(68,755)**
Total assets less current liabilities		**110,733**	**204,497**
Non-current liabilities			
Borrowings	24	(52,994)	(70,901)
Provisions	26	(556)	(605)
Total non-current liabilities		**(53,550)**	**(71,506)**
Total assets employed		**57,183**	**132,991**
Financed by			
Public dividend capital		115,880	114,741
Revaluation reserve		53,722	99,982
Income and expenditure reserve		(112,419)	(81,732)
Total taxpayers' equity		**57,183**	**132,991**

The notes on pages 142 to 195 form part of these accounts.

Matthew Kershaw, Interim Chief Executive
Date: 28 May 2019

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**114,228**	**90,754**	**(61,961)**	**143,021**
Deficit for the year	0	0	(21,405)	**(21,405)**
Other transfers between reserves	0	(1,634)	1,634	**0**
Impairments	0	6,085	0	**6,085**
Revaluations	0	4,777	0	**4,777**
Public dividend capital received	513	0	0	**513**
Taxpayers' equity at 31 March 2018	**114,741**	**99,982**	**(81,732)**	**132,991**

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 for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating deficit		(30,906)	(15,611)
Non-cash income and expense:			
Depreciation and amortisation	6	8,398	8,629
Net impairments	7	34,564	(911)
Income recognised in respect of capital donations	4	(449)	(82)
(Increase) / decrease in receivables and other assets		(11,619)	6,583
Decrease / (Increase) in inventories		88	(143)
Increase / (decrease) in payables and other liabilities		1,863	(5,660)
Increase / (decrease) in provisions		3,379	(995)
Other movements in operating cash flows		(168)	(15)
Net cash generated from / (used in) operating activities		**5,150**	**(8,205)**
Cash flows from investing activities			
Interest received		84	36
Purchase of intangible assets		(15)	(35)
Purchase of property, plant, equipment and investment property		(15,160)	(11,928)
Sales of property, plant, equipment and investment property		4,000	0
Receipt of cash donations to purchase capital assets		449	82
Net cash used in investing activities		**(10,642)**	**(11,845)**
Cash flows from financing activities			
Public dividend capital received		1,139	513
Movement on loans from the Department of Health and Social Care		11,619	26,384
Interest on loans		(1,815)	(1,718)
Interest paid on finance lease liabilities		(27)	(5)
PDC dividend paid		(4,025)	(4,185)
Net cash generated from financing activities		**6,891**	**20,989**
Increase in cash and cash equivalents		**1,399**	**939**
Cash and cash equivalents at 1 April - brought forward		**4,433**	**3,494**
Cash and cash equivalents at 31 March	21	**5,832**	**4,433**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care.

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

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in IAS1 "that the continuation of the provision of the service is the important determinant of the basis of preparation of the financial statements for public sector entities".
Croydon Health Services NHS Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust meets its control total of £15.1m deficit (pre PSF) and achieves an adjusted financial performance surplus of £1.5m (post PSF) in 2018/19.
In preparing the financial statements, the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust has submitted a financial plan for 2019/20 to NHS Improvement which delivers a breakeven position (including Provider Sustainability Fund [PSF] of £13.2m) after delivery of a £14.3m savings programme which has been agreed by the Trust Board

and is embedded in the budget. Achieving the financial targets assumes full delivery of challenging £14.3m cost improvement savings programme in year.

The 2019/20 plan does not require cash support from the DHSC provided the adjusted planned breakeven is met otherwise further cash loans will be required. The Trust has requested access to further DHSC borrowing facilities to provide adequate liquidity headroom if needed. Confirmation of continuing support in respect of access to further DHSC borrowing facilities or cash support if breakeven is not achieved has not yet been requested or confirmed, but based on prior years and departmental policy to date the Trust fully expects to have no issues with going concern in relation to this issue.

The Trust has a revenue loan of £55.89m that will mature within one year and not later than two years. The Trust will need to write to the DHSC to either request a new loan to repay the old or to extend the maturity.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2018/19 Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Note 1.2 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Going concern (see note 1.1.2)

The Trust assumed to be going concerns where the services currently provided will continue to be provided in the foreseeable future, as evidenced by inclusion of financial provision for that service in published documents.

Non consolidation of charity accounts (see note 1.3)

The Trust does not consolidate the charity accounts on the basis of materiality.

Finance leases (see note 1.13)

The Trust has made a critical judgement regarding the treatment of asset that is finance lease. This finance lease asset relates to equipment used by the Trust.
Financial Instruments (see note 1.22)

IFRS 9 contains new requirements for the classification, measurement and de-recognition of financial assets and liabilities, replacing the recognition and measurement requirements in IAS 39. The Trust applied the new adoption of IFRS 9 to replace IAS39 from 1 April 2018.

Revenue from contracts with customers (note 1.4 and note 1.23)

IFRS 15 supersedes the current revenue recognition standards including IAS 18 Revenue, IAS 11 Construction Contracts and their related interpretations. The Trust applied the new adoption from 1 April 2018.

Although IFRS 15 is principles based, it is a significant change from the previous revenue requirements and involves new judgements and estimates as revenue is recognised when control of a good or service transfers to a customer, or on satisfaction of performance obligations under contracts, which replaced the previous notion of risks and rewards.

Note 1.2.1 Sources of estimation uncertainty

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

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Revenue - Note 1.4 and Note 3 and 4

The basis of calculation for partially completed spells is detailed in note 1.4

Asset Lives – Note 14 and 15

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 minimum and maximum estimated economic lives of each class of asset are disclosed in note 1.7.5 and 1.8.3, and the carrying values of property, plant and equipment and intangible assets in notes 15 and 14 respectively.

Land and Buildings Valuations – Notes 1.7.2 and 15

Modern Equivalent Asset (MEA) concept.

Department of Health and Social care 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.

The Trust has to make assumptions that 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; however the Trust is not required to have any plans to make such changes. The MEA valuation in the accounts assumes that these services could theoretically be provided from Croydon hospital site and providing the same services but from an optimised smaller footprint (reduced Gross Internal Area [GIA], which would occupy less land) with specialist healthcare that are currently available within this location.

This is a change in valuation methodology of the building asset compared to the one adopted in previous financial years. The valuations are by nature significant estimates which are based on specialist and management assumptions which can be subject to material changes in value.

The Trust carried out a formal valuation as at 1st April 2018, completed on an MEA basis.

The first valuation on the 1st April 2018 identified a decrease in Buildings of £37.0m and a decrease of £19.7m in Land, therefore identifying a net impairment charge to Income and Expenditure Account to the value of £15.0m.

A subsequent valuation was performed at 31st March 2019 to ensure a true and fair view was reflected. The total in year net impact in year was a decrease of £78.5m made up of £18.1m for land and £60.4m for buildings, of which £43.9m was absorbed by the Trust's revaluation reserve and the remainder of £34.6m to the Income and Expenditure Account. The Trust's revaluation reserve has a closing balance of £53.7m.

The methodology adopted meets the requirements of International Accounting Standards (IAS) 16; Property, Plant and Equipment and does not deviate from the principles therein.

Provision for Impairment of Receivables – Note 20.1

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The Trust follows the guidance issued in the 2018/19 Department of Health Group Accounting Manual in relation to the recommended rate for Injury Cost Recovery receivables.

Note 1.3 Interests in other entities

Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

The Croydon Health Services Charitable Fund (Registered Charity No. 1054824) is the only subsidiary of the Trust. The Trust Board is the Corporate Trustee, and the board members of the Trust are jointly responsible for the management of these charitable funds.

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 entity's financial statements. 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 value of the Trust's charitable funds is £1.3m; because the value of the funds are not material the Trust has not consolidated these in to its annual accounts on the basis of materiality.

Joint operations

Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

From 1 April 2015, Croydon Health Services has entered into a joint operation with St George's University Hospitals NHS Foundation Trust and Kingston Hospital NHS Foundation Trust for the provision of its Pathology Services. The joint operation is known as "South West London Pathology". The Trust shares control of the joint operation equally with its partners in the operation.

The operation is under joint control: its board is made up of the three chief executives and finance directors of each trust, none of whom have overall authority, ownership is divided based on expected usage:

- Croydon Health Services NHS Trust 25.8%
- Kingston NHS Foundation Trust 27.5%
- St George's University Hospitals NHS Foundation Trust 46.7%

Note 1.4 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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

The total contract value is agreed at the beginning of the financial year. Performance is tracked on a monthly basis and reconciles against the performance obligations. The commissioners endeavour to make payments of one twelfth of the indicative contract value on the first of each month. Adjustments will be made on a quarterly basis for under and over performance of the obligations.

Revenue from NHS contracts

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

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

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

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

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.4.1 Revenue grants and other contributions to expenditure

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

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts. The

assets are measured at fair value, and the liabilities at the present value of future obligations.

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'.

In addition the Trust also operates a Local government pension scheme (LGPS) for staff not eligible for the NHS pension scheme. This is a defined contribution, off Statement of Financial Position scheme and the number of employees opting in and the value of the contributions has been negligible.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, these components are treated as separate assets and depreciated over their useful economic lives. The components, such as fittings, form part of the modern equivalent asset (MEA) building values within the elemental Depreciated Replacement Cost (DRC) approach under Royal Institute of Chartered Surveyors (RICS) mandatory rules on valuations.

Note 1.7.2 Measurement

Valuation

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

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

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

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services 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, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that

does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. " Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

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

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

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	NA	NA
Buildings, excluding dwellings	5	87
Dwellings	15	71
Plant & machinery	1	15
Transport equipment	1	5
Information technology	1	9
Furniture & fittings *	1	15

** Where a fitting is attached to a building, this component form part of the modern equivalent asset (MEA) building values within the elemental Depreciated Replacement Cost (DRC) approach under Royal Institute of Chartered Surveyors (RICS) mandatory rules on valuations.*

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it

- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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.

Amortisation

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

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Information technology	0	8
Software licences	5	7

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 Recognition

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

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

Note 1.12.2 Classification and measurement

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

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

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset 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.
The Trust does not hold any financial assets at fair value through other comprehensive income or financial liabilities held for trading.

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.

The Trust does not hold any financial assets at fair value through income and expenditure or financial liabilities held for trading.

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).

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The

Trust follows the guidance issued in the 2018/19 DHSC Group Accounting Manual in relation to the recommended rate for Injury Cost Recovery receivables.

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

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

Note 1.12.3 Derecognition

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

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

Note 1.13 Leases

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

Note 1.13.1 The Trust as lessee

Finance leases

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

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

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

Operating leases

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

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

Leases of land and buildings

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

Note 1.13.2 The Trust as lessor

Finance leases

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

Operating leases

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

Note 1.14 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.1% (2017/18: positive 0.1%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 0.76% (2017/18: negative 2.42%) for expected cash flows up to and including 5 years

- A medium term rate of negative 1.14% (2017/18: negative 1.85%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.99% (2017/18: negative 1.56%) for expected cash flows over 10 years.

All percentages are in real terms.

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

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

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 26.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) deposit, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (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 the audit of the annual accounts.

Note 1.17 Value added tax

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

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Initial application of IFRS 9

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

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.
Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £259k, and trade payables correspondingly reduced.

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

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,141k.

Note 1.23 Initial application of IFRS 15

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

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

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

There is no impact on the statement of financial position at 31 March 2019, nor on the opening retained earnings of the Trust at 1 April 2018. The Statement of Comprehensive Income for year ended 31 March 2018 was not restated in accordance with the modified retrospective transition approach.

Under IFRS 15, there was no change in the Trust's recognition of revenue from Commissioners, as revenue is recognised on satisfaction of the performance obligations of the entity, being the provision of medical services to patients. Similarly, there was no change in the Trust's recognition of income from ancillary services, as

revenue is recognised on the satisfaction of the Trust's performance obligation to the customer, being the date which services are provided.

The Trust's revenue recognition of interest income, car park income, catering income and disposal gains/(losses) was unaffected as these items are excluded from the scope of IFRS 15.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

This standard is still subject to HM Treasury FReM interpretation and the government implementation date for IFRS 16 has not yet been confirmed; however the adoption could be at 1 April 2020.

Note 2 Operating Segments

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the chief operating decision maker within the Trust. It is only at this level that revenues are reported and the overall financial and operational performance of the Trust is assessed.

The Trust's income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups (CCGs) and NHS England. This accounts for 89% of the Trust's total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.1.3

The Trust undertakes income generation activities with an aim of achieving surplus, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Note 3.1 Income from patient care activities (by nature)

	2018/19	2017/18
	£000	£000
Elective income	26,540	23,184
Non elective income	78,548	76,407
First outpatient income	18,660	16,543
Follow up outpatient income	20,503	17,650
A & E income	23,718	21,868
High cost drugs income from commissioners (excluding pass-through costs)	8,012	7,112
Other NHS clinical income	56,686	66,374
Community services		
Community services income from CCGs and NHS England	31,970	29,756
Income from other sources (e.g. local authorities)	10,504	10,124
All services		
Private patient income	329	0
Agenda for Change pay award central funding	2,830	0
Other clinical income	5,717	2,246
Total income from activities	**284,017**	**271,264**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	21,793	21,936
Clinical commissioning groups	244,026	235,497
Department of Health and Social Care	2,830	0
Other NHS providers	3,084	2,246
NHS other	0	11
Local authorities	10,504	10,124
Non-NHS: private patients	329	292
Non-NHS: overseas patients (chargeable to patient)	446	447
Injury cost recovery scheme	1,005	613
Non NHS: other	0	98
Total income from activities	**284,017**	**271,264**
Of which:		
Related to continuing operations	284,017	271,264

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

	2018/19	2017/18
	£000	£000
Income recognised this year	446	447
Cash payments received in-year	173	163
Amounts added to provision for impairment of receivables	33	770
Amounts written off in-year	145	27

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	619	593
Education and training (excluding notional apprenticeship levy income)	10,168	10,913
Non-patient care services to other bodies	3,278	2,965
Provider sustainability / sustainability and transformation fund income (PSF / STF)	16,562	3,750
Income in respect of employee benefits accounted on a gross basis	0	96
Other contract income	2,359	1,847
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	55	4
Receipt of capital grants and donations	449	82
Charitable and other contributions to expenditure	96	161
Rental revenue from operating leases	1,241	1,441
Total other operating income	**34,827**	**21,852**
Of which:		
Related to continuing operations	34,827	21,852

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

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

Note 6 Operating expenses

	2018/19	2017/18
	£000	£000
Staff and executive directors costs	198,245	192,179
Remuneration of non-executive directors	86	99
Supplies and services - clinical (excluding drugs costs)	36,635	37,383
Supplies and services - general	13,265	11,347
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	18,900	17,955
Inventories written down	4	28
Consultancy costs	1,762	948
Establishment	2,106	6,473
Premises	15,182	15,007
Transport (including patient travel)	1,889	1,772
Depreciation on property, plant and equipment	8,160	8,251
Amortisation on intangible assets	238	378
Net impairments	34,564	(911)
Movement in credit loss allowance: contract receivables / contract assets	11	
Movement in credit loss allowance: all other receivables and investments	(13)	909
Increase/(decrease) in other provisions	(250)	(869)
Audit fees payable to the external auditor		
audit services- statutory audit	61	61
other auditor remuneration (external auditor only)	9	9
Internal audit costs	149	176
Clinical negligence	15,097	14,583
Legal fees	470	395
Insurance	237	191
Education and training	950	476
Rentals under operating leases	1,543	1,710
Redundancy	296	0
Hospitality	154	177
Total	**349,750**	**308,727**
Of which:		
Related to continuing operations	349,750	308,727

Note 6.1 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	9	9
Total	**9**	**9**

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	0	344
Changes in market price *	34,564	(1,255)
Total net impairments charged to operating surplus / deficit	**34,564**	**(911)**
Impairments charged to the revaluation reserve	44,468	(6,085)
Total net impairments	**79,032**	**(6,996)**

The majority of the impairment charge relates to adoption of Modern Equivalent Asset (MEA) basis on the valuation of land and buildings.

Lands and buildings were valued independently by DVS Property Specialists for the Public Sector as at 31 March 2019 in line with the accounting policies. The revaluation has resulted in a net impairment of £79.032m, of which £44.468m was available to be absorbed by the revaluation reserve. Therefore, an impairment of £34.564m has been recognised in the Statement of Comprehensive income, of which £1.46m and £33.104m relates to lands and buildings respectively.

*This is mainly due to the change in the adoption of the MEA technique, instead of the movement in market price.

Note 8 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	129,242	127,495
Social security costs	14,715	14,237
Apprenticeship levy	675	654
Employer's contributions to NHS pensions	16,400	16,097
Temporary staff (including agency)	38,385	34,580
Total gross staff costs	**199,417**	**193,063**
Of which		
Costs capitalised as part of assets	876	884

Note 8.1 Retirements due to ill-health

During 2018/19 there were 3 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £236k (£7k in 2017/18).

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

Note 9 Pension costs

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

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

An outline of these follows:

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

In addition the Trust also operates a Local government pension scheme (LGPS) for staff not eligible for the NHS pension scheme. This is a defined contribution, off Statement of Financial Position scheme and the number of employees opting in and the value of the contributions has been negligible.

Note 10 Operating leases

Note 10.1 Croydon Health Services NHS Trust as a lessor

The Trust is the lessor of parts of its premises (front entrance) to external organisations, and for staff accommodation, for which it charges rental revenue.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,241	1,441
Total	**1,241**	**1,441**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	792	532
- later than one year and not later than five years;	2,734	1,916
- later than five years.	4,852	3,886
Total	**8,378**	**6,334**

Note 10.2 Croydon Health Services NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements for the use of accommodation to operate clinical facilities at a number of properties managed by NHS Property Services Ltd. The leases are subject to annual review and renewal.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	1,543	1,710
Total	**1,543**	**1,710**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,574	1,521
- later than one year and not later than five years;	921	1,020
- later than five years.	202	315
Total	**2,697**	**2,856**
Future minimum sublease payments to be received	0	0

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	84	36
Total finance income	**84**	**36**

Note 12 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,855	1,699
Finance leases	8	5
Total interest expense	**1,863**	**1,704**
Unwinding of discount on provisions	1	1
Total finance costs	**1,864**	**1,705**

During the year the Trust incurred revenue and capital loan interests of £1.411m and £0.444m respectively. Revenue loan interests range from 1.5% to 3.5% and capital loan interest is 2.48%.

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 13 Other gains

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	2,210	0
Total gains on disposal of assets	**2,210**	**0**

During the year the sale of diary car park at Croydon hospital site gave rise to profit on disposal of £2.2m

Note 14 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	5,177	14	5,191
Additions	15	0	15
Valuation / gross cost at 31 March 2019	5,192	14	5,206
Amortisation at 1 April 2018 - brought forward	4,467	14	4,481
Provided during the year	238	0	238
Amortisation at 31 March 2019	4,705	14	4,719
Net book value at 31 March 2019	487	0	487
Net book value at 1 April 2018	710	0	710

Note 14.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	5,142	14	5,156
Additions	35	0	35
Valuation / gross cost at 31 March 2018	5,177	14	5,191
Amortisation at 1 April 2017 - as previously stated	4,089	14	4,103
Provided during the year	378	0	378
Amortisation at 31 March 2018	4,467	14	4,481
Net book value at 31 March 2018	710	0	710
Net book value at 1 April 2017	1,053	0	1,053

Note 15.1 Property, plant and equipment - 2017/18

	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
Valuation / gross cost at 1 April 2017 - as previously stated	**49,422**	**134,964**	**4,104**	**18,260**	**27,108**	**6**	**17,891**	**1,258**	**253,013**
Additions	0	1,992	0	5,776	1,876	0	1,700	30	**11,374**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	6,085	0	0	0	0	0	0	**6,085**
Revaluations	22	1,575	113	57	(160)	0	(255)	0	**1,352**
Reclassifications	0	2,888	0	(3,067)	179	0	0	0	**0**
Disposals / derecognition	0	0	0	0	0	(6)	0	0	**(6)**
Valuation/gross cost at 31 March 2018	49,444	**147,504**	**4,217**	**21,026**	**29,003**	**0**	**19,336**	**1,288**	**271,818**
Accumulated depreciation at 1 April 2017 - as previously stated	**0**	**45**	**0**	**0**	**14,435**	**6**	**8,568**	**884**	**23,938**
Provided during the year	0	4,188	70	0	2,025	0	1,894	74	**8,251**
Impairments	0	0	0	0	140	0	204	0	**344**
Reversals of impairments	0	(1,255)	0	0	0	0	0	0	**(1,255)**
Revaluations	0	(2,938)	(70)	(2)	(160)	0	(255)	0	**(3,425)**
Reclassifications	0	(3)	0	3	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	0	(6)	0	0	**(6)**
Accumulated depreciation at 31 March 2018	**0**	37	**0**	**1**	**16,440**	**0**	**10,411**	**958**	**27,847**
Net book value at 31 March 2018	**49,444**	**147,467**	**4,217**	**21,025**	**12,563**	**0**	**8,925**	**330**	**243,971**
Net book value at 1 April 2017	**49,422**	**134,919**	**4,104**	**18,260**	**12,673**	**0**	**9,323**	**374**	**229,075**

Note 15.2 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	29,753	113,180	3,347	82	11,110	0	8,095	176	**165,743**
Finance leased	0	0	0	0	38	0	0	0	**38**
Owned - government granted	0	0	0	0	71	0	311	0	**382**
Owned - donated	0	2,266	0	434	580	0	99	84	**3,463**
NBV total at 31 March 2019	**29,753**	**115,446**	**3,347**	**516**	**11,799**	**0**	**8,505**	**260**	**169,626**

Note 15.3 Property, plant and equipment financing - 2017/18

	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 2018									
Owned - purchased	49,444	144,586	4,217	21,025	11,651	0	8,412	234	**239,569**
Finance leased	0	0	0	0	60	0	0	0	**60**
Owned - government granted	0	0	0	0	94	0	389	0	**483**
Owned - donated	0	2,881	0	0	758	0	124	96	**3,859**
NBV total at 31 March 2018	**49,444**	**147,467**	**4,217**	**21,025**	**12,563**	**0**	**8,925**	**330**	**243,971**

Note 16 Donations of property, plant and equipment

Donated Assets were received from the Croydon Health Services Charitable Fund. Income for the purchase of donated assets is shown in the statement of comprehensive income in the year of purchase.

£0.7m was received for the dental laboratory refurbishment; however spend to date was £0.52m. In addition, £0.015m was received funds for the children protection information sharing system.

Note 17 Revaluations of property, plant and equipment

The Trust's land and buildings were valued independently by the DVS Property Specialists for the Public Sector (an executive agency of HM Revenue and Customs) as at 1st April 2018 adopting the Modern Equivalent Asset (MEA) valuation technique in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant DHSC Group Manual for Accounts (DHSC GAM). The valuation report was signed by Ros Johnson, MRICS an external RICS Registered Valuer who has the appropriate knowledge, skills and understanding to undertake the valuation completely, as required by the RICS Valuation - Professional Standards, 8th edition.

The valuation took into consideration the size, location and service requirements at present within the Trust. Following a review of the recently draft Estates Strategy document it is clear that if the Croydon University Hospital (CUH) buildings were replaced with a MEA (of smaller size), then the site area required would also be smaller. The Valuer has assessed the land value based on this smaller footprint, as outlined in the Estates strategy. A desk top valuation of the estate was conducted again on the 31st March 2019 to recognise any potential changes in indices since the 1st April 2018.

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

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

Plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value as defined by IFRS 13.

Note 18 Disclosure of interests in other entities

The Croydon Health Services Charitable Fund (Registered Charity No. 1054824) is the only subsidiary of the Trust. The Trust Board is the Corporate Trustee, and the board members of the Trust are jointly responsible for the management of these charitable funds.

During 2018/19 (2017/18: £109k; £976k) the interests in Croydon Health Services Charitable Fund accounted for the using the equity method is:

	Surplus/ (Deficit)	Fund Balance
	£000	£000
Croydon Health Services Charitable Fund	325	1,301

The surplus of £325k has not reflected any entries in the statement of comprehensive income for 2018/19.

Note 19 Inventories

	31 March 2019	31 March 2018
	£000	**£000**
Drugs	955	937
Consumables	1,650	1,753
Energy	57	60
Total inventories	**2,662**	**2,750**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £36,594k (2017/18: £34,663k). Write-down of inventories recognised as expenses for the year were £4k (2017/18: £28k).

Note 20 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	30,778	-
Contract assets*	1,277	-
Trade receivables*	-	14,336
Accrued income*	-	3,803
Allowance for impaired contract receivables / assets*	(500)	-
Allowance for other impaired receivables	(1,811)	(2,497)
Prepayments (non-PFI)	861	2,079
PDC dividend receivable	1,592	75
VAT receivable	927	1,165
Other receivables	392	1,700
Total current trade and other receivables	**33,516**	**20,661**
Non-current		
Contract assets*	1,008	-
Trade receivables*	-	727
Total non-current trade and other receivables	**1,008**	**727**
Of which receivables from NHS and DHSC group bodies:		
Current	28,048	15,302
Non-current	0	0

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

Note 20.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**0**	**2,497**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	489	(489)
New allowances arising	11	418
Reversals of allowances	0	(431)
Utilisation of allowances (write offs)	0	(184)
Allowances as at 31 Mar 2019	**500**	**1,811**

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The Trust follows the guidance issued in the 2018/19 DHSC Manual in relation to the recommended rate for Injury Cost Recovery receivables.

Note 20.2 Allowances for credit losses - 2017/18

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

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**1,622**
Prior period adjustments	0
Allowances as at 1 Apr 2017 - restated	**1,622**
Transfers by absorption	
Increase in provision	909
Amounts utilised	(34)
Unused amounts reversed	0
Allowances as at 31 Mar 2018	**2,497**

Note 21 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.

	2018/19	2017/18
	£000	£000
At 1 April	4,433	3,494
Net change in year	1,399	939
At 31 March	5,832	4,433
Broken down into:		
Cash at commercial banks and in hand	15	13
Cash with the Government Banking Service	5,817	4,420
Total cash and cash equivalents as in SoFP	5,832	4,433
Total cash and cash equivalents as in SoCF	5,832	4,433

Note 21.1 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties.

	31 March 2019	31 March 2018
	£000	£000
Monies on deposit	3	1
Total third party assets	3	1

Note 22 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	13,562	14,002
Capital payables	2,596	3,792
Accruals	14,570	14,146
Social security costs	2,214	2,048
Other taxes payable	1,805	1,750
Accrued interest on loans*	0	259
Other payables	4,140	2,585
Total current trade and other payables	**38,887**	**38,582**
Non-current		
Trade payables	0	0
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	7,123	7,161
Non-current	0	0

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

Note 22.1 Early retirements in NHS payables above

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

	31 March 2019	31 March 2019	31 March 2018	31 March 2018
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	0		0	
- number of cases involved		0		0

Note 23 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,042	939
Total other current liabilities	**1,042**	**939**
Non-current		
Deferred income: contract liabilities	0	0
Total other non-current liabilities	**0**	**0**

Note 24 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	57,004	27,199
Obligations under finance leases	20	19
Total current borrowings	**57,024**	**27,218**
Non-current		
Loans from the Department of Health and Social Care	52,973	70,860
Obligations under finance leases	21	41
Total non-current borrowings	**52,994**	**70,901**

As per IFRS9, measuring of DHSC loans is at an amortised cost basis; means the carrying value of the loans include both principal and interest. Revenue and capital loan interests of £0.248m and £0.051m respectively have been added on the principal loans above.

1. The Trust has the following capital and revenue support loans (exclude interests) from the DHSC:

	£000	Maturity
i. Revenue support loan	26,400	extended
ii. Working Capital loan	21,300	18/02/2020
iii. IUSCL (Interim Uncommitted Single Currency Loan) during FSM	7,411	18/02/2020
iv. IUSCL (Interim Uncommitted Single Currency Loan) in 2017/18	10,738	18/09/2020
v. IUSCL (Interim Uncommitted Single Currency Loan) in 2017/18	14,257	18/03/2021
vi. IUSCL (Interim Uncommitted Single Currency Loan) in 2018/19	12,066	18/10/2021
vii. Capital Loan *	17,506	20/08/2040

*Repayment of the principal commenced on 18/08/2017 and every six months (£0.407m) until 20/08/2040.

Note 24.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**98,059**	**0**	**60**	**0**	**98,119**
Cash movements:					
Financing cash flows - payments and receipts of principal	11,619	0	0	0	**11,619**
Financing cash flows - payments of interest	(1,815)	0	(27)	0	**(1,842)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	259	0	0	0	**259**
Application of effective interest rate	1,855	0	8	0	**1,863**
Carrying value at 31 March 2019	**109,977**	**0**	**41**	**0**	**110,018**

Note 25 Finance leases

Note 25.1 Croydon Health Services NHS Trust as a lessee

Obligations under finance leases where Croydon Health Services NHS Trust is the lessee.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**41**	**60**
of which liabilities are due:		
- not later than one year;	20	19
- later than one year and not later than five years;	21	41
- later than five years.	0	0
Finance charges allocated to future periods	0	0
Net lease liabilities	**41**	**60**
of which payable:		
- not later than one year;	20	19
- later than one year and not later than five years;	21	41
- later than five years.	0	0
Total of future minimum sublease payments to be received at the reporting date	0	0
Contingent rent recognised as an expense in the period	0	0

The Trust uses leasing to supplement capital investment in medical equipment where appropriate taking into account of value for money. The Trust took a finance leases with a capital value of £0.093m in 2015/16. The Trust made repayments of principal under finance leases of £0.019m in 2018/19.

Note 26 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**577**	**120**	**652**	**328**	**944**	**2,621**
Arising during the year	59	0	149	160	4,077	**4,445**
Utilised during the year	(81)	(11)	(16)	(175)	(124)	**(407)**
Reversed unused	(18)	0	(65)	(153)	(423)	**(659)**
Unwinding of discount	1	0	0	0	0	**1**
At 31 March 2019	**538**	**109**	**720**	**160**	**4,474**	**6,001**
Expected timing of cash flows:						
- not later than one year;	81	10	720	160	4,474	**5,445**
- later than one year and not later than five years;	326	41	0	0	0	**367**
- later than five years.	131	58	0	0	0	**189**
Total	**538**	**109**	**720**	**160**	**4,474**	**6,001**

The provision for Early Departure Costs relating to pre-1995 early retirement is calculated using information provided by the NHS Pensions Agency. The Trust pays NHS Pensions an amount each quarter for these former employees, and the provision balance represents the estimated costs of the continuing liabilities. Legal claims are liabilities relating to Third Parties Scheme (LTPS) cases which are dealt with by the NHS Resolution on behalf of the Trust.

Included in "other liabilities" are amounts relating to pay provisions for withheld consultant increments; staff equal pay and capital provisions for ED

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

Note 26.1 Clinical negligence liabilities

At 31 March 2019, £238,157k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Croydon Health Services NHS Trust (31 March 2018: £225,808k).

Note 27 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	0	(30)
Gross value of contingent liabilities	**0**	**(30)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**0**	**(30)**
Net value of contingent assets	**0**	**0**

The Trust considers that the fair value of financial assets and financial liabilities are the same as book value.

Note 28 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	0	2,880
Intangible assets	0	0
Total	**0**	**2,880**

Note 29 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2019 £000	31 March 2018 £000
not later than 1 year	17,671	15,566
after 1 year and not later than 5 years	29,698	33,619
paid thereafter	2,380	5,112
Total	**49,749**	**54,297**

Note 30 Financial instruments

Note 30.1 Financial risk management

The applicable standards for financial instruments are IAS32/IAS39/IFRS7 and IFRS9. IAS 32 defines financial instrument as a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Examples of financial assets are cash or a contractual right to receive cash.

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 NHS Trust has with Clinical Commissioning Groups (CCG) and the way those CCGs are financed, the NHS 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 NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS 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, subject to affordability as confirmed by the NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the DHSC (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

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

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	30,752	0	0	**30,752**
Cash and cash equivalents at bank and in hand	5,832	0	0	**5,832**
Total at 31 March 2019	**36,584**	**0**	**0**	**36,584**

£2.3m Injury cost recovery (ICR) debtors have been reclassified between measurement category is included as financial instrument under IFRS 9.

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	14,336	0	0	0	**14,336**
Cash and cash equivalents at bank and in hand	4,433	0	0	0	**4,433**
Total at 31 March 2018	**18,769**	**0**	**0**	**0**	**18,769**

£2.3m Injury cost recovery (ICR) debtors have been reclassified between measurement category is included as financial instrument under IFRS 9.

Note 30.3 Carrying value of financial liabilities

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

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	109,977	0	**109,977**
Obligations under finance leases	41	0	**41**
Trade and other payables excluding non financial liabilities	31,770	0	**31,770**
Total at 31 March 2019	**141,788**	**0**	**141,788**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	98,059	0	**98,059**
Obligations under finance leases	60	0	**60**
Trade and other payables excluding non financial liabilities	14,002	0	**14,002**
Total at 31 March 2018	**112,121**	**0**	**112,121**

A revenue loan of £24.6m was expired in February 2019 and the repayment has been extended until further notice from the DHSC.

Note 30.4 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	88,794	41,220
In more than one year but not more than two years	37,124	55,346
In more than two years but not more than five years	2,454	15,555
In more than five years	13,416	0
Total	**141,788**	**112,121**

Note 31 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	68	184	17	33
Stores losses and damage to property	12	4	15	238
Total losses	**80**	**188**	**32**	**271**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	1	1
Ex-gratia payments	30	341	10	2
Total special payments	**30**	**341**	**11**	**3**
Total losses and special payments	**110**	**529**	**43**	**274**
Compensation payments received		0		0

Note 32 Gifts

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Gifts made	0	0	0	0

Note 33 Related parties

Under the Requirements of IAS 24 (Related Party Disclosures), the Trust has disclosed as a related party where key management services have been provided by another entity such as personal service companies. The total transactions for these companies where key management services were provided are detailed below:

During the year none of the DHSC Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Croydon Health Services NHS Trust.

The DHSC, as the parent of Croydon Health Services NHS Trust, is regarded as a related party. During the year the Trust has had a significant number of material transactions with the other entities listed below for which the DHSC is regarded as

the parent. Also included are local government bodies where material transactions have taken place.

** Only for transactions with a threshold of £250k and above is disclosed below.*

	2018/19		2017/18	
	Income	Expenditure	Income	Expenditure
NHS Body	**£'000**	**£'000**	**£'000**	**£'000**
Croydon CCG	217,153	23	211,807	669
Bromley CCG	5,268	0	4,945	0
East Surrey CCG	3,641	0	2,854	0
Lambeth CCG	5,162	0	4,726	0
Merton CCG	3,257	0	2,508	0
Sutton CCG	2,597	0	2,081	0
Surrey Downs CCG	342	165	352	0
NHS Wandsworth CCG	2,009	21	1,283	0
NHS Southwark CCG	659	0	610	2
NHS Lewisham CCG	800	0	780	0
Health Education England	9,663	10	8,044	0
NHS Resolution (formerly NHS Litigation Authority)	0	15,307	0	14,746
NHS England	38,842	0	25,942	5
St Georges Healthcare NHS Foundation Trust	518	13,535	486	13,766
Moorfields Eye Hospital NHS Foundation Trust	3,512	41	2,764	141
Epsom and St Helier NHS Trust	415	45	440	108
Guy's & St Thomas' NHS Foundation Trust	636	108	357	167
The Royal Marsden NHS Foundation Trust	423	498	745	499
NHS Property Services	0	1,466	0	1,640
Department of Health and Social Care	2,830	0	0	9

In addition, the Trust has a number of balances at year end with NHS bodies (outside DH group), other government departments, other central and local government bodies and external bodies. Most of these transactions have been with HM Revenue & Customs in respect of PAYE, NI contributions and VAT refunds.

	2018/19		2017/18	
	Income	Expenditure	Income	Expenditure
Body (Other government and external)	**£'000**	**£'000**	**£'000**	**£'000**
HM Revenue & Customs	0	15,390	0	14,891
National Health Service Pension Scheme	0	16,400	0	16,097
Croydon London Borough Council	10,374	1,468	10,058	1,326
NHS Blood and Transplant	0	714	0	899

* Only for outstanding with a threshold of £100k and above is disclosed below.

NHS Body	2018/19 Receivable £'000	2018/19 Payable £'000	2017/18 Receivable £'000	2017/18 Payable £'000
Croydon CCG	2,074	361	1,824	652
Bromley CCG	936	0	735	0
East Surrey CCG	1,093	0	772	0
Lambeth CCG	879	0	523	0
Merton CCG	955	0	429	0
Sutton CCG	904	0	658	0
Surrey Downs CCG	165	0	146	0
NHS Wandsworth CCG	929	39	257	18
NHS Southwark CCG	165	1	70	3
NHS Lewisham CCG	211	0	214	0
Health Education England	337	0	72	6
NHS England	11,002	0	3,782	157
St Georges Healthcare NHS Foundation Trust	1,146	2,875	668	1,764
Moorfields Eye Hospital NHS Foundation Trust	1,338	81	1,659	80
Epsom and St Helier NHS Trust	247	247	250	367
Guy's & St Thomas' NHS Foundation Trust	176	192	62	190
The Royal Marsden NHS Foundation Trust	826	802	623	792
King's College Hospital NHS Foundation Trust	48	244	42	335
Hounslow and Richmond Community Healthcare NHS Trust	0	207	0	120
NHs Property Services	13	984	0	1,144

Body (Other government and external)	2018/19 Receivable £'000	2018/19 Payable £'000	2017/18 Receivable £'000	2017/18 Payable £'000
HM Revenue & Customs	0	4,019	0	3,798
National Health Service Pension Scheme	0	2,361	0	2,282
Croydon London Borough Council	1,622	1,675	3,066	1,226
NHS Blood and Transplant	0	72	0	219

The Trust Board is the Corporate Trustee of the Croydon Health Services Charitable Fund (Registered Charity No. 1054824), and some of the members of the Trust Board are also members of the Charitable Funds Committee. The total value of the charitable contributions to the Trust was £96k in 2018/19 (£161k in 2017/18).

Note 34 Events after the reporting date

Sale of Purley Clinic for £1.525m was completed in April 2019.

Note 35 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	50,411	163,689	52,533	166,948
Total non-NHS trade invoices paid within target	20,998	80,021	15,420	90,842
Percentage of non-NHS trade invoices paid within target	42%	49%	29%	54%
NHS Payables				
Total NHS trade invoices paid in the year	2,150	33,001	1,343	31,538
Total NHS trade invoices paid within target	486	17,280	458	18,623
Percentage of NHS trade invoices paid within target	23%	52%	34%	59%

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

Note 36 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	14,746	25,958
External financing requirement	**14,746**	**25,958**
External financing limit (EFL)	15,831	26,898
Under spend against EFL	**1,085**	**940**

Note 37 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	13,979	11,409
Less: Disposals	(1,622)	0
Less: Donated and granted capital additions	(449)	(82)
Charge against Capital Resource Limit	**11,908**	**11,327**
Capital Resource Limit	11,952	11,336
Under spend against CRL	**44**	**9**

Note 38 Breakeven duty financial performance

	2018/19
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	1,507
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus	**1,507**

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,106	4,913	3,967	199	(19,683)	(27,532)	(34,490)	(23,787)	(22,151)	1,507
Breakeven duty cumulative position	1,403	2,509	7,422	11,389	11,588	(8,095)	(35,627)	(70,117)	(93,904)	(116,055)	(114,548)
Operating income		198,499	241,804	236,941	243,551	244,595	246,279	255,354	274,671	293,116	318,844
Cumulative breakeven position as a percentage of operating income		1.3%	3.1%	4.8%	4.8%	(3.3%)	(14.5%)	(27.5%)	(34.2%)	(39.6%)	(35.9%)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

The amounts in the above tables in respect of financial years 1997/98 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

Statutory breakeven duty, overall and recurrent financial position: The Trust delivered a £15.1m deficit (pre PSF) and £1.5m surplus (post PSF) for the financial year 2018-19, taking account of £0.073m post technical item adjustments for donated assets and £34.56m of impairments. As a result of change in accounting estimation for valuation of lands and buildings i.e. adoption of MEA technique has caused a negative impact on the deficit for the financial year. The Trust has been in technical breach of the statutory breakeven duty (NHS Act 2006) for some time, and it will be many years before that duty is met. The Trust has been in regular contact with NHS Improvement to implement financial recovery plan hence the auditor issuing a Section 30 referral specifically relating to a breach of the breakeven duty would not itself cause a material concern for NHS Improvement.

Glossary

Acute Trust	A trust is an NHS organisation responsible for providing a group of healthcare services. An acute trust provides hospital services (but not mental health hospital services, which are provided by a mental health trust).
Adult social care	Social care includes all forms of personal care and other practical assistance provided for people who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs or any other similar circumstances, are in need of such care or other assistance. For the purposes of the Care Quality Commission, it only includes care provided for, or mainly for, people over 18 years old in England. This is sometimes referred to as adult social care.
Audit Commission	The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trusts, primary care trusts and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for-money studies. Visit: www.audit-commission.gov.uk
Board (of Trust)	The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk
Cerner millennium system (CRS)	Cerner millennium is the newly introduced IT system at CHS. This is an electronic system that captures patient data.
Clinical Audit	Clinical Audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.
Clinical Coding	Clinical Coding Officers are responsible for assigning 'codes' to all inpatient and day case episodes They use special classifications which are assigned to and reflect the full range of diagnosis (diagnostic coding) and procedures (procedural coding) carried out by providers and enter these codes onto the Patient Administration System. The coding process enables patient information to be easily sorted

	for statistical analysis. When complete, codes represent an accurate translation of the statements or terminology used by the clinician and provides a complete picture of the patient's care.
Clinical Directorate	During 2015/16 CHS clinical services were organised into three directorates: Integrated Adult Care, Integrated Women and Children's, and Sexual Health and Integrated Surgery, Cancer and Clinical Support Services.
Clostridium difficile or C. Difficile	Clostridium difficile also known as C.difficle or C. diff, is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or persons gut are wiped out by antibiotics. C. difficile infection can range in severity from asymptomatic to severe and life-threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. difficile infection in the community and outpatient setting is increasing.
Commissioners of services	Organisations that buy services on behalf of the people living in the area that they cover. This may be for a population as a whole, or for individuals who need specific care, treatment and support. For the NHS, this is done by primary care trusts and for social care by local authorities. The host commissioner is Croydon Clinical Commissioning Group (CCG).
Commissioning for Quality and Innovation	High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Visit: www.dh.gov.uk/en/ Publications and statistics/Publications/ PublicationsPolicyAndGuidance/DH_09 1443
Complaint	An expression of dissatisfaction with something. This can relate to any aspect of a person's care, treatment or support and can be expressed orally, in gesture or in writing.
Croydon Clinical Commissioning Group (CCG)	The CCG became legally responsible for commissioning/buying healthcare services for Croydon residents from 1st April 2013 as authorized by NHS England.
Croydon Health Services NHS Trust (CHS)	Croydon Health Services NHS Trust is part of the National Health Service (NHS) and was formed in July 2010 with the integration of Mayday Healthcare NHS Trust with Croydon Community Health Services.
Croydon University Hospital (CUH)	The largest of CHS's hospitals.
Culture	Learned attitudes, beliefs and values that define a group or groups of people.
Datix	This is the name of the incident reporting system at CHS.
Department of Health and Social Care	The Department of Health and Social Care is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.
Dignity	Dignity is concerned with how people feel, think and behave in

	relation to the worth or value that they place on themselves and others. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual views and beliefs.
Discharge	The point at which a patient leaves hospital to return home or be transferred to another service, or the formal conclusion of a service provided to a person who uses services.
EWS	This is the Early Warning System is based on vital signs such as blood pressure, heart and breathing rates.
Family and Friends Test	Introduced in 2013 it is an opportunity for family and friends to give feedback to hospitals regarding their care and experience.
Foundation trust	A type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS foundation trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS foundation trusts have members drawn from patients, the public and staff, and are governed by a board of governors comprising people elected from and by the membership base.
Global Trigger Tool (GTT audit)	The Global Trigger Tool is a recognised and validated audit tool developed by the Institute for Healthcare Improvement (IHI) In Boston USA. It can be used as part of an organisation's safety improvement programme to identify and so learn about harm and safety incidents which occur as part of the patient's treatment. Twenty records are reviewed each month using the GTT and the findings plotted over time on a run chart to establish a harm rate. Barts and The London NHS Trust has been undertaking GTT auditing since 2008.
HealthWatch	HealthWatch is made of individuals and community groups which work together to improve local services. Their role is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. HealthWatch also have powers to help with the tasks and to make sure changes happen.
Healthcare	Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery.
Healthcare-associated infection	An avoidable infection that occurs as a result of the healthcare that a person receives.
Hospital Episode Statistics	Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Indicators for Quality Improvement	The Indicators for Quality Improvement (IQI) are a resource for local clinical teams providing a set of robust indicators which could be used for local quality improvement and as a source of indicators for local benchmarking. The IQI can be found on the NHS Information Centre website at: www.ic.nhs.uk/services/ measuring-for-quality improvement.
Information Governance	The structures, policies and practice to ensure the confidentiality and security of health and social care service records, especially clinical records which enable the ethical use for the benefit of the individual to whom they relate and for the public good.
Joint Advisory Group (JAG) accreditation	The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) was established in 1994 under the auspices of the Academy of Medical Royal Colleges. It aspires to: set standards for individual endoscopists set standards for training in endoscopy quality assure endoscopy units quality assure endoscopy training courses
Living Independently For Everyone (LIFE)	Created by the One Croydon alliance in 2017, LIFE brings together teams from health and social care as well as the voluntary sector. It provides coordinated short-term support to people and enable them to retain or regain their independence and continue living in their own home.
Listening into Action (LiA)	LiA worked to re-engage with employees and unlock their potential so they can get on and contribute to the success of our organisation, in a way that makes them feel proud. LiA was trialled and proven over the past eight years in one of the most challenging contexts in the world – our National Health Service – and the impact speaks for itself. It is transferable to any industry sector where employee engagement is a top priority.
MRSA	Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to antibiotics including the penicillin's and the cephalosporins. MRSA is especially troublesome in hospitals, where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.
Malnutrition Universal Screening Tool (MUST)	'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
National Confidential Enquiry into Patient Outcome and Death - NCEPOD	The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews clinical practice and identifies potentially remediable factors in the practice of anaesthesia and surgical and medical treatment. Its purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public. It does this by reviewing the management of patients and undertaking confidential surveys and research, the results of

	which are then published. Clinicians at CHS participate in national enquiries and review the published reports to make sure any recommendations are put in place.
National Institute for Health and Clinical Excellence	The National Institute for Health and Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk
National Patient Safety Agency	The National Patient Safety Agency is an arms-length body of the Department of Health and Social Care, responsible or promoting patient safety wherever the NHS provides care. Visit: www.npsa.nhs.uk
NHS Number	This is the national unique patient identifier that makes it possible to share patient information across the whole of the NHS safely, efficiently and accurately. The NHS Number is fundamental to the development of the National Programme for IT.
NHS Litigation Authority (NHSLA)	The NHSLA is a special health authority in the NHS responsible for handling negligence claims made against NHS bodies in England. In addition it has developed an active risk management programme to raise NHS safety standards and reduce the incidence of negligence. It also monitors human rights case law on behalf of the NHS, co-ordinates claims for equal pay in the NHS and handles Family Health Service appeals (i.e. disputes between doctors, dentists, opticians and pharmacists and NHS Primary Care Trusts).
Overview and scrutiny committees	Since January 2003, every local authority with responsibilities for social services has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.
Patient	A person who receives services provided in the carrying on of a regulated activity. This is the definition of "service user" provided in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Patient and Public Voice	This used to be called Patient and Public Involvement (PPI) but has recently been renamed. It highlights ways in which the public and patients are involved in a trusts patient care.
Patient-Led Assessments of the Care Environment (PLACE)	PLACE assessments provide a framework to review how the healthcare environment supports patient privacy and dignity, quality of food provided, cleanliness and general building maintenance. The inspectors are a mix of Trust members, external inspectors and patient representatives.
Periodic reviews	Periodic reviews are reviews of health services carried out by the Care Quality Commission (CQC). The term 'review' refers to an assessment of the quality of a service or the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services.

	Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/periodicreview2009/1 0.cfm
Picker Institute UK	The Picker Institute Europe is a not-for-profit organisation that supports the healthcare sector to help make patients' views count in healthcare. It works to build and use evidence to champion the best possible patient-centred care working with patients, professionals and policy makers to achieve the highest standards of patient experience. In Europe and the UK, Picker research and gather patient's views of healthcare using surveys, focus groups and other methods as for example by supporting the national survey programme in the NHS for the Care Quality Commission.
Privacy and dignity	To respect a person's privacy is to recognise when they wish and need to be alone (or with family or friends), and protected from others looking at them or overhearing conversations that they might be having. It also means respecting their confidentiality and personal information. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual beliefs.
Providers	Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.
Quality monitoring	A continuous system of monitoring to ensure that local quality measures are effective. Quality monitoring is part of quality assurance.
Quality and Clinical Governance Committee	This committee monitors, reviews and reports on the quality of services provided by the Trust. This includes the review of: Governance, risk management and internal control systems to ensure that the Trust's services deliver safe, high quality, patient-centred care. Performance against internal and external quality improvement targets and follow-up whenever required. Progress in implementing action plans to address shortcomings in the quality of services – if any have been identified.
Registration	From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).
Research	Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.
Safeguarding	Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded. For children, safeguarding work focuses more on care and development; for adults, on independence and choice.
Secondary Uses Service	A single repository of person and care event level data relating to the NHS care of patients, which is used for management and

(SUS)	clinical purposes other than direct patient care. These secondary uses include healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance. Visit: www.ic.nhs.uk/services/the-secondary-uses-service-sus/using-this-service/ data-quality-dashboards.
ViEWS	VitalPAC Early Warning System is a tool for bedside evaluation incorporated into VitalPAC. It is based on seven physiological parameters: pulse; temperature; systolic blood pressure; respiratory rate; AVPU (the level to which the patient responds), oxygen saturation, plus the patient's inspired oxygen requirements.
VitalPAC	An electronic track and trigger system that provides a recording mechanism for patient's vital signs and essential screening tools. The data entered generates an Early Warning Score (EWS) and when appropriate prompts the clinical practitioner to escalate the patient's condition appropriately.

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