NHS
Epsom and St Helier
University Hospitals
NHS Trust

Annual Report

2017 - 2018

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These are the main hospitals that we run our services from. However, our doctors, nurses and other staff also work from a number of other sites, as well as nine renal centres for patients needing dialysis.

www.epsom-sthelier.nhs.uk

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1 Overview

Welcome to the 2017-18 Annual Report – a message from our Chairman and Chief Executive

As another year comes to a close, we are delighted to be able to share an overview of how the Trust performed during 2017-18. Over the coming pages, you will find all of the information about the highlights and challenges of our year, including details of how we measured up against key NHS standards and the work that we have done to even further improve patient care.

It has been a very challenging but exciting year for our hospitals, and one which we believe will be remembered as a landmark period in securing a long term sustainable future for our hospitals and the services we provide. That's because – on top of the incredibly busy day job – we launched a huge piece of involvement work known as Epsom and St Helier 2020-2030. This work, which began in July with the publication of 'Providing high quality healthcare services 2020 to 2030', built on engagement work launched in 2015 and was based on the feedback of more than 600 hundred local residents, as well as staff at the hospitals.

The main aim of this involvement work was to make a case for creating a £400 million specialist facility for acutely sick patients where majors A&E, critical care, emergency and trauma surgery, inpatient beds for children, births, and complex emergency surgery would be delivered on one site. Doing so would mean that our acute clinical staff are concentrated in one place, enabling us to meet and exceed more care standards, fill rotas more effectively and provide care in buildings which we believe local people and our staff deserve. You can read more about this involvement work on page 14.

Of course, while that significant strategic work was carried out, our staff remained absolutely focussed on providing high quality care to our patients – and that was no small task this year. Like many other NHS trusts across the country, we saw a significant increase in the number of very sick people who needed expert care in life-threatening or emergency situations. Over a very long winter period (from November to March) we saw an almost 20% increase in patients requiring majors A&E (where we treat serious conditions such as chest pains, stomach pains or pregnancy problems) and in resuscitation (where immediate life-saving care is needed). This surge in demand across our most specialised and acute areas had a significant impact on the way we operated throughout the year, and had implications for staff and services across the Trust.

However, with team work, planning, and the support of our colleagues in primary and social care, we were able to keep our hospitals running smoothly and maintain our focus on providing compassionate care. In total, we provided care to people on 904,098 occasions – that's 2,476 appointments, A&E attendances and procedures every day.

This figure incorporates 167,190 people who came to our A&E departments and 4,648 births (plus an additional 123 babies who were born at home under the expert care of our midwives).

In order to keep up with the increasing demand on our most acute services, we had to keep a firm focus on the recruitment of permanent staff and we are delighted to say that, at the end of the financial year, we had 100 more clinical staff working on the front line than we did the previous year (and 300 more than this time in 2015).

£27.9 million investment in building for our future

This has been a record breaking year for investments into our services and facilities, and the improvements are making a huge difference to our patients and staff. In the past 12 months we have invested a record £27.9 million into improving our estates and facilities and, at the end of the year, secured an incredible £100 million to invest in our estates over the next three years. As patients and visitors to our hospitals will have noticed, our buildings are very old, and our ageing estate can sometimes hamper the care we provide. As a result, this record investment has been warmly welcomed, and has resulted in some fantastic developments for our patients. Turn to pages 24 for more information and pictures of the work in action.

While the recent improvements will mean that we can continue to provide great care for the next few years, they are not enough to secure our long term future, or to overcome all of the challenges our ageing buildings and current configuration cause us. We also have to consider the surge in demand on our most acute services this year, and how that might continue to increase in the future.

Our latest CQC report

Our hospitals underwent a routine inspection from 9 January and 6 February 2018 - one of the busiest times for us (and the whole of the NHS). Although we are delighted to say that we have seen a huge increase in the number of areas that were rated as good, our overall rating remains as 'requires improvement'. Of the Trust's 18 services one is rated as outstanding (SWLEOC), 10 as good and seven as requires improvement. The Trust is now rated as good for being caring and responsive and the improvements in the ratings for maternity, critical care, surgery at Epsom and Medicine at St Helier are marked. At the same time, we have also managed to remove the five 'inadequate' ratings of 2015, meaning that there are no red flags on our report. You can read more about the findings of the report on page 21.

Controlling our finances

Like most other NHS organisations across the country, we faced a significant financial challenge this year. Our finance team, working with departments across our hospitals, have worked hard to make sure that each area is working efficiently and keeping on track with their budgets, as we know that good financial management is the only way in which we can deliver the best value for money for our patients and the tax payer, as well as identifying opportunities to finance better care.

As a result, we can announce that we have ended the year with a Financial Performance deficit of £13.4 million, which is £4.4 million smaller than the deficit of £17.8 million that was agreed with our regulator at the start of the financial year.

However, when you turn to the annual accounts (which start on p 60), you will see that this year, some of our buildings have been re-valued by independent valuers and were assessed to be worth a significant amount less than when they were last re-valued and the cost of the improvements we have made since the last valuation. As you would expect, this needs to be recorded in our annual accounts and the drop in value is reflected in the total year end figure, but importantly, does not take cash out of our hospitals or affect our day-to-day finances.

This is a technical accounting adjustment (in line with national and international accounting standards) and is known as an impairment. It is not an indicator of the Trust's financial performance and does not affect our performance in achieving our agreed Financial Performance Total.

Meeting the Government's healthcare standards, combined with our good patient feedback, improvements in patient care and ending the year in the financial position that we planned for, is great news and is testament to the hard work of our staff and volunteers and the support of our commissioners.

We hope you enjoy our Annual Report.

Kind regards,

Laurence Newman
Chairman

Daniel Elkeles
Chief Executive

About us

We offer an extensive range of medical services to over 490,000 people in south west London and north east Surrey. We operate two busy general hospitals, Epsom Hospital and St Helier Hospital, and run services from other locations, including the former Sutton Hospital site.

St Helier Hospital is home to the South West Thames Renal and Transplantation Unit and Queen Mary's Hospital for Children, while Epsom Hospital is home to the South West London Elective Orthopaedic Centre (SWLEOC). Both Epsom and St Helier hospitals have accident and emergency departments (A&E) and maternity services.

With more than 900,000 people coming to our hospitals for care and treatment every year, our team of almost 5,000 staff and 500 volunteers work around the clock to keep our busy hospitals running smoothly.

As teaching hospitals, we play a key role in the education and training of tomorrow's doctors, nurses and other healthcare professionals. Both sites work in partnership with St George's Hospital and St George's Medical School in south London to deliver high quality education and research. Outside St George's Hospital, we support the education of more medical students than any other teaching hospital in south London.

We serve an area that is rich in diversity, with a mix of urban and rural areas, and differing levels of quality of life. We cover some of the most prosperous postcodes in the country, as well as some poorer areas.

Together with our local commissioners in Surrey, Sutton and Merton, we work to make sure that we deliver the best possible care to the communities we serve.

Our values, objectives and long term strategy

Our values

At the heart of our work is a set of beliefs – a set of values that we all support. Our values drive us to keep on improving the service we provide to our patients and their loved ones. It also guides the way in which we work together as staff and volunteers, and how we treat each other.

Our values underpin our **mission,** which is: 'to put the patient first by delivering great care to every patient, every day.'

Every month our Chief Executive hosts a special awards ceremony for staff and teams who have been praised by a patient or colleague. The nominations our Chief Executive receives are broad and varied, and over the last year have resulted in awards to quick-thinking staff who saved the life of a person in a car park to those who have taken time out of their day to make sure patients are well supported. Winners receive a framed certificate and one of our unique Patient First gold badges (look out for them on staff lanyards!).

Our values are:

Put the patient first – there should be no doubt that our patients are the number one priority for everyone at the Trust. It's up to us to make sure that our patients receive the very best of care at all times, and are treated with compassion and respect throughout their visit or stay with us.

Work as one team – as a large organisation with almost 5,000 staff and volunteers, there's no question that we are a big team. It is important we work together as it is the only way of making sure we achieve the very best for our patients.

Respect each other – working for the NHS can be challenging at times, with limited resources and more people coming to us for care in an emergency. With a mutual respect for our colleagues, we can appreciate and recognise everyone's contribution through their hard work and commitment.

Protect the environment – by doing all we can to cut our carbon footprint, we can help protect the environment and, importantly, save money in what are challenging financial times across the health service. It is not just about turning off lights when you leave the room – although that does make a huge difference – it is much bigger than that: from the way we deal with our waste and recycling to the way that we order our equipment and supplies, we can all make a difference to our hospitals' carbon footprint. PIC AND INFO: We unveiled two spacious, state-of-the-art bike 'hubs' this year, providing secure storage, changing and shower facilities for those staff who cycle to work. The new hubs, designed by Active Commuting, form part of the Trust's wider commitment to sustainable development, a key aspect of which is encouraging staff to find alternative ways to travel to and from work.

Strive for continuous improvement – over recent years, we have proved that we are a well-performing trust, despite some significant challenges. We are proud to be part of the NHS and how our staff and volunteers drive the organisation forward. It is essential that we continue to perform well against the standards the government expects of NHS hospitals, that we keep a tight grip on our finances and above all, we provide the people who need our services with a high level of care. This means keeping up the hard work and making improvements wherever we can.

In July 2017, we announced £12 million improvement works at St Helier. The multi-million pound project on B and C blocks of the hospital is the largest single improvement project the Trust has ever undertaken, and will see 133 windows replaced, the roof repaired and newly insulated, and a new 10 centimetre concrete render (which meets the highest fire safety standards) added to the outside of the building. Patients, visitors and members of the public are sure to have noticed the huge amount of scaffolding that surrounds the centre of the building – in fact, the work will use four miles of scaffolding.

Our objectives

Each year, we set corporate objective for the organisation. For 2017-18, these objectives remained unchanged, and laid out our aspirations as follows:

- Delivering **safe** and **effective** care with respect and dignity
- Creating a positive **experience** that meets the expectations of our patients, their families and carers
- Providing **responsive** care that delivers the right treatment, in the right place at the right time
- Being **financially** sustainable
- Working in **partnership**
- Ensuring we have highly engaged, patient-centred and skilled teams that are **well-led**.

Our five year strategy

For the first time in the history of the trust, in 2015 we published a five year strategy that laid out how both Epsom and St Helier hospitals will continue to provide consultant-led, 24/7 A&E, maternity and inpatient paediatric services. In addition, St Helier will provide specialist and emergency care, such as acute surgery, for our most sick patients and Epsom will expand its range of planned care. We continue to work with GPs to provide significantly more care in community settings so that people only come to hospital when it is absolutely necessary (you can read more about how we are working in partnership with our health and social care partners on page 32). You can read our strategy document in full at www.epsom-sthelier.nhs.uk/5yearstrategy.

Without a dedicated team of staff and volunteers who feel valued and supported in their work, we simply would not be able to achieve the aspirations we laid out in our five year strategy. So, along with greatly improving substantive staffing levels, we seek to engage, empower, develop and equip our teams to perform to their full potential, with clear responsibility and accountability. We have committed to help and reward all staff who actively wish to come on this change journey with us, supporting them in their education and continuing professional development. We aspire to be a high quality organisation where we are both an 'employer of choice' and a 'provider of choice'.

While the five year strategy has allowed us to set our aspirations and objectives in a clear way, which in turn has allowed us to offer some assurance to local people and stability to our staff about the future of our hospitals, it can not provide long-term solutions to the main challenges we face.

Epsom and St Helier 2020-2030

As our Chief Executive and Chairman mentioned in their introduction, in July 2017 we embarked on a major exercise with our local communities to get their views on the possible scenarios for the long term future of our hospitals – this work built on a wide-reaching review of our estate in 2015, which found that our ageing buildings are simply not suitable for delivering 21st century healthcare.

The thousands of people who took the time to read our Epsom and St Helier 2020-2030 materials (still available in hard copy and online), join us at a meeting or watch our video, will know that we propose to consolidate six services, representing 15% of patient care, onto a brand new, single acute facility. Doing so will mean that we can provide our sickest patients with the very best of care in a purpose-built facility, while 85% of patients will continue to receive care as they do now (that's 765,000 appointments and procedures being undertaken in the same location as they are currently).

Consolidating acute services (majors A&E, critical care, emergency and trauma surgery, inpatient beds for children, births, and complex emergency surgery) will mean that we can bring together specialist staff who provide this life-saving, specialist care under one roof. At the moment, we put a lot of staffing resources and money into funding duplicate services at both hospitals and as a result, begin each year with a significant deficit. Bringing services together means that there would be more senior clinicians available both day and night, meaning our patients get quicker decisions made by more experienced doctors.

If we were to bring these acute services to one site, we would be better able to meet, deliver and go beyond all the national standards (which state hospitals should ensure senior clinicians are available 24 hours, seven days a week for our sickest and most at-risk patients). Meeting these standards has been shown to improve patient care. It would also mean that we would need to rely on fewer members of expensive agency staff. This not only improves continuity in the care we provide to patients, it would also help us save money every year, which we would then reinvest directly into our services.

During the involvement work we attended 47 local meetings and events, where we met with more than 2,000 people. We held 31 drop in sessions and meetings internally reaching over 2,500 staff. More than 100,000 have watched the video we made (still available on our Youtube channel), we reached 133,800 people on Twitter in July alone and 11,977 people visited our website page on 2020-2030.

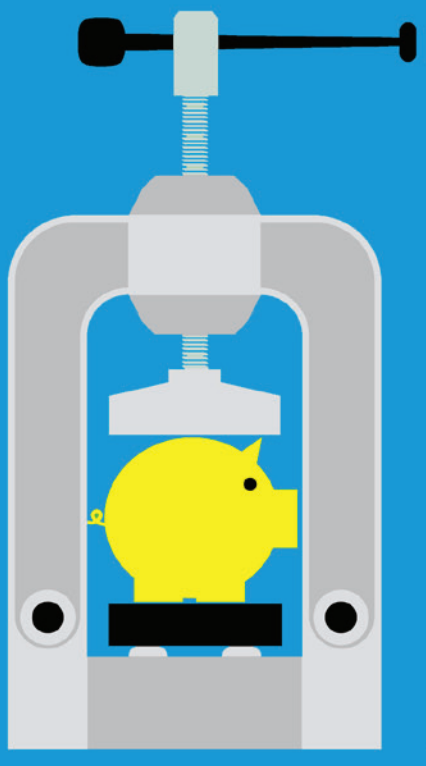
Following a 13 week period of engagement with local communities, stakeholders, patients and local councillors and MPs, we published the Strategic Outline Case (often referred to as a SOC). The Strategic Outline Case (which is available in full online at www.epsom-sthelier.nhs.uk/epsom-and-sthelier-2020-2030) provides a summary of the case for change, what we think will happen if we do nothing, the clinical model we have proposed and how it will improve our clinical quality, as well as what we heard in our engagement campaign. It also provides information on how much money we will need to build the new facilities on each of our sites and the improvement this will make to the overall financial position of our hospitals. With the support of the local NHS, we also suggest what we need to do to proceed to the next stage of decision making.

In the past 12 months:

Welcome to the world!

4,648 babies were born at our hospitals, plus an additional 123 who were born at home under the expert care of our midwives

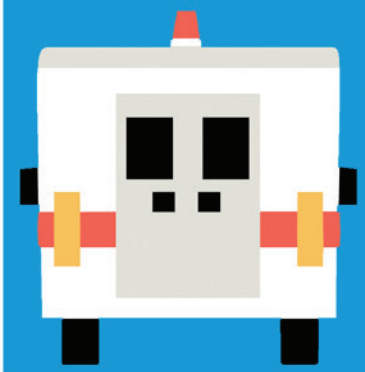
We met our Financial Performance Total



We invest £27.9 million in maintaining our buildings and buying new equipment

We provided care to people on 904,098 occasions – that's 2,476 appointments, A&E attendances and procedures every day

93.15% of patients who came to our A&E departments were seen, treated and discharged within four hours



Over winter we saw an almost 20% increase in patients requiring care in majors A&E and resuscitation

Performance analysis

Deliver safe and effective care with dignity and respect

We are absolutely committed to making sure that each person who comes into our hospitals – whether it's for a routine outpatient appointment, a planned operation, or someone who needs to be admitted in an emergency – receives the very best of care.

We measure our performance in a number of ways, from how we achieve key standards, to commissioning detailed surveys that tell us what our patients really think of our services. In January 2018, (our busiest month of the year) the Care Quality Commission undertook a routine inspection of our services. You can read more about their findings on page 21 of this report.

We also ask our patients to take part in the Friends and Family Test (which asks if patients rate our services highly enough to recommend us to a loved one should they need hospital care). During this year, 118,853 had their say and an impressive 91.1% of people surveyed would recommend us to their friends and family.

At the start of the new financial year, one of our midwives, Lydia Baker, was named as the winner of the Good Morning Britain's Hospital Health Star Award – while she was live on TV with presenters Piers Morgan and Susanna Reid!

Lydia is a Bereavement Midwife, and goes above and beyond the call of duty to support parents following a miscarriage, stillbirth or death of a child and provides specialist care to those who are pregnant again following their loss. She was nominated for the awards by a mum who she cared for, and was announced as the winner while in the Good Morning Britain studio.

Lydia said: "It's been amazing to have this recognition and I'm so grateful. I love my job, and this role means everything to me. Although I will cherish this award forever, this has never been about me, it's all about giving these women and their families support in their darkest moments.

"I work with so many amazing people and I couldn't do this job without their ongoing support and guidance. I'm completely overwhelmed and blown away by all of the supportive messages I've received."

Keeping our patients safe

An absolutely fundamental aspect of keeping our patients safe is to ensure that we have the right skill mix and numbers of staff on the wards and in departments. As part of the National Quality Board guidance (2013) all NHS Trusts are required to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week. We have invested heavily in recruiting more substantive staff this year, and as you can see by our reduction in the use of agency staff and continued strong performance, that has certainly paid off.

The hospital standardised mortality ratio (HSMR) is an indicator of whether the death rate at a hospital is higher or lower than you would expect. It looks at the majority of activity in a hospital where risk of death is significant, and compares how many people would be expected to die with the actual rate of death. Our HSMR was consistently lower than expected, meaning that we performed within the top quartile for all acute trusts throughout 2017-18. Although mortality is lower than expected at our hospitals, we take the matter very seriously and were an early adapter of new guidelines from the National Quality Board, which were introduced in March 2017 to indicate how all NHS providers should learn from the deaths of people in their care.

We have a strong record in achieving the A&E access standard (which states that at least 95% of patients attending A&E should be treated, admitted or discharged within a maximum of four hours), and in previous years have been one of the few trusts to exceed the standard. As a result of the significant increase in the demand on our emergency and inpatient services, this year we were just shy of the standard and ended the period at 93.15%. Although we are disappointed that this figure was not above the 95% mark, we remained as a strong performing trust and were consistently in the top 20% of all trusts in the country.

In September, a national report was published that showed our Hip Fracture Unit provides patients with some of the best care in the country. The results show that we have the lowest mortality rates in London and are one of three hospitals with the lowest mortality in the country (out of 177 hospitals). Our adjusted 30 day mortality was just 3%, against a national average of 6.8%. We are the 2nd best performer in the whole of the country in the Department of Health's Best Practice Tariff – a measurement that takes into account eight different standards in hip fracture care, including time to surgery being less than 36 hours of the patient coming to hospital, that they are assessed by a geriatrician within 72 hours and receive a specialist falls assessment. We are also the 2nd busiest unit in the whole of the capital, seeing a record 447 patients.

During the year, we made a commitment to improve the recognition of sepsis and management of patients with sepsis. Sepsis (also known as blood poisoning or septicaemia) is a rare but serious condition, and arises when the body's response to an infection becomes overwhelmed and it begins to injure its own tissues and organs. It can lead to shock, multiple organ failure and, if it's not recognised and treated quickly enough, can result in death. A staggering 44,000 people die as a result of sepsis every year.

The statistics paint a very stark picture, but if we can catch and treat sepsis in a timely way, we can save lives – in fact, although a large number of people die as a result of sepsis, the vast majority survive.

There has been a significant improvement in the recognition of sepsis in A&E. Our recognition rates have more than doubled since the previous year, increasing from 44% in 2016-17 to 90% in 2017-18. We are delighted to announce that the work we have done around sepsis awareness was shortlisted for a HSJ award. Sepsis week pic.

You can find out more about our performance and the measurements we use at: www.epsom-sthelier.nhs.uk/our-performance.

Protecting our patients' information

Every single member of staff at our hospitals – whether working in a ward or an office – has a duty to keep patients' information safe, secure and confidential.

Under the Data Protection Act 1998, everyone who works for the NHS, or in partnership with us, has a duty to keep information confidential. Any breach of confidentiality by a member of staff is a disciplinary offence.

This means that we only collect the information we require, that we protect the information we hold, and that we do not keep it for longer than necessary.

We have an appointed Senior Information Risk Owner (SIRO), Caldicott Guardian and Information Governance Manager. All are members of our information governance committee and ensure adherence to the relevant policies and procedures, which are available to all our staff on Victor (our internal website for staff and volunteers).

Every member of staff is required to undertake mandatory and refresher training on information governance and all portable IT equipment – such as laptops and data sticks – are encrypted. The Department of Health's 'Information governance toolkit', which the Trust is required to complete yearly, provides guidance and assurance that the risks to data security, including data protection and confidentiality, are minimised. It also requires us to have robust processes in place to monitor and report any threats or incidents.

Principles of remedy

We reaffirm our commitment to the Parliamentary and Health Services Ombudsman's Principles of Remedy which provides guidance on the way we respond to complaints and concerns raised by patients and public.

The six principles are:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement.

The principles set out are intended to promote a shared understanding of how to put things right when they have gone wrong and to help public bodies such as the trust, in the Ombudsman's jurisdiction provide fair remedies. The full document can be read at: www.ombudsman.org.uk/ improving-public-service/ ombudsmans principles/principles-for-remedy/2.

We are required to meet a number of key standards that the Government sets for hospitals.

Standard	Result
Infection control – have no more than 39 cases of Clostridium difficile	**DID NOT ACHIEVE** We recorded 40 cases of Clostridium difficile.
Infection control – have zero cases of MRSA (bacteraemia).	**DID NOT ACHIEVE** We recorded five cases of MRSA.
Emergency access – 95% of all patients attending A&E should be treated, admitted or discharged within a maximum of four hours.	**DID NOT ACHIEVE** We were just shy of this standard, with 93.15% of our patients seen within the time limit.
18 week wait – 92% of patients waiting to start their consultant-led elective treatment should be seen within 18 weeks of referral.	**DID NOT ACHIEVE** 88.9% of our patients requiring admission were treated within 18 weeks.
Cancer related targets Two week rule (the maximum wait for an urgent referral). 31 days to treatment from confirmed diagnosis. Maximum waiting time of 62 days from referral to treatment.	**ACHIEVED**: 94.6% of these patients were seen within this time. **ACHIEVED:** 98.6% of these patients were seen within this time. **DID NOT ACHIEVE** 80.5% of our patients received treatment in this period. Although we were below ere we aimed to be for the year, our performance against this standard improved greatly within the year.
Stroke care – at least 80% of patients should spend at least 90% of their hospital stay in a stroke unit.	**DID NOT ACHIEVE** 66.6% of patients spent 90% of their time in a stroke unit.

Care Quality Commission registration

All health and adult social care organisations that provide regulated activities are required by law to be registered with the Care Quality Commission (CQC). To do so, healthcare providers (such as our trust), must show they are meeting standards of quality and safety.

In January, our hospitals welcomed a team of inspectors from the CQC, as they began a detailed routine inspection of our staff and services. The CQC are the independent regulator of health and social care in England, and it's their job to make sure patients are being given safe, effective, compassionate care. To get a full and thorough understanding of exactly how well our hospitals operate, inspectors interviewed staff about their work, talked to patients about the care they receive, and monitored the care being given to make sure the right systems and processes are in place. Once the inspectors have scrutinised all of the above, they use their evidence to create a report and rating (which could either be outstanding, good, requires improvement or inadequate), which will detail what we do well and what we need to improve.

The report shows that we have made significant improvements in a number of areas since our last inspection in 2015, but have remained as requires improvement. We are absolutely committed to continuous improvement and learning lessons from this valuable feedback. Whilst the CQC has many suggestions of where we can improve, there are fundamentally four main areas where we need to focus if we are going to get to 'good' next time.

1. **Our estate**, particularly in A&E and Critical Care at St Helier, prevents us from receiving a 'good' rating in the safety rating and this is why over the coming year we are investing heavily in improving these facilities.
2. **Mandatory training** – many of our staff did not complete all of the training. This is incredibly disappointing and is something that we are working to address urgently.
3. **Mental health** – the recording of mental capacity assessments and best interests meetings and decisions in patient care records, as well as understanding when and how a Deprivation of Liberty Safeguard authorisation should be used for patients who lack capacity to agree to admission, are all areas where we need to improve.
4. **Our annual staff survey results** – the numbers of our staff completing the survey was lower than the previous year and compared to other trusts our performance has continued to deteriorate from the 2015 high and we now have 62% of the questions rated below average.

We are taking steps to address the four key points above, and – at the time of writing – were in the process of identifying a systematic plan that would help the Trust to engage and communicate more effectively with all staff across the organisation.

There is a lot that the rust does outstandingly well and our teams should feel justly proud. The CQC have recognised this and it is important that we continue to recognise our many successes, share good practice, and press on with our commitment to providing great care to every patient, every day.

You can read the latest report on our website at www.epsom-sthelier.nhs.uk/cqc-report.

Create a positive experience that meets the expectations of our patients, their families and carers

We know that coming to hospital can be a daunting experience for some of our patients, and that the vast majority of our patients would rather not need to rely on our care and medical expertise.

That's why it's so important that we can create a positive experience for our patients, and help to put them (as well as their loved ones) at ease.

Investing in the care we provide

We are absolutely delighted to announce that we have spent a record £27.9 million this year in improving our ageing buildings and buying new equipment. That amount of money has made a huge impact on our hospitals, and we have seen some significant improvements across the Trust, including:

- Endoscopy processing units for both sites – £1.4 million
- Our new Urgent Treatment Centre at Epsom - £1 million
- Our amazing new adult Audiology Department – £0.965 milion
- The new accessible lift in Ferguson House – £0.848 million
- Antenatal and Paediatric Outpatients at Epsom – £0.750 million
- Medical Ambulatory Care Unit at St Helier – £0.750 million
- Mary Moore Ward refurbishment, St Helier – £0.700 million
- Education Centre, St Helier – £0.541 million
- League of Friends Shop and Tea Room, St Helier – £0.141 million
- Surgical Care Suite, Epsom – £0.193 million.

This capital investment programme saw over £8.1 million being spent on addressing critical backlog at both Epsom and St Helier, £2.9 million in improving the Trust's IT systems, over £2.1 million in medical equipment, £2.9m in improvements to A&E Departments on both sites and £6.8 million as part of a programme to improve and extend patient facilities, especially for renal and intensive care.

£100 million investment in building for our future

This has been a record breaking year for investments into our services and facilities, and the improvements are making a huge difference to our patients and staff. In the past 12 months we have invested a record £27.9 million into improving our estates and facilities and secured an incredible £100 million to invest in our estates over the next three years.

As patients and visitors to our hospitals will have noticed, our buildings are very old, and our ageing estate can sometimes hamper the care we provide. As a result, this record investment has been warmly welcomed, and has resulted in some fantastic developments for our patients, including:

Endoscopy processing units for both sites – **£1.4 million**

A new Urgent Treatment Centre at Epsom - **£1 million**

A new adult Audiology Department at St Helier – **£965,000**

The new accessible lift in Ferguson House – **£848,000**

New Antenatal and Paediatric outpatient departments at Epsom – **£750,000**

Medical Ambulatory Care Unit at St Helier – **£750,000**

Surgical Care Suite, Epsom – **£193,000**

Overhaul B and C blocks at St Helier, including replacing windows, repairing the roof and adding new render – **£12 million**

Replacing the enormous water tanks at St Helier – **£1.5 million**

£100 million makeover underway

We are working hard to improve our buildings and facilities for you. We are investing £100 million in our estate over the next three years.

NHS
Epsom and St Helier University Hospitals
NHS Trust

Already completed:
- Urgent Treatment Centre
- Audiology
- Antenatal Outpatient Department
- Endoscopy

Coming in 2018-19:
- Renal Dialysis Unit
- Intensive Care and High Dependency Unit
- Outpatient Department at Epsom
- Heating and lighting system upgrades

We apologise for any inconvenience caused by these improvement works and would like to thank you for your continued patience.

Next year, our plans are even more ambitious, as we have a planned capital programme for 2017-18 of £50.1 million, which will include £11.7 million on new energy centres and energy efficiency measures at both sites, £2.2 million on a new staff nursery at St Helier and £3.2 million on medical equipment – amongst much more!

Modernising our Outpatient Booking Centre - Last year, we set out to improve the experience people have when they come to us as outpatients (these are the people who need hospital care but do not need to stay overnight, and they represent our largest patient group) by creating a centralised Outpatient Booking Centre. The centre has had a significant impact on how our patients can get in touch with us, and in just one year of operation received 106,652 calls and reduced the amount of time patients wait on the line before speaking to someone to 54 seconds.

Encouraging patients to have their say

We value all feedback from our patients, and are committed to recognising a job well done and learning lessons from the instances where we could have done better. During the year, the results of two national patient surveys were published – the most recent being the CQC's survey of maternity services.

This report provides an overview of the results of the Maternity Survey 2017, based on the information published by the CQC and our survey provider, Picker. 125 eligible responses were received from women who gave birth at the Trust in February 2017 (response rate of 36%, just below the national average of 37%).
Some of the key results are:

- 98% of respondents felt that their partner was involved in their care during labour and birth
- 96% of respondents were visited at home by a midwife since the birth
- 90% of respondents said that they were treated with respect and dignity
- 89% of respondents were given a choice of where to have their baby
- 78% of respondents said that the midwives listened to them during their antenatal check-ups
- 73% of respondents had confidence and trust in the midwives they saw after going home.

The first survey to be published was the results of the Emergency Department (ED) Survey 2016, based on the information published by the CQC and our survey provider Picker. 341 eligible responses were received from patients who visited one of our emergency departments in September 2016.

Some of the key results are:

- Overall: 80% of patients scored the department as 7 or more out of 10
- Overall: 83% patients felt treated with respect and dignity
- 98% of people said that the A&E Department was fairly clean/very clean
- 85% of people said they always had enough privacy when being examined or treated
- 77% of patients received test results before leaving the Trust
- 76% of patients always had confidence and trust in doctors/nurses.

Engaging with our patients

We are absolutely committed to engaging with our patients and local people, and making sure we are having open and honest conversations with all of our stakeholders. This year, we hosted the largest engagement work the Trust has undertaken for some years (our Epsom and St Helier 2020-2030 work), and are delighted to have been able to reach new audiences across the communities we serve.

We have a presence on all of the main social media platforms (Twitter, Facebook, Instagram and Youtube) and would encourage you to get in touch! At the time of writing, we have more than 8,800 followers on Twitter and 1,624 followers on Facebook.

During the year, our tweets reached a staggering 1.6 million people and we issued 1,420 tweets.

Throughout the year, we also hosted a number of public events for our patients so that they could let us know what they think of our services and our plans for the future.

We know that by listening to and engaging with patients and local people, we can improve the experience that they have when they come to our hospitals.

For more information about how we engage with our patients and other local people, please email esth.communications@nhs.uk, or call us on 020 8296 4996.

And, of course, members of the public, patients and our staff are always welcome to our trust board meetings to listen to the discussions that take place and ask executive and non-executive directors questions. You can find agendas, previous minutes and more information about the Trust Board online at www.epsom-sthelier.nhs.uk/board.

We held a touching fundraising and awareness evening for local people affected by the loss of a baby or child this year. As the sun set on Sunday 15 October, the lights at the front of St Helier were dimmed and the building was temporarily transformed into a moving canvas of flickering candles – giving local families and individuals the opportunity to come and remember any child or baby who has died. The event was free to attend, although donations to the Bearing Hope campaign were welcome. Bearing Hope is the campaign launched by local couple Hollie Perry and her partner Scott, who have raised £20,000 to completely overhaul the bereavement room in the Maternity Department at St Helier, after they lost their daughter, Hope, in August 2017.

Provide responsive care that delivers the right treatment, in the right place at the right time

When people come to our hospitals – whether they have been referred to our services for diagnostic tests or are in our A&E departments because of an injury, it is vital that we can respond to their needs quickly and either help the patient recover from pain or begin long term care.

This year, we introduced a number of new initiatives and ways of working that serve to prove how committed we are to providing responsive care to the people who need us, as well as building on our efforts to meet annual standards that are set by the Government.

As you may have read in the overview of our performance against standards, our performance against the 'referral to treatment' standard (which sets out how long a hospital has to offer a patient an appointment once they have been referred to us from the GP, have deteriorated slightly this year. There are a number of reasons for this slight drop, including a decision – in line with national guidance – to divert resources to the huge surge in very sick patients who needed care during the very busy winter. We are working hard to improve this performance for next year.

In preparation for the busier times of year, we put a number of measures in place to ensure that patients received a senior clinical review at the earliest opportunity and did not stay in hospital for longer than was necessary. This included setting up a rapid assessment hub on our acute medical units, which meant that GPs could refer patients directly to the units rather than ask a patient to wait in our very busy A&E departments. We also established a GP and nurse-led ward at St Helier, known as the 'One Step Closer to Home ward' where patients who were medically well enough to go home but who needed complex discharge plans were cared for.

We are pleased to have met the majority of standards for patients waiting for cancer treatment, including seeing patients within two weeks of a GP referral with suspected cancer, and treatment beginning within 31 days of a confirmed diagnosis.

Staff working in our A&E departments went above and beyond to ensure that our patients were seen, treated or discharged within a maximum of four hours. Despite sterling efforts from staff, we were just below the national standard of 95%, caring for 93.15% of patients in our departments within four hours. Considering the increases in the number of very sick patients who came to our A&E departments during the year, that was not an easy thing to achieve and we performed strongly when compared to other acute trusts in the local area.

Ready for anything – our resilience plans

As a large trust that runs services 24-hours-a-day, seven-days-a-week, we have to be ready to respond in the event of a civil emergency (such as heavy snow or a mass accident). In order to do that, we maintain up-to-date major incident plans and continue to work with local resilience forums, NHS partners, our staff, patients and volunteers to ensure that we can respond effectively to any emergency situation.

As part of these plans, this year we put in place a £1.69 million programme to deal with the challenges of winter, including recruiting more nurses and doctors to work in our busy A&E (accident and emergency) departments, preparing additional beds for patients who are admitted in emergencies, and opening some of our key departments for longer.

As well as our emergency and winter plans, we also develop and maintain plans for the following key areas:

- Business continuity
- Flu pandemic
- Mass casualty.

These are regularly tested and awareness training is given to staff at regular intervals.

As a 'category two responder', the trust continues to meet its obligations under the Civil Contingencies Act 2004 and NHS guidance on emergency preparedness, as well as maintaining standards expected by the Care Quality Commission and the Department of Health.

This winter has been incredibly difficult for the health service, and the most challenging period that most people working in the NHS can remember. Our Chief Executive launched the Winter Hero awards to celebrate the hard work of staff who went above and beyond to make sure patients were kept safe and well cared for during the levels of unprecedented pressure – and what a celebration it was!

We were joined by broadcaster and journalist, Jeremy Vine, who helped to award certificates and recognise the commitment of our staff. Jeremy's Dad has been a patient with us, and he has been so impressed with the care that staff have provided, he was more than happy to help. He shared his story with us, and it was a real honour to have him play a part in our celebrations.

The Winter Hero awards were also about recognising the support that staff have given to colleagues during difficult shifts, the meetings they attended to help us plan for the next spike in activity and the smiles and care they have provided to the worried loved ones of sick patients. Nominations had flooded in from staff and patients, meaning that we had a wealth of Winter Heroes and a handful of Super Heroes!

As a small token of thanks, our Winter Heroes were all given a certificate, a badge (look out for those on the lanyards) and a cinema ticket. And all sponsored by Allocate who provide our e-rostering service.

Maintain financial sustainability

We are delighted to announce that we ended the year with a smaller deficit than we had initially planned, coming in at a Financial Performance deficit of £13.4 million rather than the deficit of £17.8 million agreed with our regulator at the start of the year.

During the year, we sold an unused part of our Sutton estate to the London Borough of Sutton for £10.6 million. The Trust has been allowed to retain these proceeds to address critical building maintenance issues at St Helier. This has allowed to invest a record amount of money into our buildings, including opening new paediatric outpatients, an Urgent Treatment Centre at Epsom and a new audiology department (you may have noticed a number of these improvements detailed on pages 23).

Although we are pleased to have been able to end the year with a smaller deficit than agreed at the start of the year, there were some challenges along the way. This was a very busy year for us, during which we treated a high number of very sick patients – particularly over winter. In certain periods of the year, these surges in demand resulted in additional costs for us, including workforce costs for staffing additional clinics and escalation areas.

Furthermore, we had an ambitious cost improvement plan in place for the year, which identifies how every trust in the country can increase efficiencies and reduce in-year spending. Working in a financially challenging NHS landscape, we were unable to deliver all of these improvement plans.

However, the challenges we faced financially have helped us to set up systems and processes that allow teams across the Trust, working with their dedicated Finance and Business Manager, to scrutinise their income and expenditure more effectively. This has included setting up weekly meetings between the managers of the services and our Chief Financial Officer to assess financial performance, and our priority based budgeting system, which helps teams to match resource to the demands on their services.

Work in partnership with our patients, commissioners, other health providers and local authorities

During the year, we have taken some significant steps forward in working more closely with our health and social care partners to provide an integrated service for our patients.

A bright IDEEA

In February, NHS Surrey Downs Clinical Commissioning Group announced that a partnership of local organisations, led by Epsom and St Helier, has been awarded the contract to provide adult community services from 1 October 2018 for up to five years potentially worth over £100 million.

This partnership, which is known as the Integrated Dorking, Epsom and East Elmbridge Alliance (IDEEA), brings together CSH Surrey, Epsom and St Helier University Hospitals NHS Trust and the three GP federations that operate in the Surrey Downs area (GP Health Partners in the Epsom, Leatherhead and Ewell area, Dorking Healthcare for Dorking practices and Surrey Medical Network for practices in the East Elmbridge area).

This new partnership is a very exciting development for the region, and is set to have huge benefits for patients. It will allow the NHS locally to work more closely together, so whether a patient needs care in hospital, with a GP or in their own home, healthcare professionals across all disciplines will be able to work around the individual and put the patient right at the heart of all that we do.

The model is based around six 'primary care hubs' of GPs and community teams who will work in close partnership to keep frail elderly people in particular safe and well in the community.

This will provide a service that will be more personalised and more joined up for patients so that together we provide the best care for people living in the Surrey Downs area.

Building on the success of Epsom Health and Care

Epsom Health and Care – the pioneering partnership that brings together acute care, GPs, community services and social care, providing joined up services for people over 65 in the Epsom area – expanded its remit with the launch of a brand new stroke service. All of the partners (the Trust, CSH, Surrey County Council and the GP federation in Epsom) have publicly committed to work together for patients who have suffered a stroke and need rehabilitative care. Building on the foundation of the work already done, the new stroke service will enable seamless care to be provided to patients in a new way, bringing together: the Trust's hyper-acute stroke unit, the acute stroke unit and the TIA Service; the inpatient stroke rehabilitation service previously provided by CSH Surrey; and the Community Neuro Rehabilitation Team, including the Early Supported Discharge Service. This integration of services will help to ensure patients have continuity of care during their recovery through a seamless journey from high intensity acute services through to community rehabilitation, and on-going coordination within the primary, community and voluntary services supporting their life after stroke. It also works with the voluntary sector to ensure that carers and stroke patients get the support and information they need as they recover.

Over the year, the '@ home' service has supported over 1,700 patients and has provided care and support in the home to ensure that, on average, three patients are able to remain at home and have two patients brought home sooner from hospital every single day. This is equivalent one ward of patients being actively looked after at home. This has resulted a 6% reduction in the number of people requiring an overnight admission in Epsom Hospital for over 65s compared to the previous year.

Taking part in RAPID cancer care

We have partnered with the Royal Marsden to become one of the pilot sites in a new initiative to make sure patients who have suspected prostate cancer have the necessary tests and check-ups as soon as possible. Using cutting edge technology, we hope to slash diagnosis times for prostate cancer from six weeks to one day in a world-leading new approach that virtually eliminates the risk of deadly sepsis. The new scanning and diagnosis method means a 'one-stop-shop' for suspected prostate cancer, the most common cancer in men in the UK, with over 40,000 new cases diagnosed every year.

The vast majority of people referred to us do not have cancer, but we appreciate that this can be a worrying time, and we want to reach a full diagnosis as soon as is possible. As such, when a GP refers a patient to hospital with a suspected cancer, you will have an appointment within two weeks. From there, the approach involves specialist clinical expertise as well as equipment, with NHS England looking into how it could be rolled out to other major cancer centres across England. The new technique uses highly detailed 'multi-parametric' MRI – mpMRI – scans, currently being rolled out across the NHS, which provide much higher quality imagery. Between a third and 40% of patients who have an mpMRI scan will find out on the same day that they do not have prostate cancer and can safely avoid having a biopsy. The machines are also able to pick up growths that are much harder to detect. If a biopsy is needed, the new FUSION machines will overlay ultrasound images with 3D MRI scans to create a highly detailed map of the prostate that can be used to accurately target suspect areas for taking tissue samples. The new system means an area as small as a grain of rice can be hit first time.

SWLEOC

SWLEOC (South West London Elective Orthopaedic Centre) is an NHS treatment centre providing regional elective orthopaedic surgery services (including inpatient, day-case and outpatient) based on the Epsom site. Established by the four south west London acute trusts to deliver strategic change in the delivery of planned orthopaedic care, SWLEOC provides high quality, cost efficient, elective orthopaedic services ranked amongst the best in the world.

Since opening in January 2004, SWLEOC has earned a reputation as a centre of excellence for elective orthopaedic surgery with excellent outcomes, low complications and high patient satisfaction. Performing around 5,200 procedures a year, 3,000 of these joint replacements, SWLEOC is recognised as the largest joint replacement centre in the UK and one of the largest in Europe. It is also one of the largest shoulder surgery centres in the UK. Other sub-specialities include soft tissue, spine, foot and ankle procedures.

The unit consists of five state-of-the-art operating theatres, a 17-bedded post-anaesthetic unit (PACU) bed recovery area with high dependency and critical care facilities and two wards of 27 beds.

Ensuring we have highly engaged, patient centred and skilled teams that are well-led.

There have been a number of key ways in which we have strengthened the way we work this year to ensure all of our teams are skilled, patient centred and are well-led. This includes appointing an Equality, Diversity and Inclusion Manager who is developing a work programme that incorporates both patient and staff equality issues.

We have also reviewed the structure of our Patient Experience and Complaints team, which has resulted in a significance improvement in our complaint response times and the way in which we share patient feedback – both good and bad – across our organisation.

The Trust has had a high degree of continuity and stability at Board level, with no interim appointments to the Executive Team during the year.

Furthermore, we offer all staff a number of training courses, development opportunities and apprenticeships.

ACCOUNTABILITY REPORT

Annual Governance Statement 2017-18

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 Epsom and St Helier University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Epsom and St Helier University Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

The Governance Framework

Our Board of Directors is the corporate decision making body, and plays a key role in shaping the strategy and vision of the Trust, whilst ensuring value for money. The Board is also responsible for assuring that risks to the organisation are managed and mitigated effectively.

The Board provides a framework of governance within which we deliver high quality healthcare services across Surrey and south west London. The Board clearly recognises that effective corporate governance underpins good leadership and accountability, and the Board continually seeks to improve governance arrangements within the Trust.

The Trust has an integrated approach to governance, ensuring that decision making is informed by a wide range of clinical, financial, corporate and other information, working at all times to increase the efficiency, effectiveness and overall quality of our services.

In response to NHS Improvement guidance issued in July 2017 advising that NHS Trusts should undertake externally-facilitated developmental reviews every three to five years, the trust undertook an initial self-review against the NHSI well led framework as a first step in understanding the organisation's strengths and weaknesses. A detailed analysis was undertaken of the responses which identified a number of themes. Work is now commencing on triangulating the outcome of the self-assessment review, the results from the NHS national staff survey and the outcome of the CQC well led inspection carried out in February 2018. The Board has agreed that this initial self-assessment should inform the scope of a broader, externally facilitated well led review to be commissioned and undertaken in the 2018-19 financial year.

The Trust Board

The Trust Board is comprised of a chairman, five non-executive directors, one associate non-executive director, and six voting executive directors. The six voting executive directors are:

- Chief Executive
- Two joint Medical Directors (with one shared vote)
- Chief Nurse
- Chief Operating Officer
- Chief Finance Officer.

Five other executive directors without voting rights attend each Trust Board meeting:

- Director of Human Resources
- Director of Strategy, Corporate Affairs and ICT
- Director of Estates, Facilities and Capital Projects
- Director of Communications and Patient Experience
- Director of Transformation and Turnaround.

The Trust has a relatively high degree of continuity and stability at Board level, with the following changes in year:-

- Steve Poulton stood down as a Non-Executive Director and was replaced by Aruna Mehta (previously an Associate Non-Executive Director at the Trust). The Executive and Non-Executive team would like to thank Steve for his contribution to the Trust.
- Martin Kirke was appointed as a new Associate Non-Executive Director
- Caroline Landon was replaced by Dan Bradbury as Chief Operating Officer
- Chris Williams was appointed as Director of Transformation and Turnaround

Membership of the Board to the date of approval of the Annual Report was as follows:-

Board Member	Position	Period
Executive Directors		
Daniel Elkeles	Chief Executives	From January 2015 to date
Ruth Charlton	Deputy Chief Executive and Joint Medical Director	From September 2011 to date
James Marsh	Joint Medical Director	From September 2013 to date
Charlotte Hall	Chief Nurse	From May 2015 to date
Rakesh Patel	Chief Finance Officer	From May 2015 to date
Caroline Landon	Chief Operating Officer	From June 2016 to October 2017
Dan Bradbury	Chief Operating Officer	From October 2017 to date
Kevin Croft	Director of HR	From June 2011 to date
Trevor Fitzgerald	Director of Estates, Facilities and Capital Projects	From December 2015 to date
Peter Davies	Director of Strategy, Corporate Affairs and ICT	From June 2013 to date
Lisa Thomson	Director of Communications and Patient Experience	From April 2017 to date
Chris Williams	Director of Transformation and Turnaround	From February 2017 to date
Non-Executive Directors		
Laurence Newman	Chairman	From November 2011 to date
Pat Baskerville	Deputy Chairman and Non-Executive Director	From January 2011 to date
Elizabeth Bishop	Non-Executive Director	From July 2013 to date
Richard Noble	Non-Executive Director	From June 2014 to date
Iain MacPhee	Non-Executive Director	From January 2014 to date
Steve Poulton	Non-Executive Director	From October 2014 to December 2017
Aruna Mehta	Associate Non-Executive Director Non-Executive Director	From April 2016 to January 2018 From January 2018 to date
Martin Kirke	Associate Non-Executive Director	From February 2018 to January 2020

The Board met a total of eight times in public in 2017-18 and all meetings were quorate. In months that the Board did not meet in public, the Board hosted a Public Briefing to enable more in-depth discussion in public of performance, quality, finance, strategy and risk. The intention of these Public Briefings is to encourage openness and engagement with patients and stakeholders via discussion of strategy and performance against key operational metrics. There were five Public Briefings in 2017-18. The Board meets in private every month.
Prior to all Board Meetings and Public Briefings, the Board undertake a 15 Steps Challenge Walkabout within different parts of our hospitals. The findings from the walkabout are reported back in public at the subsequent Board Meeting or Public Briefing.

The Board held its Annual Public Meeting in July 2017.

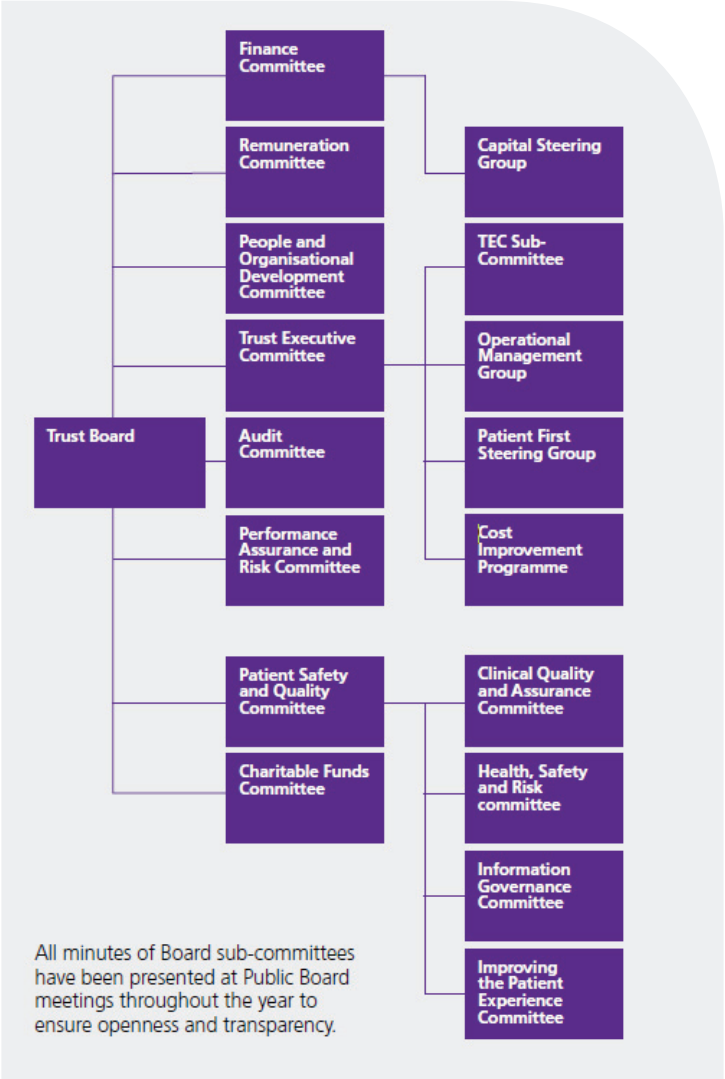
All non-executive directors and all directors complete a declaration for the Fit and Proper Person's Test upon appointment.
The Board's Register of Interest is regularly updated and is available for inspection on the Trust's website.

The Committee Structure

The Trust Board has eight standing sub-committees:

- Audit Committee
- Finance Committee
- Patient Safety and Quality Committee
- Performance Assurance and Risk Committee
- People and Organisational Development Committee
- Trust Executive Committee
- Charitable Funds Committee
- Remuneration Committee

All Board sub-committee Chairs have presented committee reports at Public Board meetings throughout the year to ensure openness and transparency.



The **Audit Committee** met on five occasions in 2017-18. The Committee supports the Board by providing an independent and objective review of the financial and corporate governance assurance processes and the internal control environment across the Trust. Membership comprises three non-executive directors (one of whom is Chair of the Committee), with the Chief Executive, the Chief Finance Officer, the Head of Internal Audit and a representative from the external auditors in attendance. Other officers of the Trust are invited to attend to report on standing items, and also as requested on exceptional items. The Audit Committee receives assurance on fraud deterrence via regular reports from the Trust's Local Counter Fraud Group, and the Local Counter Fraud Specialist is invited to attend all meetings.

Major reports received by the Committee during the year included:

- Annual accounts and associated documents including the annual audit letter and Head of Internal Audit Opinion
- Quality Account
- Annual Governance Statement
- Internal and external audit
- Counter fraud
- Deep dives, including reporting on compliance against the National Audit Office good practice guide 'Cyber Security and Information Risk Guidance for Audit Committees'.

The **Finance Committee** meets monthly and is chaired by a non-executive director. The committee approves the annual financial plan and reviews financial performance to ensure the trust achieves its annual financial targets, and also reviews and approves investments in service development opportunities and approves tender proposals and business cases. The committee also has responsibility for financial risk management, and provides the Board with an objective oversight of financial issues and, where necessary, makes recommendations to the Board.

The **Patient Safety and Quality Committee** meets monthly with a remit to seek assurances that the quality of patient services is of the highest standard with a particular focus on patient safety, clinical effectiveness and patient experience. The committee is chaired by a non-executive director, with the membership comprising two further non-executive directors, all executive directors (with the Deputy Chief Executive/Joint Medical Director as the executive lead) and Associate Director of Quality. The committee receives reports on Serious Incidents and Never Events, and themes and trends arising therefrom, and also updates on action plans to further improve the quality of services provided.

The **Performance Assurance and Risk Committee** has a remit to review performance against national and contractual standards (particularly in relation to the NHS Constitutional Access Standards) and the risks to delivery of the Trust's corporate objectives, with a particular focus on issues that are Trust-wide. The committee enables the Board to benefit from a 'drill down' of the principal risks and to review the effectiveness of mitigating actions to control the risk. The committee has also enabled a more forward looking approach to the review of key risks and how they may impact on the delivery of annual objectives.

The **People and Organisational Development** Committee maintains a strategic overview of the Trust's workforce and associated educational and organisational arrangements and meets bi-monthly. It oversees the development of the people and organisational development strategy and annual plans for delivering that strategy, for approval by the Board. The committee is chaired by a non-executive director, and advises the Board on any areas of concern in relation to people management and workforce strategy.

The **Trust Executive Committee** is chaired by the Chief Executive and comprises the senior clinical leadership body of the trust, with a membership of over 55 people. The committee meets monthly with a remit to set the Trust's direction of travel, both strategic and operational, in terms of decisions not reserved to the Board, and the proposing and refining of issues on matters reserved to the Board.

The **Charitable Funds Committee** monitors arrangements for the control and management of the Trust's charitable funds in accordance with statutory and legal requirements or best practice as required by the Charities Commission. The Committee is chaired by the Chairman.

The **Remuneration Committee** is chaired by the Chairman and makes recommendations to the Board on Trust remuneration policy and the specific remuneration and terms of service of executive directors to ensure that they represent value for money and comply with statutory and Department of Health requirements.

Capacity to handle risk

Following the 2015 CQC inspection, the Trust overhauled its governance arrangements, building on good practice at exemplar Trusts. Our Board now has three principal assurance documents in relation to risk to ensure effective management of the Trust's business:

- The Integrated Performance Report
- The Corporate Risk Register
- The Board Assurance Framework.

The Trust now has a comprehensive, integrated approach to the management of risk overseen by the Board and entailing scrutiny at a number of key committees.

The key committee in reviewing risk is the Performance Assurance and Risk Committee (PARC), which was established in April 2016 as a sub-committee of the Board with the membership comprising all non-executive directors (NEDs) and Executives, and chaired by a NED.

The role of PARC is to obtain assurance on:

- performance against national and contractual standards particularly in relation to NHS Constitutional Access Standards
- the risks to delivery of the trust's corporate objectives, with a particular focus on issues that are cross-cutting or trust-wide
- specific divisional and corporate issues and risks that meet, or are just below, the threshold for Trust Board consideration.

The Board lead for overall risk management is the Deputy Chief Executive/Joint Medical Director with leadership in terms of the corporate risk register sitting with the Director of Strategy, Corporate Affairs and ICT.

The Trust's Risk Management and Risk Register Policy and Risk Assessment Policy under pins how the Trust manages risk, which includes the recording of incidents on Datix (the Trust's reporting system) which is available to all staff.

Risk management training is available for all staff, with the course providing the training necessary to undertake formal risk assessments. The course is mandatory for all staff who sign, approve, review, agree, or monitor risk assessments. Attendance at this training is required every three years. By the end of the course, participants are expected to be able to:

- describe the legislative requirements
- describe the five step model for Risk Assessment
- understand the purpose of an organisational Risk Register
- complete a Risk Assessment relating to an identified hazard
- be knowledgeable about the content of the Trust Risk Assessment Policy, Procedure, and documentation.

The risk and control framework

The risk register was redesigned following the 2016 CQC inspection and maps all aspects of risk against the Trust's four key challenges (staffing, variability in quality of care, estates and infrastructure and finances).
The risk register is scrutinised at an Executive team meeting prior to discussion at the following Board committees on a monthly basis:

- Patient Safety and Quality Committee (in the context of patient safety and quality of the patient experience)
- Trust Executive Committee
- Performance Assurance and Risk Committee.

The Board reviews the risk register at all of its monthly meetings. Risk is a key consideration in discussing a wide range of items at Board and any areas of concern will be referred for further review and discussion at the appropriate Board sub-committee.

The risk register is very much considered a 'live' document and forms part of the Integrated Performance Report. The risk register template requires the recording of three risk ratings:

- The original risk rating when the risk was first identified
- The current risk rating
- The target, end of year risk rating ('risk appetite').

Importantly, the corporate risk register focuses attention on what current mitigations, controls and assurances are in place and what further actions or assurances are required. Each risk listed within the risk register has a single executive 'owner' to ensure accountability for risk management and mitigation.

The scoring of risk ratings is achieved against the NPSA standard risk matrix to ensure consistency of a wide range of risks from clinical through financial to reputational issues. The same framework is used within the divisions, by executives and at PARC to moderate risks and to determine risk appetite. Although a 'live' document that can be amended/ updated at any point, the usual process for updating the risk register is as follows:

- Datix report run detailing all risks at 12 and above
- Report reviewed by Director of Corporate Affairs/Executive team prior to PARC
- Risk is on the agenda of, and discussed at, the monthly performance meetings with the Divisions to identify any risks that need to be escalated upwards
- Risk register discussed at CTM, TEC and PSQ and PARC
- Risk register discussed at Board.

This approach takes place monthly and is implicit for all risks on the corporate risk register.

The Board Assurance Framework (BAF) collates in one document progress against, and risks to the achievement of, the Trust's corporate objectives. The BAF details the main sources of assurance against each corporate objective, enabling the Board to get a clear understanding of the risks faced by the organisation in terms of performance/ progress against the key corporate objectives.

Against each corporate objective, the BAF details the individual actions required to deliver that objective and maps and RAG rates progress on a quarterly basis against each of those actions. Where gaps in progress are identified, the BAF details the sources of assurance for the Board. The BAF also details a year end projected RAG rating for each corporate objective.

The BAF is discussed at Board and Board sub-committees on a quarterly basis, and provides an evidence base to assist the Board in deciding where to focus assurance resources. As an example, the Quarter 2 BAF reported, inter-alia, that "Referral To Treatment performance remains challenged" and as a result the Performance Assurance and Risk Committee agenda was expanded to include regular reporting on RTT performance.

The Integrated Performance Report (IPR), Corporate Risk Register and BAF are complementary documents. The IPR indicates key performance and shortfalls which lead on to a risk discussion. For example risks to delivery of the A&E 4-hour access standard and the 18-week RTT standard were escalated and added to the Corporate Risk Register and are now reviewed in greater detail to obtain appropriate assurance at the monthly meeting of PARC ahead of each Board.

The IPR, Corporate Risk Register and BAF together form the key source of evidence that links the Trust's corporate objectives to the risks, controls and assurances detailed within the corporate risk register, and are the main tools that the Board uses in terms of internal control. As such, the IPR and Corporate Risk Register are reviewed monthly, while the BAF is reviewed by the Board on a quarterly basis in the context of identifying any risks to delivery of the corporate/strategic objectives identified by the Board that require inclusion on the risk register.

The highest rated risks (20 and above) on the March 2018 Corporate Risk Register were as below:

Staffing	
There is a risk to the safety and integrity of the stroke service due to unfilled consultant posts	20
Capacity and ability of senior leadership teams to deliver all of the trust's operational, quality, patient experience, financial, strategic objectives, including significant infrastructure projects during 2017/18	25*
There is a risk to the effective delivery of high quality services, especially in Care of the Elderly and Gastro-Intestinal Medicine due to challenges around effective leadership, vacancies at Consultant level and in middle grade and junior doctor cover	20
There is a risk of losing trainees as a result of a visit by HESL and the issuing of three immediate mandatory requirement actions	20
Variability in Quality of Care	
Due to additional number of patients being admitted due to winter pressures, there are not enough wards open to manage patient. Aim is to ensure that the right patient is in the right bed at the right time, including clinical care.	20
Estates and Infrastructure	
Loss of provision of clinical services throughout the Trust due to poor condition of external buildings (roofs, windows, walls, structure)	20
Significant disruption to clinical services and clinical risk throughout the Trust due to the failure of the electrical infrastructure	20
Inability to provide inpatient services across St Helier Hospital due to the loss of the central hot water and heating system	20
Risk to the loss of theatres and critical clinical areas across the Trust due to the failure of air handling and cooling systems	20
Increased clinical risk and loss of inpatient beds across the Trust due to the failure of mechanical bed lifts where this is a single lift serving the building	20
Inadequate facilities for HDU/ITU at St Helier	20
Finances	
Inability to achieve Financial Performance Total through under deliver of cost improvement plans and income, or expenditure in excess of budgets	20
Inability to achieve long term financial sustainability due to inefficiencies of providing range of services across two 'subscale' acute sites, contributing to an increasing underlying structural deficit	20

*This risk was subsequently downgraded to a 20 in April

Copies of the corporate risk register are available with the Public Board and Public Briefing papers, available on the trust website at https://www.epsom-sthelier.nhs.uk/board-papers-and-agendas.

Quality governance

The Trust is committed to putting the patient first by delivering great care to every patient, every day, focusing on providing high quality, compassionate care that:

- Is safe and effective
- Creates a positive experience that meets the expectations of our patients, their families and carers
- Is responsive and delivers the right treatment, in the right place at the right time.

The Trust has a statutory duty to produce an annual Quality Account. Quality Accounts are reports to the public on the healthcare services a healthcare provider delivers and reflect the three domains of quality: patient safety, clinical effectiveness and patient experience.

The Trust's Quality Account demonstrates to patients and the public how the Trust is performing against agreed quality priorities and where it will focus priorities for quality improvement. Prior to publication, the Trust is required to formally engage with, and seek assurance from, specific groups including Healthwatch, commissioners and the Overview and Scrutiny Committee, on the content of the Quality Account.

The Quality Account is reviewed through our internal assurance processes; by the Trust Executive Committee and the Patient Safety and Quality Committee and is noted at our Audit Committee.

Our Quality Account contains information about the quality of our services, including the improvements we have made during 2017-18 against the priorities that we set and determines our key priorities for next year (2018-19). The report also includes feedback from our patients and commissioners (the NHS organisations who pay for our services) on how well they think we are doing.

Our Quality Account is divided into four parts:

Part one looks at our performance in 2017-18 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience. If we have not achieved what we set out to do we explain why and outline how we intend to address these areas for improvement.

Part two sets out the quality priorities and goals for 2018-19 and explains how we decided on them, how we intend to meet them and how we will track our progress.

The quality priorities for 2018-19 are:

- Priority 1 – To improve the proportion of our patients seen daily by a Consultant
- Priority 2 – Learning from avoidable deaths in hospital
- Priority 3 – To improve the recognition and management of patients with sepsis
- Priority 4 – To work with external stakeholders to reduce the incidence of potentially avoidable hospital admissions and readmissions.
- Priority 5 – Responding to our patients' experience in the Emergency Department, specifically looking at the Friends and Family Test, and feedback received through PALS and complaints.
- Priority 6 – Strengthening the Trust involvement with carers

Part three sets out our Statements of Assurance. These statements of assurance follow the statutory requirements for the presentation of Quality Accounts, as set out in the Department of Health's Quality Account regulations.

Part four sets out further performance information which also follows statutory requirements.

Clinical Audit

During 2017-18 the Trust participated in 32 (100%) national clinical audits and 5 (100%) national confidential enquiries on the quality accounts list in which it was eligible to participate.

The reports of 12 national clinical audits were fully reviewed and discussed by the appropriate committees. Actions from these audits have been agreed and aim to improve the quality of healthcare within the Trust. The audit department additionally reviewed the reports of 198 local clinical audits in 2017-18 at clinical audit half day meetings and via appropriate divisional management team meetings.

Learning from audits continues to be shared at joint specialty quality half day meetings, educational meetings and through presentations and posters at the clinical audit open morning which is held annually in June.

Serious Incidents and Never Events

The Trust reports all Serious Incidents and Never Events in line with the national and local frameworks.

In 2017-18, the Trust reported two Never Events. The occurrence of all Never Events is reported publicly, but they are considered in more detail in private as part of the monthly review of all Serious Incidents at both the Patient Safety and Quality Committee and Trust Board.

A thorough investigation of all Serious Incidents is considered to be an essential component of the Trust's approach to patient safety and provides continuous learning in the understanding of why an incident occurred, the care and service delivery issues identified and how future risk and harm can be reduced by effective understanding, review and action.

CQC

The trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust was inspected against its core services in January 2018 and against the well-domain in February 2018. The inspection report was published in May 2018 and noted significant improvements across a range ofservices. However, the Trust remains Requires Improvement. The development of action plans to address the issues identified in the reports are underway.

Employer responsibilities

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

The environment

The Trust has undertaken risk assessments and established Carbon Reduction Delivery Plans in accordance with the requirements of the Civil Contingencies Act 2004. These ensure that the organisation's obligations under the Climate Change Act 2008 are met along with sector-wide Adaptation Reporting requirements.

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

The Trust ensures that staff comply with the SFIs, Scheme of Delegation and Standing Orders. Appropriate reports are presented to the Finance and Investment Committee and Audit Committee and reported through to the Board via the Integrated Performance Report. The Finance and Investment Committee meets monthly to consider all elements of financial performance including delivery of cost improvement programmes. The internal audit programme includes a review of the financial systems and processes and has also undertaken a review of expenditure on temporary medical staffing.

Financial risks including mitigations and controls are considered at the Trust's Performance and Risk Committee.
The Trust has in place a Service Improvement Team and a Project Management Office to support delivery of the Trust's efficiency and cost reduction programme. The Trust uses wide ranging data to inform the cost improvement programme including the Model Hospital, feedback from GIRFT reviews and procurement benchmarking tools. The Trust is also a part of collaborative efficiency programmes with the three acute trusts in south west London.

Performance reporting

The Integrated Performance and Risk report details Trust delivery of both national and local standards, reporting performance against metrics in six domains (the five CQC domains of safe, effective, caring, responsive and well-led, and an additional local domain of money and resources). The key metrics reported against these domains are:

- Safe and effective (mortality, risk assessment (stroke, VTE, dementia), incident reporting, duty of candour reporting, harm free care, falls, safe staffing, infection control)
- Caring (maternity care, patient experience, complaints)
- Responsive (cancer access, planned care, urgent care)
- Well Led (workforce including vacancy rate, agency usage, sickness absence, staff turnover, training, performance monitoring) communications and engagement
- Resources (financial performance).

The corporate risk register is also a key component of the report.

The Integrated Performance and Risk Report is presented to Board on a monthly basis, including public board and is discussed in detail at Public Briefings. Before presentation at Board, the report is scrutinised by the Patient Safety and Quality Committee, the Performance Assurance and Risk Committee, the Finance Committee, the People and Organisational Development Committee (on a bi-monthly basis) and the Trust Executive Committee.

The report highlights any performance variations from plan and, where there are concerns about performance against national or local targets, exception reports are provided to provide assurance that plans are in place to improve performance. The narrative against individual indicators includes a description of the indicator, trend analysis, an explanation for any deviation from planned performance and may include benchmarking data against other trusts where available.

Elective waiting times are monitored and validated daily to ensure quality and accuracy of the information. A number of elective reports including the Patient Tracking List are produced every morning to reflect the position for the previous day, which will then be validated by the pathway co-ordinators within each clinical division. There is a separate data validation team focusing on people who have had to wait for treatment, which is supervised by the General Manager for Patient Services. There are weekly performance meetings with General Managers and Service Managers to review the specialty level position chaired by the Director of Planned Care.

Information governance

On an annual basis the Trust completes the NHS Digital information governance toolkit and for the 2017-18 financial year obtained a score of 71% (not satisfactory) against a target of 72%. This 'unsatisfactory performance' was related solely to the completion rate for information governance training, against which the Trust achieved 88.5% against a target of 95%. The Trust will be focussing on improving performance in the first three months of 2018-19.

The Trust's Information Governance Committee is chaired by the Senior Information Risk Owner (the Director of Strategy, Corporate Affairs and ICT). The Caldicott Guardian, a senior clinician, is a key member of the Committee and has over sight of information risks.

The Information Governance Committee meets every two months and receives reports on information incidents and reviews the information governance risk register in detail.

The Information Governance Committee reports in to the Patient Safety and Quality Committee. During the 2017/18 financial year the Trust experienced one IG level 2 SIRI Incident relating to the loss of a camera used in a Dermatology Clinic. It was determined that harm to patients had not occurred. This incident was reported to the Information Commissioners office who determined that no enforcement action would be taken against the Trust.

Penetration tests were undertaken in 2017/18 and any remedial action identified is immediately undertaken and monitored by the IG Committee. Systems are patched in accordance with manufacturer's guidance on a regular basis. The Trust is signed up to receive security alerts and guidance from NHS Digital.

In February and March, NHS Digital conducted a cyber audit alongside all other trusts. This audit identified five actions which need to be addressed as a critical priority, and a further ten actions were Identified which need to be addressed as a high priority. The Trust has all actions in hand and will report back on progress at the Audit Committee.

Counter fraud

Fraud awareness campaigns have included presentations to management and frontline staff promoting an anti-fraud culture and educating staff on how to report fraud. A counter fraud briefing is included at all staff inductions. The Counter Fraud Service has drafted a number of articles for staff communications on successful fraud investigations undertaken.

The Local Counter Fraud Specialist (LCFS) attends and presents at monthly staff induction to inform new staff of the Trust's zero tolerance to fraud. The LCFS is undertaking a fraud awareness campaign at the Trust with a view to delivering counter fraud training to staff in all departments.

The LCFS updated the Trust's Counter Fraud publicity material which includes a Counter Fraud leaflet containing the contact details of the LCFS, details of the Bribery Act 2010 and information on what staff should do if they suspect fraud. Additionally, the leaflet refers staff to key policies such as the Counter Fraud and Corruption Policy and Procedures, Declarations of Interest Policy, and Raising Concerns at Work.

Investigations into fraud are conducted in accordance with relevant legislation and are undertaken by accredited LCFSs 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. Where considered appropriate, an investigation is carried out in accordance with a plan agreed with the Chief Financial Officer.

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 and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

The Trust, like the rest of the NHS, faced significant operational challenges in 2017-18 which impacted on achievement against some corporate priorities.

Similar to other Trusts across the country, we experienced an increase in activity and acuity for patients presenting to our emergency departments which impacted on delivery against the NHS Constitution standard that a minimum of 95% of patients attending an A&E department should be admitted, transferred or discharged within four hours of their arrival. Whilst the Trust achieved 93.15% against the 95% standard, we were consistently ranked within the top 3 trusts in London and in the top 20% nationally.

Operational pressures also impacted on trust performance against the proportion of patients waiting 18 weeks and over from referral to starting treatment. In response, the trust has prepared an RTT recovery plan and has detailed the actions that it needs to take to meet the direction set in the joint NHSE/NHSI Operational Guidance for 2018-19 in relation to referral to treatment times, including proposed actions on staffing and governance.

The CQC rated the Trust as Requires Improvement in its latest report published in May. Action plans to address the points raised in the report are in the process of being developed.

A further reflection of the challenges faced over the winter period was a decision to include a risk on the corporate risk register relating to the capacity of the senior leadership teams to deliver all of the trust's operational, quality, patient experience, financial, strategic objectives, including significant infrastructure projects during 2017-18. A decision was taken to temporarily escalate this risk to a 25 at the January meeting of the Performance Assurance and Risk Committee.

This was de-escalated in April as a result of supplementing Board capacity via the appointment of an additional Associate Non-Executive Director and a Director of Transformation and Turnaround, finalising the refresh of the 2017/19 Operating Plan, agreeing a smaller number of corporate priorities for the 2018-19 financial year and achieving the Financial Performance Total.

The Trust obtained an unsatisfactory score against the NHS Digital information governance toolkit because of its failure to achieve the 95% standard for completion of IG training. The Trust will be focussing on improving performance in the first three months of 2018-19. In February and March, NHS Digital conducted a cyber audit alongside all other trusts. This audit identified five actions that need to be addressed as a critical priority and ten actions that need to be addressed as a high priority. The Trust has all actions in hand and will report on progress at the Audit Committee.

Overall, the Trust finished the year in a good position, having delivered its Financial Performance Total for the year, agreed contracts for the 2018-19 financial year, and having submitted a refreshed Operating Plan for 2018-19.

Chief Executive Date: xx May 2018

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.

Siged.....

Chief Executive

Date.....

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 inthe 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.

By order of the Board

Date.....

Chief Executive

Date.....

Chief Finance Officer

Financial review – an overview

At the beginning of 2017-18, the Trust agreed a Financial Performance Target with NHS Improvement (the body responsible for overseeing NHS trusts) to deliver an adjusted financial performance deficit of £17.8 million. The Trust exceeded this and posted an adjusted financial performance deficit of £13.4 million, representing an improvement of £4.4 million over the Financial Performance Total.

However, we are obliged to ensure that the value of our assets are reflected accurately in the change to accounts, and as a result, an independent valuation was undertaken this year. During this valuation, it was found that the value of some of our buildings had depreciated, resulting in an impairment of £26.0 million. £5.4 million of the impairment was accounted for from the affected assets' revaluation reserves, which is used to account for any increase and subsequent decrease in the value of an asset). This means that the Trust's overall accounting deficit was £34.5 million.

The impairment is a technical adjustment following revaluation of the Trust's buildings. It is not an indicator of the Trust's financial performance and is not chargeable against the Trust's NHS Improvement Financial Performance Target.

The Trust received £13.8 million of Sustainability and Transformation Funding (STF) for delivering the financial and performance targets. STF was received from NHS Improvement as part of a funding boost to the NHS, designed to help trusts reduce their deficits and allow them to focus on transforming services to deliver excellent care for patients every day of the week.

It also achieved an overall profit of £10.4 million on disposal of assets, of which £10.6 million was the profit on disposal of surplus land at its Sutton site and the remainder losses on the disposal of surplus equipment assets and the reversal of a provision for a prior year disposal cost which did not arise.

The Trust also achieved a saving of £12.1 million through its cost improvement programme.

The Trust has agreed a new Financial Performance Total with NHS Improvement for 2018-19 of a deficit of £13.6 million.

Key financial targets for 2017-18

Target	2017-18 performance	Target met?	2016-17 performance	Target met?
Achieve the Financial Performance Total for its overall deficit as set by NHS Improvement	The Trust posted a reported deficit of £13.4 million and improved on this by £4.4 million	Yes	The Trust posted a reported deficit of £12.7 million (including £13.1 million of STF funding). Underspend of £2.4 million	Yes
Do not overshoot the External Finance Limit	Undershot by £4.5 million	Yes	Undershot by £1.6 million	Yes
Do not overshoot the Capital Resource Limit	Undershot by £0.4 million	Yes	Undershot by £0.4 million	Yes
Meet the capital cost absorption rate (CCAR) of 3.5% on net relevant assets	The Trust kept within the 3.5% CCAR, resulting in dividend payments of £2.5 million	Yes	The Trust kept within the 3.5% CCAR, resulting in dividend payments of £3.7 million	Yes
Meet the requirement of the Public Sector Payment Policy to settle creditors within 30 days	The Trust achieved a settlement rate of 93% for non-NHS and 61% for NHS invoices, by volume, and 94% for non-NHS and 50% for NHS invoices, by value	No	The Trust achieved a settlement rate of 65% for non-NHS and 44% for NHS invoices, by volume, and 81% for non-NHS and 50% for NHS invoices, by value	No

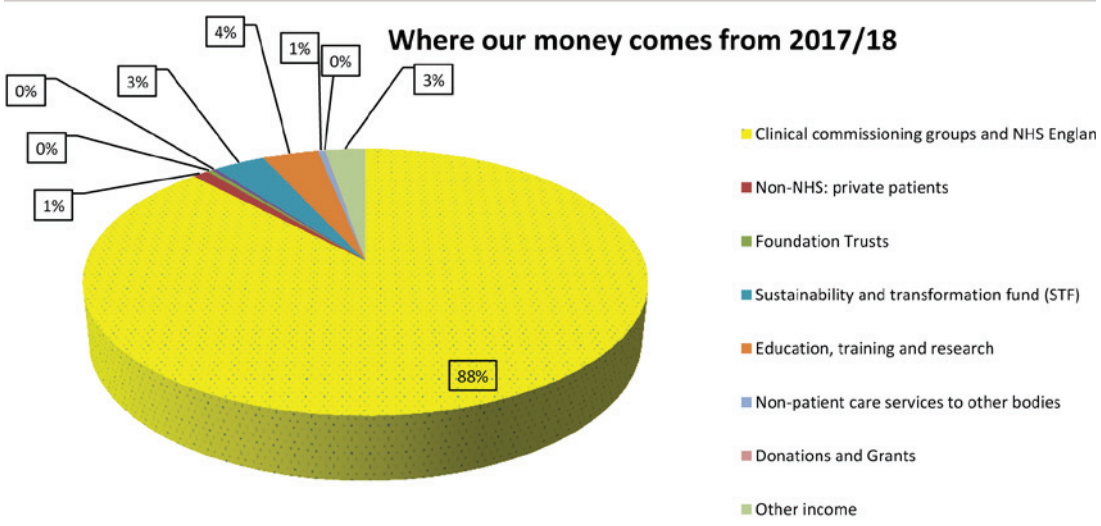
Where our money comes from

Trust income increased by £6.4 million between 2016-17 and 2017-18, mainly due to a £4.1million increases in NHS patient care income due to non- elective activity and tariffs being higher but offset by lower tariffs and funding on elective activity.

The Total income received by the Trust during 2016-17 was £398.6 million of which £357.3 million was for clinical services and £41.3 million related to income for non-patient care, such as research and development, training and education and facilities income (and including STF funding).

The following table and chart shows the breakdown of different types of income received by the Trust during the year and compares income received during 2017-18 to 2016-17.

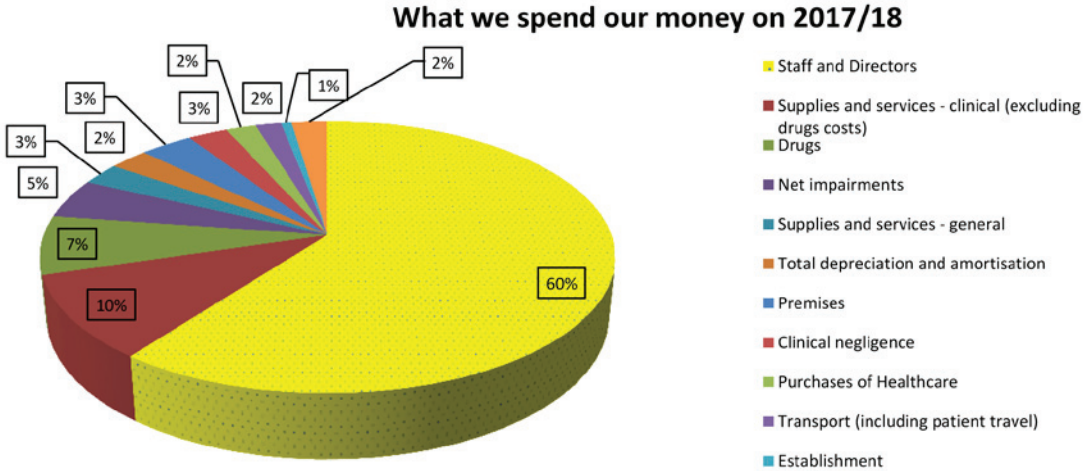
	2017-18 Amount £m	2016-17 Amount £m	Variance £m	Variance %
Clinical commissioning groups and NHS England	350.3	345.4	4.9	1%
Non-NHS: private patients	4.4	4.3	0.1	2%
Foundation Trusts	1.4	2.1	-0.8	-36%
Other patient care income	1.2	1.3	-0.1	-8%
Total Patient Care income	**357.3**	**353.1**	**4.1**	**1%**
Sustainability and transformation fund (STF)	13.8	13.1	0.6	5%
Education, training and research	14.9	15.0	-0.1	-1%
Non-patient care services to other bodies	1.9	1.9	-0.1	-3%
Donations and Grants	0.1	1.0	-0.8	-88%
Other income	10.6	7.9	2.7	34%
Total Non-Patient Care Income	**41.3**	**39.0**	**2.3**	**6%**
Total	**398.6**	**392.2**	**6.4**	**2%**



What we spend our money on

The Trust spent £439.7 million on operating costs during 2017-18, an increase of £28.4 million from 2016-17. The largest expenditure was staffing at £265.2 million, which accounts for 60% of all expenditure, followed by expenditure on clinical supplies and services at 17%. The following table and chart shows the breakdown of different types of expenditure incurred by the Trust during the year and the table compares spend incurred during 2017-18 to 2016-17:

	2017-18 Amount £m	2016-17 Amount £m	Variance £m	Variance %
Staff and Directors	265.2	256.6	8.7	3%
Supplies and services - clinical (excluding drugs costs)	44.1	41.4	2.6	6%
Drugs	30.7	30.6	0.0	0%
Net impairments	20.6	0.3	20.3	7008%
Supplies and services - general	11.5	12.2	-0.7	-6%
Total depreciation and amortisation	11.3	10.9	0.4	4%
Premises	15.3	15.9	-0.5	-3%
Clinical negligence	11.5	8.4	3.1	37%
Purchases of Healthcare	8.7	14.6	-5.9	-40%
Transport (including patient travel)	7.4	6.6	0.8	12%
Establishment	3.0	2.8	0.2	9%
Other	10.4	11.0	-0.6	-5%
Total	**439.7**	**411.3**	**28.4**	**7%**



Impairment

The Trust is obliged to ensure that the value of its assets are reflected accurately in its accounts, it does this in a number of ways, including an annual review of assets.

The Trust identified assets that showed evidence of impairment and commissioned Deloitte LLP to carry out a valuation of these assets. Their valuation was £26.0 million lower than the Trust's current valuation of these assets, of which £20.6m was charged to the Trust's expenditure for 2017-18, the remainder being charged to the revaluation reserve.

The impairment although charged to the Trusts expenditure does not count against the NHS Financial Performance Target set by NHS Improvement.

The impairment is largely as a result of the Trust's ageing estate, which increasing is falling behind the standards required for providing healthcare in suitable facilities.

Disposal of part of the Sutton Hospital site

The Trust has been following a strategy of relocating services and staff from the Sutton Hospital to its other sites and releasing the land for sale. It has previously sold two plots of land at Sutton Hospital to the London Borough of Sutton, one in March 2015 and another in March 2017.

In December 2018 the Trust concluded the sale of another part of Sutton Hospital to the London Borough of Sutton for a sale price of £14.1 million, resulting in a profit on disposal of £10.6 million after the net book value of assets sold of £3.1million and disposal costs of £0.4million.

Capital investment

The Trust delivered a capital investment programme of £27.9 million, which saw over £8.1 million being spent on addressing critical backlog at both Epsom and St Helier, £2.9 million in improving the Trust's IT systems, over £2.1 million in medical equipment, £2.9m in improvements to A&E Departments on both sites and £6.8 million as part of a programme to improve and extend patient facilities, especially for renal and intensive care.

The Trust has a planned capital programme for 2017-18 of £50.1 million, which will include £11.7 million on new energy centres and energy efficiency measures at both sites, £7.3m rationalising the Epsom site, £2.2m on a new staff nursery at St Helier, £3.2m on medical equipment, £3.0 million on Information Technology, £6.6m to finish the urgent repairs started on B and C blocks at St Helier and £9.8 million on a new facilities for Critical Care, Surgical Care and Renal.

This will be funded from internally generated funds and NHS Capital Investment Loans of £15.7m. We also plan to secure loans of £16.3m for energy saving projects from funding available to the public sector to reduce its carbon foot print.

Improving value for money

The Trust made £12.1 million of efficiency savings during the financial year, which equates to 2.8% of total expenditure (ignoring impairments).
The Trust plans to deliver a further £17 million in improving the Trust's IT systems, and transformation and cost improvement programme during 2018-19.

Counter Fraud Services are provided through the Trust's contract with the London Audit Consortium. The Trust also has a counter fraud and whistle blowing policy.
The Counter Fraud service provide advice and support to the Trust and advise on appropriate proactive initiatives whilst carrying out reactive investigations where required.

External auditors

Following changes to the local external audit arrangements from the Local Audit Accountability Act 2014, NHS Trusts were required to procure and locally appoint their own auditors for the year 2017-18and subsequent financial years.

As required by the legislation, the Trust set up an Auditor Panel of non- executive directors to advise on the appointment, and after a procurement and evaluation process appointed KPMG as its external auditors for the 2017-18 accounts and the two years following.

The Trust's external auditor is KPMG. The total cost of their statutory work in 2017-18 was £67,000, (£86,000 in 2016-17). This included the auditing of the annual accounts and this annual report. The Trust previous external auditors were Grant Thornton.

The charitable funds

Epsom and St Helier University Hospitals NHS Trust act as Trustees to the same name charity. Copies of the most recent accounts can be obtained from the Charity Commission website, www.charity-commission.gov.uk.

Looking forward to 2018-19

The Trust has agreed a new Financial Performance Total with NHS Improvement for 2018-19 of a deficit of £13.6million. The Trust also has an ambitious capital programme that, subject to funding, will see £50.1million invested on its main sites next year. The Trust has obtained approval for NHS capital funding as well as using proceeds from further land sales.

The Trust also hopes to obtain external funding for investment in energy saving measures at both sites over the next two years.

Preparation of the Accounts on a Going Concern Basis

The Trust recorded an adjusted retained Financial Performance deficit for the year ended 31 March 2018 of £13.4 million in £4.4 million better than the £17.8 million agreed with NHS Improvement at the start of 2017-18. The Trust received cash funding from NHS Improvement to manage its deficit as well as Sustainability and Transformation Funding.
For the Financial year commencing 1 April 2018, the Trust has agreed a Financial Performance Target of a deficit of £13.7 million. This plan has been submitted to NHS Improvement and includes Sustainability and Transformation Funding of £14.5million and cash financing for the deficit.

In line with previous years, the Trust believes it is reasonable to expect that NHS Improvement will continue to support the Trust with the cash resources required to meet is liabilities.

In accordance with IAS 1 Presentation of Financial Statements, as adapted for the public sector, taking into account the circumstances set out above, the expectation is that services will continue to be provided by the Trust, management has made an assessment of the Trust's ability to continue as a going concern and concluded the financial statements should be prepared on a going concern basis.

	(a) Real increase in pension at pension age (bands of £000	(b) Real increase in pension lump sum at pension age £000	(c) Total accrued pension at pension at 31 March 2018 (bands of £000	(d) Lump sum at pension age related to accrued pension at 31 £000	(e) Cash Equivalent Transfer Value at 1 April 2017 £000	(f) Real increase in Cash Equivalent Transfer £000	(g) Cash Equivalent Transfer Value at 31 March 2018 £000	(h) Employer's contribution to stakeholder pension £000
Daniel Elkeles Chief Executive	2.5-5	0-2.5	40-45	95-100	549	52	606	0
Rakesh Patel Chief Financial Operating Officer	0	0	0	0	0	0	0	0
Dr Ruth Charlton Deputy Chief Executive and Joint Medical Director, board member	2.5-5	2.5-5	60-65	155-160	996	124	1130	0
Dr James Marsh Joint Medical Director, board member	2.5-5	0-2.5	50-55	135-140	883	93	985	0
Caroline Landon Chief Operating Officer	0-2.5	0	42278	0	99	15	130	0
Daniel Bradbury Chief Operating Officer	0	0	0	0	0	0	0	0
Charlotte Hall Chief Nurse	0-2.5	5-7.5	40-45	120-125	769	81	858	0
Kevin Croft Director of Human Resources	0-2.5	0	35-40	90-95	565	59	629	0
Peter Davies Director of Strategy	5-7.5	0	55-60	0	563	107	677	0
Trevor Fitzgerald Director of Estates and Capital Projects	2.5-5	5-7.5	30-35	80-85	434	94	533	0
Lisa Thomson Director of Communications	0-2.5	0	15-20	40-45	313	12	328	0
Tim Hamilton Director of Communications	0	0	0	0	17	-17	0	0

The amounts disclosed above for Dr James Marsh and Dr Ruth Charlton, joint medical directors of the Trust, includes remuneration paid for work performed both as a clinical member of staff and a senior manager.

Dr Ruth Charlton and Dr James Marsh receive salary in the band of £145,000 to £150,000 and £140,000 to £145,000, respectively, for their clinical roles.

The amounts paid or payable by the Trust is only in respect of the period the senior manager held office. All pension related benefits are those from participating in the pension scheme that year, where a whole year has not been served these are on a pro rata basis.

The following did not serve the entire financial year:

	From	To
Caroline Landon Chief Operating Officer	01/04/2017	08/10/2017
Dan Bradbury Chief Operating Officer	17/10/2017	31/03/2018
Lisa Thomson Director of Communications and Patient Experience	01/05/2017	31/03/2018
Martin Kirke Associate Non-Executive Director	01/03/2018	31/03/2018
Steve Poulton Non-Executive	01/04/2017	13/10/2017

0117/18 Senior manager's remuneration report (pensions) audited

	2017/18						2016/17					
	(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)	(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	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Name and title												
Mr Laurence Newman Chairman	20-25	0	0	0	0	20-25	20-25	0	0	0	0	20-25
Patricia Baskerville Non-Executive	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Elizabeth Bishop Non-Executive	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Dr Iain MacPhee, Non-Executive Director	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Steve Poulton Non-Executive	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Richard Noble, Non-Executive Director	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Aruna Mehta Non-Executive Director	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Martin Kirke Associate Non Executive Director	0-5	0	0	0	0	0-5	N/A	0	0	0	0	N/A
Daniel Elkeles Chief Executive	180-185	0	0	0	47.5-50	225-230	175-180	0	0	0	42.5-45	220-225
Rakesh Patel Chief Finance Officer	130-135	0	5-10	0	0	140-145	125-130	0	0	0	0	125-130
Dr James Marsh Joint Medical Director	205-210	0	0	0	40-42.5	245-250	200-205	0	0	0	97.5-100	300-305
Dr Ruth Charlton Deputy Chief Executive and Joint Medical Director, board member	215-220	0	0	0	67.5-70	280-285	205-210	0	0	0	47.5-50	250-255
Caroline Landon Chief Operating Officer	65-70	0	0	0	20-22.5	85-90	95-100	0	0	0	35-37.5	130-135
Dan Bradbury Chief Operating Officer	55-60	0	0	0	0	55-60	N/A	0	0	0	N/A	N/A
Charlotte Hall Chief Nurse	115-120	0	0	0	22.5-25	140-145	115-120	0	0	0	17.5-20	135-140
Kevin Croft Director of Human Resources	110-115	0	0	0	27.5-30	140-145	110-115	0	0	0	30-32.5	145-150
Peter Davies Director of Strategy	115-120	0	0-5	0	105-107.5	225-230	105-110	0	0	0	17.5-20	125-130
Trevor Fitzgerald Director of Estates and Capital Projects	110-115	0	0-5	0	80-82.5	195-200	100-105	0	0	0	100-102.5	205-210
Lisa Thomson Director of Comunications	95-100	0	0-5	0	7.5-10	105-110	N/A	0	0	0	N/A	N/A
Tim Hamilton Director of Comunications	5-10	0	0	0	17.5-20	0	95-100	0	0	0	17.5-20	115-120

The Real Increase in cash equivalent transfer values (CETV)

This reflects the increase in CETV effectively funded by the employer. It takes account of does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).and uses common market valuation factors for the start and end of the period.

Cash equivalent transfer values

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

Fair Pay Disclosures

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 mid-point of the banded remuneration of the highest-paid director in the Trust in financial year 2017-18 was £212,250, (2016-17 £207 250). This was seven times (six times in 2016-17) the median remuneration of the workforce, which was £31,780 (2016-17 median remuneration £33,033).

In 2017-18 no employees (2016-17 none) received remuneration in excess of the highest paid director.

Staff report

The average whole time equivalent (WTE) employed by the Trust this year is 5187 WTE (2016-175 5,126 WTE)in the following staff groups:

	2017-18			2016-17
Average staff numbers	**Total YTD number**	**Permanently employed number**	**Other number**	**Total YTD number**
Medical and dental	**786**	**689**	**97**	**771**
Administration and estates	**1,145**	1,023	122	1,444
Healthcare assistants and other support staff	**1,083**	803	280	1,001
Nursing, midwifery and health visiting staff	**1,665**	1,430	235	1,746
Nursing, midwifery and health visiting learners	**0**	0	0	3
Scientific, therapeutic and technical staff	**287**	228	59	283
Social care staff	**0**	0	0	0
Healthcare science staff	**221**	219	2	178
TOTAL	**5,187**	**4,392**	**795**	**5,126**
Staff engaged on capital projects (included above)	**35**	18	17	18

The composition of the permanently employed workforce by headcount, gender and band is shown below.

Pay Bands	Female	Female%	Male	Male%
AfC Band 1	39	1.0%	21	0.4%
AfC Band 2	606	12.5%	178	3.6%
AfC Band 3	404	7.9%	55	1.1%
AfC Band 4	361	7.2%	53	1.2%
AfC Band 5	671	14.1%	116	2.5%
AfC Band 6	689	13.7%	121	2.4%
AfC Band 7	491	9.9%	81	1.5%
AfC Band 8A	158	2.8%	36	0.7%
AfC Band 8B	46	0.9%	17	0.3%
AfC Band 8C	29	0.6%	11	0.2%
AfC Band 8D	11	0.2%	7	0.1%
AfC Band 9	7	0.1%	2	0.0%
VSM	5	0.1%	7	0.1%
Doctors	368	7.3%	373	7.1%
Other	8	0.1%	5	0.1%
Grand Total	**3893**	**78.2%**	**1083**	**21.8%**

Of these, the number of senior managers (91) are in the following bands.

Senior Managers	Headcount
AfC Band 8B	39
AfC Band 8C	20
AfC Band 8D	12
AfC Band 9	8
VSM	12
Grand Total	**91**

The composition of Board members during the year is shown below.

Board Members

Gender	Head count	%
Female	6	37.53
Male	10	62.56

Staff sickness absence	Total number	Total number 2015-16
Total days lost		**40584**
Total staff years		**4,294**
Average working days Lost		9.5

Staff polices applied during the financial year

Epsom and St Helier University Hospitals NHS Trust is committed to the employment and career development of disabled people. To demonstrate our commitment we use the Disability Symbol which is awarded by the Employment Service. As a symbol user, we guarantee an interview to anyone with a disability whose application meets the minimum criteria for the post.

The Trust has a Policy for the Provision of Occupational Health, which ensures management and employees receive appropriate advice on sickness absence, rehabilitation, programmes, and ill-health retirement and on adaptations to work areas.

The Trust also has a Policy for promoting attendance and managing sickness at work which seeks to ensure that employees receive prompt and appropriate support including occupational health care and advice as appropriate.

Expenditure on consultancy

The Trust spent £2,381k on consultancy services.

Off Payroll Engagements

Table 1: Off-payroll engagements longer than 6 months

No. of existing engagements as of 31 March 2018	8
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	4
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	3

Table 2: New Off-payroll engagements longer than 6 months

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

Table 3; Off-payroll board member/senior official engagements

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	0
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements. (2)	0

Exit Packages

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000			13	41,332	13	41,332		
£10,000 - £25,000			4	47,202	4	47,202	1	22500
£25,001 - £50,000					0	0		
£50,001 - £100,000					0	0		
£100,001 - £150,000					0	0		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total			**17**	**66,034**	**17**	**88,534**	**1**	**22,500**

Other Exit Packages 2017-18

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of exit package agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice*	16	66
Exit payments following Employment Tribunals or court orders		
Non contractual payments requiring HMT approval **	1	23
Total	**17**	**89**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary		

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF EPSOM AND ST. HELIER UNIVERSITY HOSPITALS NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Epsom and St. Helier University Hospitals NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 to the financial statements which indicates that the Trust has forecast a planned deficit of £13.7m, and is seeking additional cash support from the Department of Health for 2018/19 of £14.1m which has not been confirmed. In past years, the Trust has secured funding from the Department of Health during the year when required, and the Directors expect that this support will continue to be granted.

These events and conditions, along with the other matters explained in note 1.1.2, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 32, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 32 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Basis for adverse conclusion

In considering the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources and specifically in terms of sustainable resource deployment, we identified the Trust has made an in-year deficit of £13.4 million against a turnover of £398.6 million, and a cumulative deficit of £78.3 million (from 2008/09 to 2017/18). The Trust's in year deficit target of £17.8 million was agreed with NHSI to reflect the cost pressures facing the Trust, such a multi-site operations and the condition of the Trust's estate. The Trust achieved a financial outturn of a £13.4 million deficit, which is £4.4 million better than the target set.

Adverse conclusion

As a result of the in year and cumulative deficit identified in the basis for adverse conclusion paragraph above, we are unable to satisfy ourselves that, in all significant respects Epsom and St. Helier University Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 32, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by 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.

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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- 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 issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

On 8 May 2018 we wrote to the Secretary of State in accordance with Section 30(1)(b) of the 2014 Act in respect of the Trust's failure to deliver its breakeven duty as set out in paragraph 2(1) of Schedule 5 of the National Health Service Act 2006. The Trust's financial statements for financial year ended 31 March 2018 identify a cumulative deficit of £78.3m, with £13.4m of that incurred in the 2017/18 financial year.

We have no other matters to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Epsom and St. Helier University Hospitals NHS 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 Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Epsom and St. Helier University Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Neil Thomas
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

25 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Revenue from patient care activities	3	357,281	353,149
Other operating revenue	4	41,279	39,012
Operating expenses	6,8	(439,731)	(411,303)
Operating surplus/(deficit) from continuing operations		**(41,171)**	**(19,142)**
Finance income	11	62	14
Finance costs	12	(1,296)	(1,105)
PDC dividends payable		(2,467)	(3,697)
Net finance costs		**(3,701)**	**(4,788)**
Other gains / (losses)	13	10,390	11,117
Surplus / (deficit) for the year from continuing operations		**(34,482)**	**(12,813)**
Surplus / (deficit) for the year		**(34,482)**	**(12,813)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(5,419)	-
Revaluations	15.1	8,271	6,159
Other reserve movements		(163)	-
Total comprehensive income / (expense) for the period		**(31,793)**	**(6,654)**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	639	1,237
Property, plant and equipment	15	180,255	185,183
Trade and other receivables	17	407	307
Total non-current assets		**181,301**	**186,727**
Current assets			
Inventories	16	3,793	3,602
Trade and other receivables	17	35,976	27,828
Cash and cash equivalents	19	12,818	3,562
Total current assets		**52,587**	**34,992**
Current liabilities			
Trade and other payables	21	(52,946)	(49,651)
Borrowings	24	(82)	-
Provisions	26	(675)	(1,243)
Other liabilities	23	(2,684)	(857)
Total current liabilities		**(56,387)**	**(51,751)**
Total assets less current liabilities		**177,501**	**169,968**
Non-current liabilities			
Borrowings	24	(79,659)	(42,188)
Provisions	26	(1,967)	(2,062)
Total non-current liabilities		**(81,626)**	**(44,250)**
Total assets employed		**95,875**	**125,718**
Financed by			
Public dividend capital		182,111	180,161
Revaluation reserve		45,603	43,545
Income and expenditure reserve		(131,839)	(97,988)
Total taxpayers' equity		**95,875**	**125,718**

The notes on pages 5 to 37 form part of these accounts.

Daniel Elkeles
Chief Executive Officer
Date 25 May 2018

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	**180,161**	**43,545**	**(97,988)**	**125,718**
Surplus/(deficit) for the year	-	-	(34,482)	**(34,482)**
Impairments	-	(5,419)	-	**(5,419)**
Revaluations	-	8,271	-	**8,271**
Transfer to retained earnings on disposal of assets	-	(631)	631	**-**
Public dividend capital received	1,950	-	-	**1,950**
Other reserve movements	-	(163)	-	**(163)**
Taxpayers' equity at 31 March 2018	**182,111**	**45,603**	**(131,839)**	**95,875**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**177,561**	**37,750**	**(85,539)**	**129,772**
Surplus/(deficit) for the year	-	-	(12,813)	**(12,813)**
Other transfers between reserves	-	(364)	364	**-**
Impairments	-	-	-	**-**
Revaluations	-	6,159	-	**6,159**
Public dividend capital received	4,578	-	-	**4,578**
Public dividend capital repaid	(1,978)	-	-	**(1,978)**
Taxpayers' equity at 31 March 2017	**180,161**	**43,545**	**(97,988)**	**125,718**

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

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(41,171)	(19,142)
Non-cash income and expense:			
Depreciation and amortisation	6.1	11,297	10,909
Net impairments	7	20,613	290
Income recognised in respect of capital donations	4	-	(665)
(Increase) / decrease in receivables and other assets		(7,561)	(8,639)
(Increase) / decrease in inventories		(191)	648
Increase / (decrease) in payables and other liabilties		4,890	(120)
Increase / (decrease) in provisions		(64)	506
Net cash generated from / (used in) operating activities		**(12,187)**	**(16,213)**
Cash flows from investing activities			
Interest received		62	14
Purchase of intangible assets		-	(228)
Purchase of property, plant, equipment and investment property		(26,994)	(12,263)
Sales of property, plant, equipment and investment property		14,100	14,000
Receipt of cash donations to purchase capital assets		-	471
Net cash generated from / (used in) investing activities		**(12,832)**	**1,994**
Cash flows from financing activities			
Public dividend capital received		1,950	4,578
Public dividend capital repaid		-	(1,978)
Movement on loans from the Department of Health and Social Care		36,533	17,588
Capital element of finance lease rental payments		(82)	-
Interest paid on finance lease liabilities		(107)	-
Other interest paid		(805)	(1,043)
PDC dividend (paid) / refunded		(3,214)	(4,033)
Net cash generated from / (used in) financing activities		**34,275**	**15,112**
Increase / (decrease) in cash and cash equivalents		**9,256**	**893**
Cash and cash equivalents at 1 April - brought forward		**3,562**	**2,669**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**3,562**	**2,669**
Cash and cash equivalents at 31 March	19	**12,818**	**3,562**

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 2017/18 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 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
These accounts have been prepared on a going concern basis.
For the financial year commencing 1 April 2018, the Trust has forecast a planned deficit of £13,663k after a savings requirement of £17,000k. This plan is has been submitted to NHS Improvement and requires additional cash support of £14,100k to settle our liabilities as they fall due over the twelve months from the signing of these financial statements.The Directors are seeking additional support from the Department of Health for 2017/18 of £14,100k. The Department of Health has not, at the date of the approval of these financial statements, confirmed this support. Although this represents a material uncertainty 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. While there is also uncertainty with regard to income in 2018/19 as all elective activity is being commissioned on a PbR basis total activity growth has been very stable for the last three years in the range 1.5% - 2.0% and the Trust expects this trend to continue. In addition, as directed by the 2017/18 Department of Health 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 and therefore to comply with the Group Accounting Manual these financial statements should be prepared on a going concern basis.
On this basis and in accordance with IAS 1 Presentation of Financial Statements – the Trust anticipates its services will continue to be provided and that cash support will be made available by the Department of Health - 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 judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:
i) Ascertaining if an arrangement contains a lease; and if it does so assess whether it is an Operating or Finance Lease.
ii) During the year the Trust undertook an impairment review of its land and buildings. To support this review the Trust commissioned a third party valuer to value eight of its buildings as at 1 April 2018. This valuer - Deloittes LLP - made a series of judgements around the current depreciated replacement cost of these buildings and the buildings level of functional obsolescence. The Trust has reviewed these judgements and considers them reasonable.

iii) The Trust did not consolidate the NHS charitable funds for which it is a corporate Trustee as the Epsom and St Helier NHS Trust Charitable Fund's income, resources, assets and liabilities are not material for the year ended 31 March 2018. The Trust have assessed the impact of not consolidating the accounts of its related Charity and deemed it to be immaterial and not adversely affect the interpretation of the accounts by its stakeholders.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

i) The useful economic life of Trust assets is set by:
a) Buildings: Professional third party valuers
b) Plant, equipment, and intangible assets: Trust professionals responsible for the custody and maintenance of the assets.
No asset class is estimated to have a residual value, with current fair value depreciated or amortised over its estimated useful life to £nil

ii) The Trust holds land and buildings at fair value (as defined by our accounting policies). To ensure they remain at fair value, land and buildings are subject a full valuation every five years and indexed between these dates using revaluation indices as supplied by a professional third party valuer.

iii) Accruals and deferred income are based on best estimates of the expenditure still to be incurred for this financial year and the income received that relates to next financial year.

Provisions are based on the best estimates of future payments that will need to be made to meet current obligations. The basis of these estimates and the timing of the cash flows are described in the relevant note. Provisions are discounted and unwound using rates as set by HM Treasury.

Inventories are counted annually at the balance sheet date and valued on a first in: first out basis.
Management impair the value of inventories when the FIFO method does adequately reflect current fair value or when the stock is not obsolete.

Note 1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred. 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.

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 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 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the 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. There, the schemes are accounted for as though they are defined contribution schemes.
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.

Note 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.6.2 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. The way this valuation is calculated for buildings depends on whether the building is specialised for healthcare purposes or not. A specialist building is valued at depreciation replacement cost with an allowance for functional obsolescence: a non specialist building is valued at market value. An item of property, plant and equipment 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.

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 economic 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’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets 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 1.6.3 Derecognition
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 ie:

- 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 dropped 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 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 Intangible assets

Note 1.7.1 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.

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, eg, 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 and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Note 1.7.2 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".

Amortisation

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

Note 1.7.3 Useful economic lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	5	5

Note 1.8 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.

Note 1.9 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 1.10 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 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade date.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement
Financial assets are categorised as fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.
The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.
Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.
They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.
Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and through the use of an bad debt provision. When management assess it is unlikley the asset will be discharged through the reciept of furture cashflows a bad debt provisioin is crfeated to the value unliley to be recieved. The debt is will be written off ahainst this allowance when management asccess it is no like economical to continue recover action.

Note 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 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 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 1.12.2 The trust as lessor

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

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

Note 1.13 Provisions

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

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 but is not recognised in the trust’s accounts.

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

Note 1.14 Contingencies

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

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. 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) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

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

Note 1.16 Value added tax

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

Note 1.17 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 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had 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 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The Trust has identified two accounting standards which are not yet effective or adopted which may have a material impact on the Trust's balance sheet and income and expenditures. These are International Financial Reporting Standard 15 'Revenue from contracts with customers' (IFRS 15) and International Financial Reporting Standard 16 'Leases' (IFRS 16). IFRS 15 will come into effect on 1 April 2018 and IFRS 16 is applicable for accounting periods beginning on or after 1 January 2019.
The Trust considers that IFRS 15 will not have a material impact on when income is recognised as healthcare provision contracts agreed with our commissioners are mostly short term in nature, generally do not contain complicated provisions which link payments to specific conditions or targets, and provide homogeneous and comparable services. Where complicated provisions do exist (for example, income due to the Commissioning for Quality and Innovation (CQUIN) framework) they are readily identifiable and are already recognised separately from other revenue streams that exist in the same contract
The Trust considers that IFRS 16 will not have material impact on the Trust. This is because:
• The new definition of lease will not mean that any currently unrecognised used assets (for example, those provided through a service agreement) are now recognised as leases
• The vast majority of the Trust's property, plant, and equipment are either on an existing finance lease or owed. Showing the Trust's operating leased assets as on balance sheet will not materially change the Trust's reported statement of financial position or income and expenditures.

Note 2 Operating Segments

The Trust has identified only one operating segment, that of Health Care activities. It has done this as this is the basis on which it reports to the Chief Operating Decision Maker and all its activities face the same level of business risk.

	Health Care activities		Total	
	2017/18	**2016/17**	**2017/18**	**2016/17**
	£000	£000	**£000s**	£000
Income	**357,281**	353,149	**357,281**	353,149

No other single customer accounted for more than 10% of the Trusts income. Note 4 provides a breakdown of the amount disclosed above. All Clinical Commissioning Groups and NHS England are considered as one customer as they are under common control.

Note 3 Revenue from patient care activities

Note 3.1 Revenue from patient care activities (by nature)	**2017/18**	**2016/17**
	£000	**£000**
Acute services		
Elective income	68,541	74,801
Non elective income	95,619	87,489
First outpatient income	22,920	24,313
Follow up outpatient income	35,471	39,188
A & E income	17,760	17,255
High cost drugs income from commissioners (excluding pass-through costs)	20,042	20,173
Other NHS clinical income	89,612	81,736
All services		
Private patient income	4,401	4,304
Other clinical income	2,915	3,890
Total income from activities	**357,281**	**353,149**

Note 3.2 Revenue from patient care activities (by source)

Revenue from patient care activities received from:	**2017/18**	**2016/17**
	£000	**£000**
NHS England	49,598	48,818
Clinical commissioning groups	300,723	296,585
Other NHS providers	1,446	2,205
NHS other	44	347
Non-NHS: private patients	4,401	4,303
Non-NHS: overseas patients (chargeable to patient)	206	327
NHS injury scheme	768	564
Non NHS: other	95	-
Total income from activities	**357,281**	**353,149**
Of which:		
Related to continuing operations	357,281	353,149

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

	2017/18	2016/17
	£000	£000
Income recognised this year	206	327
Cash payments received in-year	176	258
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	174	-

Note 4 Other operating revenue

	2017/18	2016/17
	£000	£000
Research and development	701	710
Education and training	14,200	14,315
Receipt of capital grants and donations	-	665
Charitable and other contributions to expenditure	114	291
Non-patient care services to other bodies	1,892	1,945
Sustainability and transformation fund income	13,756	13,142
Rental revenue from operating leases	117	68
Other income	10,499	7,876
Total other operating income	**41,279**	**39,012**
Of which:		
Related to continuing operations	41,279	39,012

Other income relates to the provision of car parking, crèche services, accommodation provided to the Trust's staff, and other miscellaneous income.

Note 5 Fees and charges

	2017/18	2016/17
	£000	£000
Income	3,326	3,191
Full cost	(2,018)	(2,098)
Surplus / (deficit)	**1,308**	**1,093**

The above table relates to the operation of the Private Patient Unit.

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,492	5,040
Purchase of healthcare from non-NHS and non-DHSC bodies	5,221	9,536
Staff and executive directors costs	265,180	256,527
Remuneration of non-executive directors	68	68
Supplies and services - clinical (excluding drugs costs)	44,056	41,421
Supplies and services - general	11,500	12,230
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	30,667	30,637
Inventories written down	30	53
Consultancy costs	2,381	4,984
Establishment	3,036	2,789
Premises	15,319	15,862
Transport (including patient travel)	7,383	6,616
Depreciation on property, plant and equipment	10,721	10,385
Amortisation on intangible assets	576	524
Net impairments	20,613	290
Increase/(decrease) in provision for impairment of receivables	476	722
Change in provisions discount rate(s)	-	104
Audit fees payable to the external auditor		
audit services- statutory audit	59	86
other auditor remuneration (external auditor only)	8	10
Internal audit costs	135	198
Clinical negligence	11,517	8,393
Legal fees	580	637
Insurance	40	40
Research and development	688	575
Education and training	2,751	2,019
Rentals under operating leases	960	734
Hospitality	5	9
Losses, ex gratia & special payments	33	-
Other	2,236	814
Total	**439,731**	**411,303**
Of which:		
Related to continuing operations	439,731	411,303
Related to discontinued operations	-	-

Other spend relates to expenditure incurred as part of our work with Epsom Health and Care.

The £59,000 audit fee noted above is gross of VAT as the Trust cannot recover VAT on audit fees. The recipient of this fee pay this VAT to HMRC: the actual cash they receive for the audit is therefore £49,000.

Note 6.2 Other auditor remuneration

Other auditors remuneration was paid for the audit of the Trust's quality accounts.

Note 6.3 Limitation on auditor's liability

The contract, signed on 1 February 2018, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £2,000k, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	-	290
Other	20,613	-
Total net impairments charged to operating surplus / deficit	**20,613**	**290**
Impairments charged to the revaluation reserve	5,419	-
Total net impairments	**26,032**	**290**

During the year the Trust undertook an impairment review of its land and buildings. This review included obtaining external valuations on eight assets (mainly at the Trust's St Helier site) which had characteristics of potential impairment such as a recent change in use or having been declared not fit for the delivery of modern healthcare. These valuations reduced the eight buildings book value from £51,757k to £25,725k (a fall of £26,302k).

Note 8 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	211,330	181,335
Social security costs	21,915	20,719
Apprenticeship levy	1,007	-
Employer's contributions to NHS pensions	23,738	22,740
Termination benefits	-	39
Temporary staff (including agency)	12,525	35,064
Total gross staff costs	**270,515**	**259,897**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**270,515**	**259,897**
Of which		
Costs capitalised as part of assets	2,907	1,623

Note 8.1 Retirements due to ill-health

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £175k (£42k in 2016/17).

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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 10 Operating leases

Note 10.1 Epsom and St Helier University Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Epsom and St Helier University Hospitals NHS Trust is the lessor.

The Trust sub-leases a floor of its East Street, Epsom, office building.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	117	68
Total	**117**	**68**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	96	96
- later than one year and not later than five years;	187	283
- later than five years.	-	-
Total	**283**	**379**

Note 10.2 Epsom and St Helier University Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Epsom and St Helier University Hospitals NHS Trust is the lessee. The Trust's significnat leases are:

i) A five year lease - concluding in 2021/22 - for the provision of endoscopy equipment;

ii) A five year lease - concluding in 2021/22 - for the rental of office space at 70, East Street, Epsom. This property is used as office space for the Trust's corporate staff including IT, HR, and finance, and frees up the space previously occupied by these staff at our clinical sites for use in the provision of patient care;

iii) The lease of Woodcote Lodge, for staff accommodation in Epsom, and Manorgate House in Kingston, which is used for the provision of renal services;

iv) A long term lease from Sutton Council for land at the Trust's St Helier site.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	1,077	734
Less sublease payments received	(117)	-
Total	**960**	**734**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,082	1,469
- later than one year and not later than five years;	2,600	2,788
- later than five years.	36	576
Total	**3,718**	**4,833**

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	62	14
Total	**62**	**14**

Note 12.1 Finance Costs

Finance Costs represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,046	1,105
Other loans	-	-
Total interest expense	**1,153**	**1,105**
Unwinding of discount on provisions	2	-
Other finance costs	141	-
Total finance costs	**1,296**	**1,105**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	11,158	11,140
Losses on disposal of assets	(768)	(23)
Total gains / (losses) on disposal of assets	10,390	11,117
Total other gains / (losses)	**10,390**	**11,117**

Gain on disposal relates to profit on disposal of part of the Trust's Sutton site (further details are set out in Note 18) and the reversal of a prior year cost of disposal that did not materialise.

Note 14.1 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**4,821**	**4,821**
Gross cost at 31 March 2018	**4,722**	**4,722**
Amortisation at 1 April 2017 - brought forward	**3,584**	**3,584**
Provided during the year	576	**576**
Amortisation at 31 March 2018	**4,083**	**4,083**
Net book value at 31 March 2018	**639**	**639**
Net book value at 1 April 2017	**1,237**	**1,237**

Note 14.2 Intangible assets - 2016/17

	Software licences	Total
	£000	£000
	4,394	**4,394**
Valuation / gross cost at 1 April 2016 - brought forward		
Additions	303	**303**
Reclassifications	124	**124**
Valuation / gross cost at 31 March 2017	**4,821**	**4,821**
Amortisation at 1 April 2016 - as previously stated	**3,060**	**3,060**
Provided during the year	**524**	**524**
Amortisation at 31 March 2017	**3,584**	**3,584**
Net book value at 31 March 2017	**1,237**	**1,237**
Net book value at 1 April 2016	**1,334**	**1,334**

The Trust's intangible assets comprise purchased computer software and software licences. They are held in the balance sheet at depreciated purchase cost and have finite lives of between 5 and 10 years.

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**38,122**	**194,198**	**902**	**6,052**	**37,222**	**13,856**	**1,352**	**291,704**
Additions	-	15,378	-	7,368	2,263	2,846	-	**27,855**
Impairments	-	(26,032)	-	-	-	-	-	**(26,032)**
Revaluations	2,828	5,417	26	-	-	-	-	**8,271**
Reclassifications	-	3,601	42	(4,168)	107	421	(3)	**-**
Transfers to/ from assets held for sale	(2,448)	(597)	-	-	-	-	-	**(3,045)**
Disposals / derecognition	-	(283)	-	(195)	(5,605)	-	-	**(6,083)**
Valuation/gross cost at 31 March 2018	**38,502**	**191,682**	**970**	**9,057**	**33,987**	**17,123**	**1,349**	**292,670**
Accumulated depreciation at 1 April 2017 - brought forward	**7,393**	**64,497**	**363**	**-**	**24,228**	**8,700**	**1,340**	**106,521**
Provided during the year	**-**	**6,668**	**56**	**-**	**2,436**	**1,559**	**2**	**10,721**
Disposals / derecognition	-	(58)	-	-	(4,769)	-	-	**(4,827)**
Accumulated depreciation at 31 March 2018	**7,393**	**71,107**	**419**	**-**	**21,895**	**10,259**	**1,342**	**112,415**
Net book value at 31 March 2018	**31,109**	**120,575**	**551**	**9,057**	**12,092**	**6,864**	**7**	**180,255**
Net book value at 1 April 2017	**30,729**	**129,701**	**539**	**6,052**	**12,994**	**5,156**	**12**	**185,183**

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**39,352**	**181,489**	**874**	**3,454**	**35,436**	**10,735**	**1,352**	**272,692**
Additions	-	7,142	-	4,962	2,156	2,131	-	**16,391**
Impairments	-	-	-	-	(290)	-	-	**(290)**
Revaluations	-	6,131	28	-	-	-	-	**6,159**
Reclassifications	599	543	-	(2,308)	-	1,042	-	**(124)**
Transfers to / from assets held for sale	(1,829)	(848)	-	-	-	-	-	**(2,677)**
Disposals / derecognition	-	(259)	-	(56)	(80)	(52)	-	**(447)**
Valuation/gross cost at 31 March 2017	**38,122**	**194,198**	**902**	**6,052**	**37,222**	**13,856**	**1,352**	**291,704**
Accumulated depreciation at 1 April 2016 - as previously stated	**7,393**	**58,104**	**311**	**-**	**21,649**	**7,887**	**1,333**	**96,677**
Provided during the year	**-**	**6,902**	**52**	**-**	**2,610**	**814**	**7**	**10,385**
Transfers to/ from assets held for sale	-	(506)	-	-	-	-	-	**(506)**
Disposals/ derecognition	-	(3)	-	-	(31)	(1)	-	**(35)**
Accumulated depreciation at 31 March 2017	**7,393**	**64,497**	**363**	**-**	**24,228**	**8,700**	**1,340**	**106,521**
Net book value at 31 March 2017	**30,729**	**129,701**	**539**	**6,052**	**12,994**	**5,156**	**12**	**185,183**
Net book value at 1 April 2016	**31,959**	**123,385**	**563**	**3,454**	**13,787**	**2,848**	**19**	**176,015**

The Trust's land is not depreciated but has brought forward accumilated depreciation due to prior year revaluations that are reported in the brought forward balance.

The Trust's accounting policy to ensure that its land and buildings remain held at fair value is:

- Revalue the whole estate every five years;
- In between the five year period apply revaluation indices as prepared by qualified third party experts

In line with these requirements during 2014/15 the Trust commissioned a revaluation of its land and buildings, from Deloitte LLP, RICS qualified third party experts, as at 1 April 2014. The next formal revaluation is planned for 1 April 2019. Between the 1 April 2017 and 31 March 2018 the Trust applied its revaluation indices as prepared by Deloitte LLP, RICS qualified third party experts, which lead to an increase of £5,458k in the carrying value of its buildings and £2,828k of its land.

In addition to these accounting policies, and to ensure that the Trust complies with applicable accountings standards and ensures its assets are held at fair value, the Trust undertakes an annual impairment review. The outputs of this review is set out in Note 7 and resulted in a £26,032k fall in the holding value of the Trust's buidlings.

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	31,109	116,997	551	9,057	9,509	6,864	7	**174,094**
Finance leased	-	-	-	-	1,020	-	-	**1,020**
Owned - donated	-	3,578	-	-	1,563	-	-	**5,141**
NBV total at 31 March 2018	**31,109**	**120,575**	**551**	**9,057**	**12,092**	**6,864**	**7**	**180,255**

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	30,729	125,421	539	6,052	11,003	5,155	12	**178,911**
Finance leased	-	-	-	-	-	-	-	**-**
Owned - donated	-	4,280	-	-	1,991	1	-	**6,272**
NBV total at 31 March 2017	**30,729**	**129,701**	**539**	**6,052**	**12,994**	**5,156**	**12**	**185,183**

Note 16 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,294	1,329
Consumables	2,454	2,223
Energy	45	50
Total inventories	**3,793**	**3,602**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £44,398k (2016/17: £36,336k). Write-down of inventories recognised as expenses for the year were £30k (2016/17: £53k).

Note 17 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	13,419	10,711
Accrued income	18,414	13,112
Provision for impaired receivables	(2,063)	(1,077)
Prepayments (non-PFI)	3,264	3,315
PDC dividend receivable	687	-
VAT receivable	2,128	1,284
Other receivables	127	483
Total current trade and other receivables	**35,976**	**27,828**
Non-current		
Trade receivables	528	384
Provision for impaired receivables	(121)	(77)
Total non-current trade and other receivables	**407**	**307**
Of which receivables from NHS and DHSC group bodies:		
Current	28,510	18,765
Non-current	-	-

Note 17.1 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**1,154**	**432**
Increase in provision	476	709
Amounts utilised	554	-
Unused amounts reversed	-	13
At 31 March	**2,184**	**1,154**

Debts are impaired if there is specific credit control information that suggests the value of the debt should be impaired. All debts for injury recovery costs are subject to a 22.84% provision for unrecoverable debt. (2016/17: 20.1%)

Note 17.2 Credit quality of financial assets

	31 March 2018		31 March 2017	
Ageing of impaired financial assets	**Trade and other receivables £000**	**Investments & Other financial assets £000**	**Trade and other receivables £000**	**Investments & Other financial assets £000**
Over 180 days	2,184	-	1,154	-
Total	**2,184**	**-**	**1,154**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	21,894	-	16,314	-
30-60 Days	1,550	-	953	-
60-90 days	467	-	746	-
90- 180 days	1,315	-	759	-
Over 180 days	2,927	-	3,611	-
Total	**28,153**	**-**	**22,382**	**-**

Over 88% of income was paid by Clinical Commissioning Groups and NHS England. As these NHS bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 18 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Assets classified as available for sale in the year	3,045	**2,171**
Assets sold in year	(3,045)	**(2,171)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

During the year the Trust Board declared an unused element of the Trust's Sutton site as surplus to requirements and available for purchase. In line with the requirements of International Financial Report Standard 5 the Trust ceased depreciating the surplus buildings when they were declared surplus and thereafter accounted for the land and buildings as available for sale. Land and buildings with a value of £3,045k were transferred to non-current assets available for sale. These assets were sold to the London Borough of Sutton in March 2017 leading to a net profit after disposal expenses of £10,556k.

Note 19 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.

	2017/18	2016/17
	£000	£000
At 1 April	**3,562**	**2,669**
Net change in year	9,256	893
At 31 March	**12,818**	**3,562**
Broken down into:		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	12,814	3,558
Total cash and cash equivalents as in SoFP	**12,818**	**3,562**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**12,818**	**3,562**

Note 20 Third party assets held by the trust

The Trust has no third party assets.

Note 21 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	18,733	19,569
Capital payables	4,893	4,786
Accruals	22,923	19,611
Receipts in advance (including payments on account)	59	-
Social security costs	3,114	2,871
VAT payables	-	-
Other taxes payable	2,824	2,443
PDC dividend payable	-	60
Accrued interest on loans	310	125
Other payables	90	186
Total current trade and other payables	**52,946**	**49,651**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	16,982	11,720
Non-current	-	-

Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	-		9	

Note 22 Other financial liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**

Note 23 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,684	857
Total other current liabilities	**2,684**	**857**

The Trust has no non-current financial liabillities

Note 24 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Obligations under finance leases	82	-
Total current borrowings	**82**	**-**
Non-current		
Loans from the Department of Health and Scoial Care	78,721	42,188
Obligations under finance leases	938	-
Total non-current borrowings	**79,659**	**42,188**

Note 25 Finance leases

Obligations under finance leases where Epsom and St Helier University Hospitals NHS Trust is the lessee.

	2018 £000	2017 £000
Gross lease liabilities	**1,020**	**-**
of which liabilities are due:		
- not later than one year;	82	-
- later than one year and not later than five years;	938	-
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**1,020**	**-**
of which payable:		
- not later than one year;	82	-
- later than one year and not later than five years;	938	-
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

The Trust has entered into a non-cancellable contract for the provison of a managed equipment radiology service. Signed on 14 March 2017 and lasting for seven years this agreement will replace and modernise the Trust's radiogy equipment base and provides guarenteed service levels.

Note 26 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**1,660**	**49**	**1,596**	**3,305**
Change in the discount rate	-	-	-	**-**
Arising during the year	159	28	233	**420**
Utilised during the year	(248)	-	(142)	**(390)**
Reversed unused	(19)	-	(676)	**(695)**
At 31 March 2018	**1,553**	**77**	**1,012**	**2,642**
Expected timing of cash flows:				
- not later than one year;	248	77	350	**675**
- later than one year and not later than five years;	990	-	342	**1,332**
- later than five years.	315	-	320	**635**
Total	**1,553**	**77**	**1,012**	**2,642**

Early Departure Costs

The provision represents the future liability of the Trust for early retirements from NHS service. The estimate of the full forecast liability is based on actuarial estimates from the Pensions Agency. Timings are based on the current rate of payments from the provision.

Legal Claims

The amount included is based on the excess the Trust would pay should the claim be successful.

Other Provisions

This includes the following i) Injury Benefits (£745k) This category of provision represents the future liability of the Trust for injury benefits. Payments are made to the NHS Pensions Agency for staff who retired from the Trust due to a work related injury. The estimate of the full forecast liability is based upon an actuarial estimate from the Pensions Agency. Timings are based on the current rate of payments from this provision ii) Employment Tribunals (£266k) This category of provision represents the future liability of the Trust for Employment Tribunals

Note 26.1 Clinical negligence liabilities

At 31 March 2018, £220,675k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Epsom and St Helier University Hospitals NHS Trust (31 March 2017: £210,725k).

Note 26.2 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
Other - legal claims	(29)	(27)
Net value of contingent liabilities	**(29)**	- **(27)**

Note 26.3 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	9,392	4,222
Total	**9,392**	**4,222**

Note 26.4 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 2018	31 March 2017
	£000	£000
not later than 1 year	1,568	1,568
after 1 year and not later than 5 years	6,674	6,674
paid thereafter	3,776	3,776
Total	**12,018**	**12,018**

Note 27 Financial instruments

Note 27.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS organisation has with commissioners and the way those commissioners 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 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. 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 is exposed to a risk that its cost of borrowings - which are fixed over the life of the agreement - is in excess of the borrowing costs avaliable in the future.

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 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

During the current year the Trust has been making operating losses and has no access to wider money markets to fund these losses. Losses are currently funded through Department of Health loans on which the Trust pays interest of 1.5%. These loans are disclosed in Note 24. The Trust believes that futher loans - at a value covering the Trust's operating losses - will be made available by the Department of Health in 2017/18. See Note 1.1, Going Concern, for further details.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	30,337	**30,337**
Cash and cash equivalents at bank and in hand	12,818	**12,818**
Total at 31 March 2018	**43,155**	**43,155**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	23,536	**23,536**
Cash and cash equivalents at bank and in hand	3,562	**3,562**
Total at 31 March 2017	**27,098**	**27,098**

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	78,721	**78,721**
Obligations under finance leases	1,020	**1,020**
Trade and other payables excluding non financial liabilities	47,007	**47,007**
Provisions under contract	345	**345**
Total at 31 March 2018	**127,093**	**127,093**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	42,188	**42,188**
Trade and other payables excluding non financial liabilities	45,187	**45,187**
Total at 31 March 2017	**87,375**	**87,375**

Note 27.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 27.5 Maturity of financial liabilities

	2018	2017
	£000	£000
In one year or less	47,434	45,187
In more than one year but not more than two years	82	-
In more than two years but not more than five years	856	-
In more than five years	78,721	42,188
Total	**127,093**	**87,375**

Note 28 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	48	174	-	-
Stores losses and damage to property	-	-	-	-
Total losses	**48**	**174**	**-**	**-**
Special payments				
Compensation under court order or legally binding arbitration award	9	3	4	6
Extra-contractual payments	-	-	-	-
Ex-gratia payments	33	30	30	25
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**42**	**33**	**34**	**30**
Total losses and special payments	**90**	**207**	**34**	**30**
Compensation payments received		-		-

Note 29 Gifts

No gifts have been received in the year.

Note 30 Related parties

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Epsom and St Helier University Hospital NHS Trust The Trust is a member of the London Audit Consortium and the Director of Finance is the nominated representative of the Trust in the capacity of a Non-Executive Director. Day to day operations are directed and controlled by the two executive directors and the full board set strategic direction and approve operations of the consortium. The Trust has paid the Consortium £135,000 (2016/17: £198,000) for its Internal Audit Services.

The Department of Health is regarded as a related party and parent Department. During the year Epsom and St Helier University Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The main entities are listed below with the value of the transactions for 2017/18:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Surrey Downs CCG	46	111,826	0	993
Sutton CCG	0	106,373	0	2,588
HM Revenue and Customs	16,506	0	5,314	0
National Health Service Pension Scheme	22,740	0	0	0

The Trust has also received donations from its charitable fund, of which it is the Corporate Trustee. These were: Revenue Epsom & St Helier NHS Trust Charitable Funds £114,000 (2016/17 £291,000); Capital Additions Epsom & St Helier NHS Trust Charitable Funds £nil (2016/17 £191,000)

Note 31 Events after the reporting date

In May 2018 NHS Sutton Clinical Commissioning Group’s Governing Body directly award an interim, transitional contract for Sutton Community Services to the Sutton Health and Care Provider Alliance (with Epsom and St Helier University Hospitals NHS Trust hosting the contract) for a period of one plus one years (April 2019 to March 2021). This contract is expected to increase the Trust's annual income and expenditures by £15,000k.

Note 32 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	84,114	241,248	73,570	212,979
Total non-NHS trade invoices paid within target	78,311	227,389	68,442	200,983
target	93.10%	94.26%	93.03%	94.37%
NHS Payables				
Total NHS trade invoices paid in the year	3,943	13,232	3,417	12,539
Total NHS trade invoices paid within target	2,389	6,666	1,934	6,146
Percentage of NHS trade invoices paid within target	60.59%	50.38%	56.60%	49.02%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 33 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	29,145	19,295
External financing requirement	29,145	19,295
External financing limit (EFL)	33,671	20,896
Under / (over) spend against EFL	4,526	1,601

Note 34 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	27,855	16,690
Less: Disposals	(4,323)	(2,579)
Less: Donated and granted capital additions	-	(665)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	23,532	13,446
Capital Resource Limit	23,894	13,819
Under / (over) spend against CRL	362	373

Note 35 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(13,361)
Breakeven duty financial performance surplus / (deficit)	(13,361)

Note 35.1 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,877	3,332	(12,277)	(12,094)	(7,400)	78	(25,788)	(12,687)	(13,361)
Breakeven duty cumulative position	(996)	1,881	5,213	(7,064)	(19,158)	(26,558)	(26,480)	(52,268)	(64,955)	(78,316)
Operating income		327,548	334,761	331,320	343,567	356,010	365,769	372,591	392,161	398,560
Cumulative breakeven position as a percentage of operating income		0.57%	1.56%	-2.13%	-5.58%	-7.46%	-7.24%	-14.03%	-16.56%	-19.65%

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

You can also download the Trust's full accounts from our website;
www.epsom-sthelier.nhs.uk