ABOVE ALL WE VALUE RESPECT

NHS
Epsom and St Helier University Hospitals
NHS Trust

Annual Report 2018 - 2019

On the cover, in the top picture: Head of Nursing for Medicine Richard Hughes talks to 'aspiring clinician' Owen Lyons.

Bottom picture: Our Stroke Team at Epsom Hospital reached the highest possible rating in the Sentinel Stroke National Audit Programme (SSNAP), which uses a set of 10 standards to measure the quality and organisation of stroke care in the NHS, including how long a stroke patient spends being cared for on the stroke unit.

If you, or someone you know, cannot read this document, please contact us and we will do our best to provide the information in a suitable format or language. For more information, contact the Communications Team on 020 8296 4996 or email esth.communications@nhs.net.

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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, including in the community, as well as nine renal centres for patients needing dialysis.

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1 Overview

Health Minister for Life Sciences, Baroness Blackwood, took the time to meet with staff during her visit to St Helier Hospital to declare our £12 million transformation of B and C block officially complete!

A welcome and overview from our Chairman and Chief Executive

Dear all

We are delighted to present this year's Annual Report – the official overview of how the Trust performed during the financial year of 2018-19. This overview includes a full rundown of the highlights and challenges of our year, including how we measured up against key NHS standards of care, how we performed against financial targets, and made best use of tax payers' money, and the steps we have taken to further improve the care we provide to our patients.

It has been another busy year for our hospitals and staff, marked by a number of achievements and developments, but there are four main ways in which 2018-19 was a transformative year for us:

1. We have continued to perform at a high standard, and have a strong track record in providing high quality care, and delivering against operational standards and our financial targets.
2. This year marked a turning point in our working culture, supported by values and behaviours, as we launched a comprehensive programme to improve the morale of our organisation and our leadership.
3. We have made huge strides in improving integrated care across the communities we serve. We have strengthened the working ties between acute care, community health services, social care and our local authorities to ensure that the populations we serve receive a joined up service, no matter the public health and social care body - this is sometimes referred to as a 'place-based' approach and it means that patients and service users receive a better service, and our organisations can work together to govern the common resources available for improving health and care in their area. These pioneering partnerships are known as Sutton Health and Care and Surrey Downs Health and Care.
4. We are determined to find a long term, sustainable future for Epsom and St Helier hospitals through the Improving Healthcare Together programme.

More information on all of these four transformations are detailed over the coming pages.

MP for Sutton and Cheam, Paul Scully, pictured during a briefing with our Chairman Laurence Newman.

Surrey County Council Care Practice Advisors joined us for an information stand during Carer's Week.

In the last year, we saw a significant increase in the number of people who needed our services. During this 12 month period, we provided care to people on **912,700** occasions – that's **2,500** patients appointments and procedures every single day (and is a marked increase to the 904,000 patients we saw last year). This includes **181,836** people coming to our A&E departments and significant rises in the number of ambulances bringing patients to our hospitals, including a 12% and 5% increase in ambulances carrying paediatric patients arriving at St Helier Hospital and Epsom respectively.

In addition, our expert maternity teams also helped thousands of new families, supporting **4,395** births in our hospitals and planned home births.

On average, patients who were cared for as inpatients last year stayed in our hospitals for 3.36 days and those over the age of 65 stayed for 4.12 days. This was within expected levels, but we know that patients do not want to stay in hospital for longer than is necessary and it is not in their best interests, and as such, we will continue to work with our partners in planning of the whole process of care, as well as active discharge planning.

We are incredibly proud to be such an important support to the communities we serve, and in order to keep up with the increasing demands on our services while still ensuring that patients receive the very best of care, we have put a sharp focus on the importance of integrated care. Historically, there have been boundary lines between the organisations that provide care to people in their homes, in GP surgeries and in hospitals, but we have always been in united in our duty to provide high quality care to the people who need us.

It's on those grounds that a large part of our work this year was in preparing to launch two pioneering partnerships that bring together acute services, social care, community health and GPs in Surrey Downs and Sutton. Bringing together our expertise will allow us to improve patient care and will enable local people to access the right support, care and treatment more easily than ever before, and we continue to work to bring mental health and additional social care services into both partnerships.

Keeping our patients safe and providing timely care

We are absolutely committed to providing care to the people who need us in a timely way, and we are delighted to announce that we met the key waiting time standards for patients with suspected and diagnosed cancer.

We were shy of 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). In previous years, we have been one of the few trusts to exceed the standard and this year were in the top three London trusts and top 20% of trusts nationally, ending the period at 91.90%.

We won the prestigious HSJ Award for Acute Innovation for our work in a local pilot to provide a 'one stop shop' for the diagnosis of prostate cancer, reducing diagnosis times from six weeks to one day!

We will continue to work hard to ensure this standard is met in future, and have put a number of measures in place to help us achieve that – including expanding both our A&E departments and creating new rapid assessment and clinical decision units. Changes to these standards are currently being piloted in other areas of the country, but if and when the standards do change, we will remain committed to proving high standards of care in a timely way to meet the needs of patients.

We are very proud of the high level of care we provide to our patients, and are pleased to say that mortality rates at our hospitals are far lower than expected too. This is measured at a national level by Hospital Standardised Mortality Rates (HSMR). For the period of February 2018 to January 2019, our HSMR is 98.91.

In March, the Stroke Team at Epsom were awarded the highest possible rating in a national audit – making us one of the very best performing units in the country. The Sentinel Stroke National Audit Programme (SSNAP), which uses a set of 10 standards to measure the quality and organisation of stroke care in the NHS, including how long a stroke patient spends being cared for on the stroke unit, has shown that the team at Epsom have reached the highest possible rating, which is A.

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

Building and planning for our future

This year, we have spent a record £49.7 million on improving our facilities and equipment. This work has transformed some of the areas where we care for patients and has made meaningful improvements to the way we can work. But unfortunately, as lots of local people are aware, because of our ageing buildings and the way our services are currently configured, Epsom and St Helier cannot continue as we are forever. To secure a long term future that is clinically and financially sustainable, we need to build a state-of-the-art, brand new facility (on one of our existing hospital sites) where our sickest patients will be cared for.

Before any decisions are made, there would be a public consultation so that local people can have their say about where they think this new facility should be built. Our local commissioners (the clinical commissioning groups (CCGs) of Surrey Downs, Sutton, and Merton) are working together to look at the long term future of health and social care in the region, known as 'Improving Healthcare Together 2020-2030', which will aim to:

- Deliver care closer to patients' homes by integrating health and care services so they work together in the most effective way
- Ensure high standards of healthcare by meeting the clinical standards set for our local area
- Ensure we keep services for patients with serious or life-threatening conditions operating within our local area.

The CCGs have begun pre-consultation engagement with the public on a new clinical service model for Epsom and St Helier, which includes creating a single acute specialist facility on one of our three sites. Importantly, we have ensured that we have enough space at each of our three hospital sites to build a new acute facility once a decision is made on its location.

However, a development of that size will of course take some years to complete, and in the meantime we cannot stand still. We have to do what we can to manage the many issues we have with our existing buildings.

To ensure we are making the most of our estate and assets, we have looked at what land we have but do not use, and the areas within our grounds that we will never need. This is known as estate rationalisation, and it's something that all NHS trusts have a duty to do.

As part of this work, we identified some parts of the Epsom site, containing the derelict York House and old accommodation block, as surplus to our current and future needs. It was therefore declared surplus and suitable to sell – with the public sector offered priority in bidding. This plan was approved by our Trust Board in April 2018 and the sale was agreed in March 2019.

Selling the surplus land means we have additional money to spend at Epsom for vital improvements:

- Building a link corridor between Langley Wing and Wells Wing by 2020-21 (so no more patients will need to be pushed from department to department through all weathers whilst lying in bed). We will also be refurbishing the whole building so we can use it all for clinical and administrative space, hopefully including the new Epsom and Ewell Cottage Hospital too (as per the CCG's consultation from 2016)
- Double glazing for all of the windows in the main ward blocks – at the moment, some of these windows cannot be opened, meaning the wards are unbearably hot in the summer and there's no fresh air through the wards. This has been a particular issue during the summer's heatwave
- Creating a new outpatient department in Woodcote Wing so that the main thoroughfare in Headley Wing doesn't cut through small, busy corridors and patients can find their way around more easily
- Replacing the old steam boilers (they currently need 24-hour-a-day maintenance attendance, and mean that our heating can only really be on or off with limited temperature setting in between)
- Looking to install a new deck car park to create additional spaces
- Lighting in our wards and areas used 24/7 will be replaced for new energy efficient LED lighting – improving light level and reducing our electricity bill.

Our SWLEOC team help a patient to get back on her feet following an operation.

As part of the department's £500,000 refurbishment, our Nuclear Medicine Unit now has a wonderful sky light design.

Steady finances

Like most other NHS organisations across the country, we faced a significant financial challenge this year. That has meant taking some tough decisions, but we would like to assure all of our patients, visitors and local people that we did so without compromising patient care.

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.

For the third year in a row, we have met our deficit control total (which is agreed with our regulator at the start of the year).

We have ended the year with a Financial Performance deficit of £26.3 million against a control total deficit of £28.2 million, which is £1.9 million better than our plan. Over the coming year, we will – once again – work hard to maintain our financial grip, and have agreed a deficit control total with our regulators. We will also be working within the framework of the Acute Provider Collaborative, a new approach that will see the four acute trusts in south west London working together to improve the clinical and financial position of the sector.

Meeting the Government's healthcare standards, combined with our good patient feedback, improvements in patient care and ending the year ahead of 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.

Laurence Newman
Chairman

Daniel Elkeles
Chief Executive

Our Chief Executive Daniel joins the children of St Helier's onsite nursery as they celebrated the marriage of Prince Harry and Meghan Markle.

Our values, mission and objectives

Above all, we value respect

Over the course of the past four years, Epsom and St Helier hospitals have been on an impressive improvement journey. Operating in an incredibly difficult environment, we have delivered huge improvements in patient care, safety, and waiting times. We have seen staggering improvements in the hospital environment (although fundamental issues around our infrastructure remain) and have put in the foundations for securing a long term, sustainable future for our hospitals, including setting a five year strategy and improving the ways we work with social care and community services.

However, this year it became apparent that – despite significant progress – the Trust needed to focus on the working culture of our hospitals. The results of our staff survey showed us that we were not engaging with staff enough and that morale is not as good as it could be (even taking account of the difficult context the NHS operates in). That was reinforced by the findings of the Care Quality Commission (CQC) inspectors who visited in January of 2018 and published their report in May 2018.

It was on those grounds that we launched 'Your Voice Your Values' – a Trust-wide programme that aimed to establish what matters to our staff and what change was required to make Epsom and St Helier an outstanding place to work. The first phase of the programme, based on more than 3,000 pieces of feedback from our staff, showed that respect and respectful behaviour was the common factor in determining whether our staff and teams would have a good or bad day at work.

As a result, '**respect'** is now our singular value, and it is something we are working hard to embed across our organisation.

We have launched a comprehensive set of materials to help our staff put respect at the heart of every interaction they have – including providing constructive feedback, dealing with disrespectful behaviours and recruiting with values.

Over the coming year, we have a great deal of work to do in ensuring that respect becomes an integral part of our culture, but would like to thank all staff and patients who engaged in the process and enabled the Trust to take meaningful steps in improving our collective mood and behaviours.

Our mission remains to provide great care to every patient, every day. 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.

We installed a canopy over the entrance to our Children's Outpatient Department at Epsom, offering shelter from the weather and making the entrance to the department more welcoming than ever before. Sister Hannah and HCAs Josie, Jacqueline and Sarah are thrilled with the new addition!

2 PERFORMANCE ANALYSIS

Happy staff from the St Helier Renal Department.

Deliver safe and effective care with dignity and respect

The experience our patients have in our hospitals – whether they need life-saving surgery or a routine appointment in an outpatient department – is vital, and we are committed to providing high quality, compassionate care to every patient.

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. You can read more about the ways in which we provide assurance about performance measurements and risk in the Annual Governance Statement on page 23. 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, which were published in May of this financial year, on page 14 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, almost 83,000 patients had their say, with 93.5% of people reporting that they would recommend our services.

The Inpatient Survey of 2017 (which was published within the financial year on 13 June 2018) highlighted a number of particularly positive aspects of our patients' experience:

- 97% of respondents with a planned admissions said their specialist had been given all the necessary information
- 96% of respondents said that their room or ward was clean or very clean
- 94% of respondents said they got enough to drink
- 93% of respondents said they always had enough privacy when being examined or treated.

The Maternity Survey 2018 (which was published 29 January 2019) highlighted the following particularly positive aspects:

- 93% of respondents felt involved enough in decisions about their care
- 95% of respondents felt that their partner was involved in their care during labour and birth
- 94% of respondents said that were able to contact a midwife or midwifery team at home after the birth
- 95% of respondents said that, during their care whilst pregnant, they had a telephone number for a midwife or midwifery team that they could contact
- 96% of respondents were visited at home by a midwife since the birth of their baby
- 96% of respondents were asked by a health visitor or midwife how they were feeling emotionally
- 97% of respondents were told by a midwife that they would need to arrange a postnatal check for their own health with their own GP (around 6-8 weeks after the birth)
- 97% of respondents said they had confidence and trust in staff.

We also conducted a Cancer Patient Experience Survey 2017 (which was published in September 2018):

- Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.6
- 93% of respondents said that they were given the name of a Clinical Nurse Specialist (CNS) who would support them through their treatment
- 87% of respondents said that it had been 'quite easy' or 'very easy' to contact their CNS
- 90% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital
- 96% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

In November, the Royal College of Physicians published the National Hip Fracture Database – a country-wide report that uses a number of standards to determine how well hospitals are caring for patients with a fractured hip – and for the 6th year in a row, we topped the London table.

The report shows that we were the 2nd busiest unit in London (and the busiest in south west London), caring for 434 people with fractured neck of femur. Despite such high numbers of patients, we were the best performing hospital in London for the Best Practice Tariff for excellence in hip fracture care – a measurement that takes into account a number of different standards, such as time to surgery and ensuring patients have the right assessments done by the right professional at the right time.

Our mortality rates for patients with a fractured neck of femur remain low and significantly below the national average.

Our Hip Fracture Unit is a great example of how consolidating care and concentrating the skills of our experts (across all of the disciplines) allows us to provide great care to patients when it really matters. For elderly patients, a fractured hip is a significant injury and recovery and rehabilitation can be very difficult – in fact, some patients do not return to independence after such a serious injury.

How we performed:

Standard	Result
Infection control – have no more than 38 cases of Clostridium difficile	**ACHIEVED** We recorded 33 cases of Clostridium difficile.
Infection control – have zero cases of MRSA (bacteraemia).	**DID NOT ACHIEVE** We recorded one case of MRSA (down from five last year).
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 shy of this standard, with 91.90% 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 (although achieved agreed standard with local commissioners)** 87.4% 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**: 97.2% of these patients were seen within this time. **ACHIEVED:** 99.1% of these patients were seen within this time. **ACHIEVED:** 89% of our patients received treatment in this period.
Stroke care – at least 80% of patients should spend at least 90% of their hospital stay in a stroke unit.	**DID NOT ACHIEVE:** 70.5% of patients spent 90% of their time in a stroke unit.

Care Quality Commission (CQC) registration

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

Following its inspection in November 2015, the CQC re-inspected some of the services at Epsom and St Helier University Hospitals NHS Trust in January this year and has improved its assessment on two of its five key areas, rating the Trust 'Good' for caring and responsive. In addition, the CQC reported clear improvements and progress improving the ratings across 25 different domains.

This inspection was carried out during one of the busiest periods ever seen at the hospitals when the Trust was caring for a record number of very sick patients. The Trust's overall rating of 'Requires Improvement' remains unchanged as the CQC did not inspect all areas. However, the inspectors reviewed 10 of the Trust's 18 services and this now means that of the 18 services one is rated as outstanding (SWLEOC), 10 as good and seven as requires improvement.

Staff in action in our busy A&E departments.

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

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.

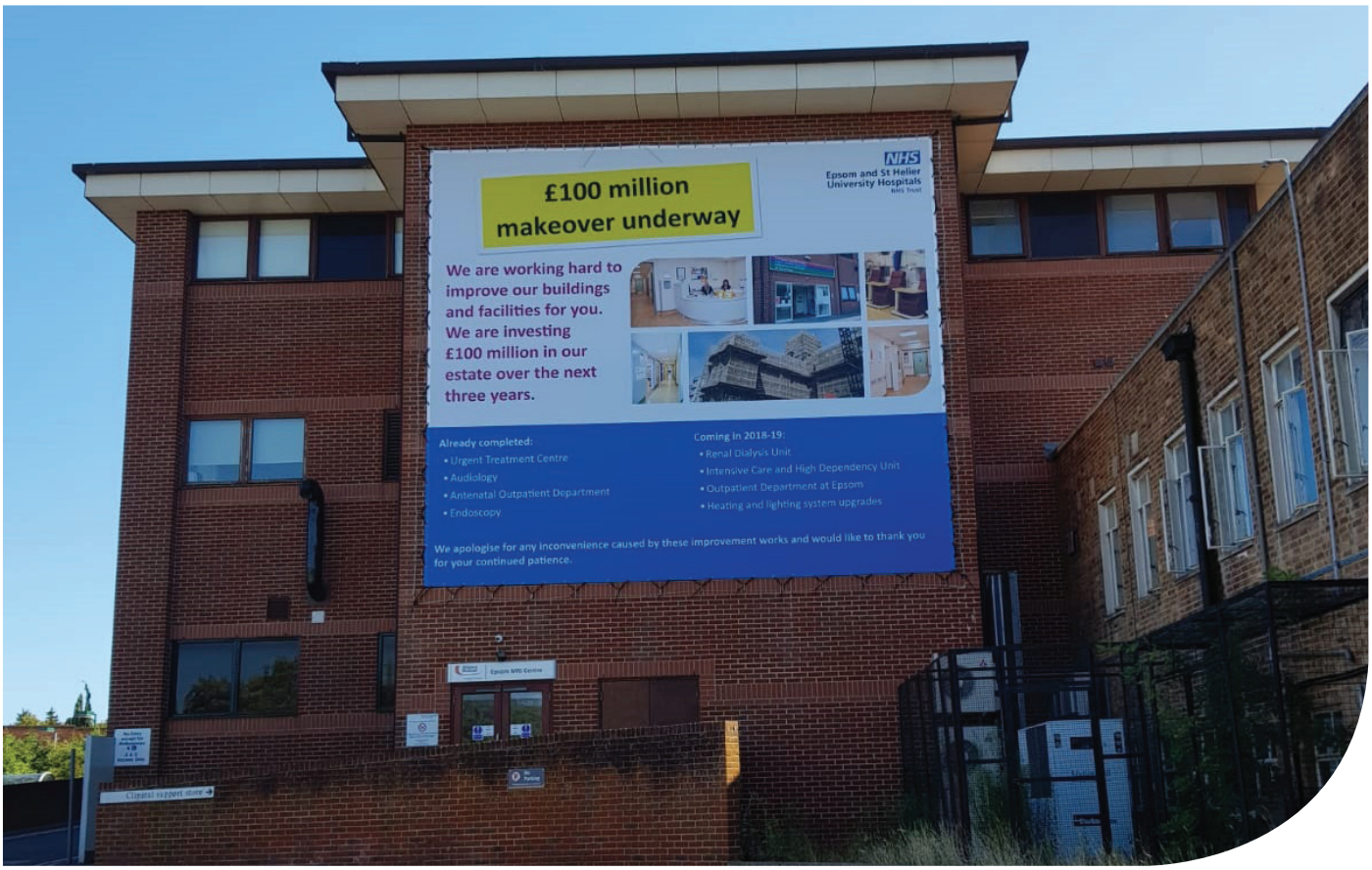
The principles set out are intended to promote a shared understanding of how to put things right when they have gone wrong and to help public bodies such as the Trust, in the Ombudsman's jurisdiction provide fair remedies. The full document can be read at: www.ombudsman.org.uk/improving-public-service/ombudsmans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

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

Clockwise from top left: Joint Medical Director and Deputy Chief Executive, Dr Ruth Charlton, launches our Your Voice Your Values survey – the first step in our work to transform the working culture of ESTH; Our Chief Executive assesses the progress on the £12 million refurbishment of B and C block at St Helier; Baroness Blackwood declares the project officially complete! A healthcare assistant offers support to a patient during lunch time.

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

We know that having a procedure or having to stay overnight in hospital can be a daunting experience, and our staff do their utmost to ensure our patients' experience in hospital is as positive as it can be.



There were two new arrivals at Epsom and St Helier this year, as we installed two giant banners to let people know about our record £100 million makeover.

Investing in the care we provide

We understand that a positive experience for our patients and their loved ones also relies on our staff having the best tools for their work.

During the year, surgeons performing knee replacements at the South West London Elective Orthopaedic Centre (SWLEOC) took delivery of a new cutting edge assistant in the operating theatre – a robotics-assisted surgical system called NAVIO that helps improve accuracy during surgery. The NAVIO surgical system (which is a hand held tool attached to a computer) uses infrared signals to produce a detailed computer model of the patient's knee before and during the procedure. The software also helps the surgical team to work out how the knee will move after surgery, and gives real time feedback on alignment and positioning of the implants. The system can also show the surgeon a 3D image of how much bone needs to be removed before the implant is put in and improves the overall accuracy of the position.

The Trust became the first in London to receive the UNICEF Baby Friendly Initiative Gold Award this year. Maternity services at Epsom and St Helier are one of a handful (just four in England) to have received the Gold Award. The award is recognition that not only is the service providing the best standards of care for mothers and babies, but that it has the leadership, culture and systems in place to maintain this over the long term.

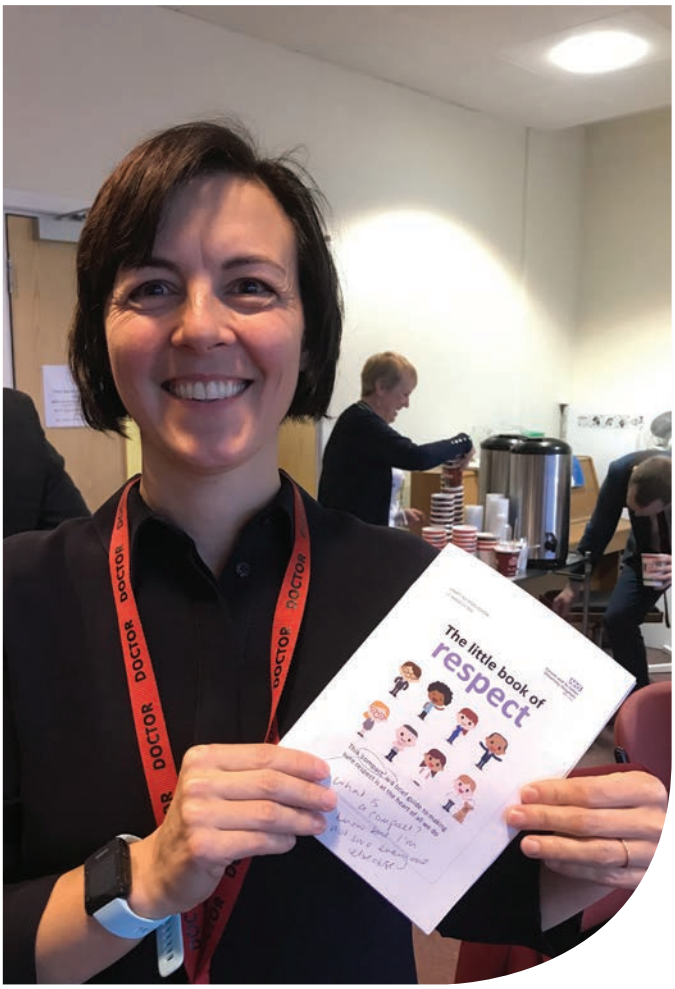
The Baby Friendly Initiative, set up by UNICEF and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve and maintain the best standards of care for all mothers and babies. In the UK, the initiative works with public services to protect, promote and support breastfeeding, safe bottle feeding and to strengthen mother-baby and family relationships.

A particular area of focus for us has been working with young carers, an area that was not previously covered in the Carers Guideline. Through working with partner organisations from across Surrey, including the local authority, we have developed bespoke information leaflet for young carers (including signposting to key resources and support services).

In January 2019, the Trust signed up to the Young Carers Pledge and to discuss what support is available to young carers who may visit our hospitals. The pledge is a commitment given to young carers based on what they have said mean the most to them. Signing up to the pledge means that we will:

- **SEE** them and listen to what they have to say
- **RECOGNISE** that they have their own needs as the carer
- **VALUE** their thoughts and opinions on how we take care of the person they look after
- **CREATE** a welcoming and caring environment for them
- **RESPECT** that they know a lot about the person they care for.

Our expanded A&E department needed new monitors, which came complete with a mobile unit that travels with patients if they transfer from A&E to a ward. Our Chief Executive Daniel is pictured with nurse Sophie, who was working a non-clinical day and helping to install them.



Dr Rebecca Suckling, Associate Medical Director and Consultant Nephrologist, pictured with the first draft of our 'Little Book of Respect' – a guide for all staff to help ensure respect is at the heart of everything we do.

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

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. 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 remained steady this year. We are working hard to improve this performance for next year.

We were delighted to win the prestigious HSJ Award for Acute Innovation for our work in a local pilot to provide a 'one stop shop' for the diagnosis of prostate cancer, reducing diagnosis times from six weeks to one day! Known as RAPID (Rapid Access to Prostate Imaging and Diagnosis), the new approach is a collaboration with the Royal Marsden, St George's and Imperial College Hospital.

Under the 'rapid pathway' approach, men with suspected prostate cancer have an MRI before a biopsy – allowing one third of those patients to be discharged the same day. We are also using cutting edge technology so that those who do require a biopsy benefit from precise 3D-MRI with live ultrasound images to target suspicious areas. Before RAPID, the standard practice was to have a biopsy (intended to confirm the presence of prostate cancer), without an MRI scan having taken place. This can lead to significant cancers being missed, insignificant cancers being identified that require no treatment, and a risk of sepsis.

And the RAPID results speak for themselves. Since its introduction:

- 84.5% of men were informed of their diagnosis within 28 days
- Number of days from diagnosis to treatment fell by an average of 10 days
- Diagnosed 10% more men with high risk cancers, with a 10% reduction in diagnosing insignificant cancers
- Improved 62 days performance for prostate cancer as a region, from 83.2% (Q1 2017-18) to 86.9% (Q3 2017-18).

The new digital maternity notes system, which is known as BadgerNet, is available both as a secure online portal and the 'Maternity Notes' app, which allow both healthcare professionals and pregnant women to access the necessary clinical information they require from anywhere there is internet coverage – and all at the touch of a button.

Users can access BadgerNet through a PC, tablet or mobile device; all they need to do to is login using their secure password and username, and everything is there at their fingertips. Pregnant women are also welcome to add information so that the healthcare professionals supporting their pregnancy can be made aware of any preferences regarding their birth plan. Soon it will also be possible to add information about allergies and other relevant health issues prior to booking.

A new Urgent Treatment Centre has opened at Epsom Hospital following a £1 million investment, meaning patients can be directed to the right team for non-emergency care faster than ever before.

The new department was created to make sure people who need urgent treatment (such as patients who need stitches or have ran out of asthma medication) can access medical attention quickly without having any impact on the emergency and life-saving cases in the A&E department.

As part of the design of the new Urgent Treatment Centre, which has been built alongside the A&E department (where the old antenatal waiting room was in the Bradbury Wing), a new reception has been created. This means that every patient who does not arrive in an ambulance will initially be seen by a streamer nurse who will make an instant decision about whether a patient needs urgent medical attention in majors This ensures that the sickest walk-in patients will be escalated when needed to a senior doctor, sooner than ever before.

For our other patients, we now have two triage rooms, and can take bloods and ECG tests (to look at the rate, rhythm and electrical activity in the heart) in secondary triage. We have seven consultation rooms, giving our emergency nurse practitioners more space and additional capacity to see more patients, and we have a designated room for a GP colleague to see patients from 10am-8pm every single day.

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 £26.3 million rather than the deficit of £28.2 million agreed with our regulator at the start of the year.

During the year, we sold an unused part of our Epsom estate for £15 million. The Trust has been allowed to retain these proceeds to address critical building maintenance issues at Epsom. This has allowed us 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.

It has also allowed us to invest £20 million into a programme that will transform the hospital environment for patients, reduce the amount of energy we use and decrease the amount of money spent on energy bills by approximately £670,000 per year.

The work is ongoing and will include replacing the six steam boilers that currently power the hospitals (some systems of which date back to the 1930s and require 24/7 maintenance support), new lighting across the hospitals and new heating for the wards and departments.

This is the biggest investment ever made into energy efficiency at the Trust. As an organisation that operates 24 hours a day and 365 days a year, we absolutely recognise our duty to protect the environment and use the energy that we rely on as efficiently as possible.

For the third year running we have delivered on our cost improvement plans and have ambitious plans in place to do the same next year. As a result, we aim to improve our underlying deficit position. However, the structural underlying deficit from running two sites with sub-scale services (recognised by NHS Improvement as a the primary cause of our deficit) means that we will never be able to completely eradicate our deficit working as we do now.

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. 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.

The Trust spent £476.0 million on operating costs during 2018-19, an increase of £36.3 million from 2017-18. The largest expenditure was staffing at £280.9 million, which accounts for 59% of all expenditure, followed by expenditure on clinical supplies and services at 16%. You can see a breakdown of different types of expenditure incurred by the Trust during the year in our accounts section.

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

A large focus for the Trust this year was creating a new partnership known as Surrey Downs Health and Care (bringing together our staff, CSH Surrey and the GP federations in Surrey Downs, with Surrey County Council joining the partnership as an associate member) and the expansion of Sutton Health and Care, which is made up of our staff, the GP federation in Sutton, the London Borough of Sutton and South West London and St George's Mental Health Trust.

Historically, there have been boundary lines between the organisations that provide care to people in their homes, in GP surgeries and in hospitals, but we have always been united in our mission to provide great care to the people who need us. It is on those grounds that both partnerships were brought together – we want local people to receive the care that they need in the right environment. Bringing together our expertise allows us to improve patient care and will enable local people to access the right support, care and treatment more easily than ever before.

We are a system leader in bringing together acute, mental health, social care, community health and GPs in Surrey Downs and Sutton, and look forward to being able to publish more information about the benefits of these partnerships shortly. **Epsom Health and Care** (a similar model that paved the way for the larger scale Surrey Downs Health and Care), which was introduced in 2016, has reduced length of stay for people aged over 65 and helps to keep people living independently.

We are proud to be a part of the **Acute Provider Collaborative**, whereby the four acute trusts in south west London work together to improve the clinical and financial position of the sector as a whole.

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

This year we launched a comprehensive and far-reaching programme to ensure our staff feel engaged and are able to develop their skills and careers in the way that they would want to. As a result, we can now proudly say: Above all else, we value respect.

We have also put a number of measures in place to ensure that all clinical areas are well-staffed, our recruitment processes are well managed and our staff can easily work additional shifts should they chose to. These include:

- South West London collaborative nurse bank technology enables nurses to see available bank shifts across south west London
- Agency staff - proportion of agency staff is consistently below national median
- Temporary medical staff reduced in 2018 due to improved recruitment
- Re-imagining HR – a programme to bolster all HR policies, including recruitment and retention (this includes ensuring all interview panels for senior jobs feature one female and one member of staff with a black, asian and minority ethnic background (BAME), and a 'refer a friend' bonus).

During the year we increased the number of clinicians working at the Trust by 248.1 whole time equivalents.

Matron for improving Patient Experience , Sue Tyne, is pictured filling in her response to the year's staff survey (while making the most of the sunshine in the secret garden at St Helier!).

Training and education

The brand new £521,000 education centre at St Helier Hospital was officially opened by special guest Professor Martin Rossor from The Worshipful Society of Apothecaries.

The centre features a brand new library (complete with an extensive collection of medical journals and textbooks) and a suite of purpose built rooms, all kitted out with brand new Information Communication Technology (ICT) equipment. This includes: high definition (HD) projectors, fully equipped ICT suites, virtual reality (VR) headsets, classrooms with sound-proofing for flexible use of space, a brand new lecture theatre and an ID-card based security system (allowing for secure out of hours access).

A number of departments at Epsom and St Helier hospitals have been recognised for educational excellence in providing training for GPs of the future.

Training posts in emergency medicine, palliative care, public health and orthogeriatrics (the care of elderly orthopaedic inpatients, most commonly following a fractured hip) have all been awarded the new prestigious charter mark for GP training by Health Education England's GP School, demonstrating an excellent level of support to the trainee GPs studying at the hospitals.

As a university hospital, we are absolutely committed to providing fantastic training and development opportunities to the healthcare professionals of the future. Health Education England's charter mark for GP training recognises excellence in a training programme and in order to be awarded it, we have to evidence that trainees are getting good support, good training, access to clinics and teaching, and give excellent feedback on their experience. This is a new process which has been in development for over a year and it has required sustained and consistent excellence from our teams.

During a recent assessment, our teams in our orthogeriatric care, emergency medicine, public health and palliative care departments met the stringent criteria set out by Health Education England in order to achieve a 'recommended' status. The award follows a formal assessment made by the GP School, which looks at the evidence provided by us and also involves meeting with trainees face-to-face.

Staff nurse Hannah was one of the first members of the team to receive one of our new yellow badges – designed to be easier to read for our patients and visitors.

Chief Nurse Arlene talks to a member of staff in A&E during one of her 'Walk and Talk with the Chief Nurse' events.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

SCHEDULE 2 (Regulation 8)

Information for 1st April 2018 to 31st March 2019

Table 1

Relevant union officials

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

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
31	*24.43 WTE (union reps)*

Table 2

Percentage of time spent on facility time*

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	*20*
1-50%	*9*
51%-99%	*0*
100%	*2*

Table 3

Percentage of pay bill spent on facility time*

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

	Figures
Provide the total cost of facility time	£50,528
Provide the total pay bill	£283,217,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.0178%

Table 4

Paid trade union activities*

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

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	120.5 hours /1765.73 x 100
(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	**= 6.82%**

* This information is based on the information received from the Trade Union Representatives

ANNUAL GOVERNANCE STATEMENT 2018-19

Chief Nurse Arlene in the busy reception of Epsom's A&E department.

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 Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our Board 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 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 committee of the Board with the membership comprising all non-executive directors (NEDs) and executive directors, and chaired by a non-executive director.

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 Corporate Services.

The Trust's Risk Management and Risk Register Policy and Risk Assessment Policy underpins how the Trust manages risk, which includes the recording of incidents on Datix (the Trust's incident 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 policies relating to risk and associated documentation.

In November 2018, our internal auditors undertook a risk maturity assessment into the Trust's internal systems and processes. The resulting report noted that a significant amount of work has been undertaken to improve risk awareness and management at all levels and, amongst other things, identified the following areas of good practice:

- There is regular reporting on risk to various committees within the Trust allowing for full awareness
- The Trust has established a strong process for the identification of risks, including the review of complaints and incidents as a source of risk identification.

The risk and control framework

The corporate risk register 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)
- People and Organisational Development (workforce)
- 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 committee.

The corporate risk register is very much considered a 'live' document and forms part of the Integrated Performance Report. The corporate 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 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 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.

The highest rated risks (20 and above) on the March 2019 corporate risk register were as below:

Staffing	
Capacity and ability of senior leadership teams to deliver all of the Trust's operational, quality, patient experience, behaviour and culture programme, financial, strategic objectives, including significant infrastructure projects and developing wider partnerships for community services.	20
Nursing staffing shortages impact on service quality and financial performance	20
Variability in quality of care	
Delays due to suspension of out of hours interventional radiology	20
Delays in completion of Investigations of Incidents within the Medicine Division which leads to delays in implementing learning.	20
Critical Care Outreach Team – lack of staffing	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
Finance	
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

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

The Board recognises that risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify the context of risk, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of the Trust's aims and objectives. To this end, the Trust has developed a Risk Appetite Statement which was approved at PARC in March 2019. It describes the amount and type of risk that the Trust is prepared to accept to achieve its corporate priorities; sets out the Board's strategic approach to risk-taking by defining its boundaries and supports delivery of the Trust's Risk Management Policy.

As a general principle the Trust will not accept and will therefore seek to control all risks which have the potential to:

- Cause significant harm to patients, staff, visitors and other stakeholders
- Endanger notably the reputation of the Trust
- Have severe financial consequences which could jeopardise the Trust's viability
- Jeopardise significantly the Trust's ability to carry out its normal operational activities
- Threaten the Trust's compliance with law and regulation.

In 2018-19, the design of the Board Assurance Framework (BAF) has been overhauled and it now collates in one document progress against, and risks to the achievement of, the Trust's corporate objectives. The document details the main sources of assurance against each corporate objective, enabling the Board to gain a clear understanding of the risks faced by the organisation in terms of performance/progress against the key corporate objectives.

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.

The Integrated Performance Report (IPR), Corporate Risk Register and BAF are complementary documents. The IPR indicates key performance shortfalls which lead on to a risk discussion. For example, risks to delivery of the A&E four hour emergency access standard continue to be escalated and are reviewed in detail to obtain appropriate assurance at the monthly Board committees ahead of each Board meeting.

The IPR, Corporate Risk Register and BAF together form the main tools that the Board uses in terms of internal control.

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 and seeking to make continuous improvement. The Board is also responsible for ensuring 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.

In November 2018, in line with a recommendation from NHS Improvement, the Board commissioned an externally facilitated well-led review. The output from this will be reviewed at a Board Seminar in April 2019, following which an action plan will be developed to address the points raised.

The Trust Board has been accepted on a quality improvement Board Development Programme run by NHS Improvement intended to help the boards of NHS providers to develop the knowledge and skills needed to lead and embed quality improvement at an organisational level.

It takes the hard work and commitment of almost 6,000 staff across our hospitals and in the community to keep our services running smoothly.

The Trust Board is comprised of a chairman, five non-executive directors (NEDs), two associate non-executive directors, and six voting executive directors. The 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 Corporate Services
- Director of Estates, Facilities and Capital Projects
- Director of Communications and Patient Experience
- Director of Integrated Care
- Director of People.

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

- The Chief Nurse retired in May 2018 and was replaced by Arlene Wellman.
- The Director of People and Organisational Development left the Trust in August 2018. In response, the portfolio of the Director of Strategy, IT and Corporate Governance was expanded to include responsibility for Human Resources, with support provided through the appointment of a new Director of People, Debbie Eyitayo. Subsequently, the Board has decided that from 1 May 2019, the Director of People will be directly accountable to the Chief Executive and attend Board in their own right.
- To bolster the resources needed to take forward work on integrated care, given that the Trust assumed responsibility for two large community contracts from 1 April 2019, a new Director of Integrated Care, Thirza Sawtell, was appointed.
- Two associate NEDs were alos recruited:
    - Martin Kirke, with a special interest in the workforce and diversity agenda
    - Chris Elliot, with a special interest in community integration.

The Board met a total of six times in public in 2018-19 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 2018-19. In addition, the Board meets in private every month.

Prior to all Board Meetings and Public Briefings, the Board undertakes a '15 Steps Challenge Walkabout' (which aims to determine what our patients and visitors experience within the first 15 steps of entering a ward or clinical department) within different parts of our hospitals. The findings from the walkabouts are reported back in public at the subsequent Board Meeting or Public Briefing.

The Board held its Annual Public Meeting in July 2018.

All NEDs and executive directors complete a declaration for the Fit and Proper Person's Test upon appointment.

The committee structure

The Trust Board has nine 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
- Equality, Diversity and Inclusion Committee

VIP Professor Martin Rossor from The Worshipful Society of Apothecaries did us the honour of cutting the ribbon to our new Education Centre at St Helier.

The **Audit Committee** met on five occasions in 2018-19. 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 NEDs (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.

Chair of NHS England, Lord Prior, visited the Epsom Health and Care hub to learn more about our integrated care systems.

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
- Annual Governance Statement
- Internal and external audit reports
- 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 NED. The Committee approves the annual financial plan and reviews financial performance to ensure the Trust achieves its annual financial targets. The Committee also reviews and approves investments in service development opportunities and approves tender proposals and business cases. The Committee 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 NED, 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 Committee has the delegated authority to approve the Trust's Annual Quality Account.

The **Performance Assurance and Risk Committee** was established in May 2016 with 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. The Committee is chaired by a NED, 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 of the Trust.

The **Remuneration Committee** is chaired by the Chairman of the Trust 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.

The **Equality, Diversity and Inclusion Committee** was established by the Trust during the year and held its first meeting in August 2018. The membership comprises two NEDs and all executive directors (the four core executives are the Director of Communications and Patient Experience, the Director of Corporate Services, the Chief Nurse and the Director of People). The remit of the Committee is to set the Trust's direction and framework for equality, diversity and inclusion issues, ensuring a co-ordinated approach to diversity work. The Committee is involved in developing and monitoring the annual EDI work plan, ensuring that the views, needs and preferences of diverse groups inform the delivery of services across the Trust and raising the profile of equality and diversity across the Trust through supporting good practice and promoting and monitoring equality, inclusion, diversity and dignity training.

Workforce

During 2018-19 the Trust has reviewed its people and organisational development governance arrangements in order to best support its workforce. The new framework enables the executive team to have oversight of all aspects of the Trust's workforce metrics and the ongoing development of its workforce strategy. The functioning of the People and Organisation Development Committee, which reports directly to the Board, has recently been reviewed and a number of new sub-groups agreed to enable a focus on the following key priorities:

- Staff Engagement
- Recruitment
- Retention
- Performance

MP for Carshalton and Wallington, Tom Brake, delivered a thank you and happy birthday card to mark the Trust's 20th anniversary.

Focusing on retention of staff has been a key factor for the Trust during 2018-19 and as such we have participated in the NHS Improvement Retention programme for nurses and midwives. Work around staff retention will include a refreshed approach to engagement with staff and developing leadership and training programmes at all levels including a development programme for Band 5/6 staff to enable the Trust to retain experienced nurses and to help them to progress to the next level of promotion within their careers.

The nursing establishment for the Trust is a key area of focus. A nursing workforce strategy is being developed which will tie in with the expansion of planned care and the integration of community services. Medium term recruitment strategies will include a focus on ensuring the correct skill mix for a modern workforce, with the Trust aiming to increase the extended skills of its nurses through further implementation of roles such as advanced clinical practitioner and emergency clinical practitioner roles alongside a number of new nursing associates being trained.

A particular success in term of recruitment during 2018-19 has been the appointment of nearly 100 extra healthcare assistants. During the year, the Trust has also commissioned a medical workforce improvement programme which focused on resolving staffing issues and ensuring rotas are adequately staffed. As a result of this work, there has been a significant reduction in the number of clinical vacancies across the Trust although some areas do remain challenged.

Staff engagement

In response to a range of insights including the staff survey, in 2018-19 the Trust launched a major staff engagement programme called *Your Voice Your Values*. This engagement initiative has prompted over 3,000 pieces of feedback from staff as well as patients on what would make the Trust a good place to work and be treated. From this work the value of 'Respect' has been identified as a priority and we are now embarking on a Trust-wide cultural change programme to ensure that 'Respect' is at the heart of everything we do, from recruitment, performance appraisals and management as well creating a respectful work environment through addressing poor behaviours and bullying and harassment. Around 900 of our leaders and managers attended masterclasses in March/April to equip them with tools to lead with respect.

Equality Diversity and Inclusion

Embedding Equality Diversity and Inclusion (EDI) has been an important area for the Trust with the Chief Executive setting this as a key priority area from the Board to the rest of the organisation. The Trust's performance against this agenda is monitored through a committee of the Trust Board chaired by a NED. In September 2018, the newly established Equality, Diversity and Inclusion Committee met for the first time to address a range of initiatives including:

- Establish Equality, Diversity and Inclusion (EDI) Committee
- To implement the NHS Workforce Race Equality Standard (WRES) action plan
- To implement Accessible Information Standard (AIS)
- To implement Equality Delivery System 2 (EDS2)
- Gender Pay Gap Reporting
- To implement a BAME Staff Network
- Improving staff experience to ensure all staff experience the Trust as a fair and rewarding place to work and want to stay
- Delivering equality and diversity Training
- Seek ways to celebrate diversity.

Our happy Stroke Team!

A recent action to address EDI issues has included ensuring that all recruitment panels for Band 6 posts and above have a BAME representative on the appointment panel. Over the coming months the Trust plans to focus on leadership development and will be focusing on promoting diversity in leadership roles, reflecting the community we serve.

A staff BAME network group has been set up with executive level oversight and support from the Trust's Chief Nurse. The contribution of EU workers to the health care provided by the Trust is valued highly and the Trust has offered support with the application process for settled status and has put in place other resources including setting up a peer support group.

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

CQC

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

The CQC undertook an unannounced inspection of the Paediatric and Critical Care facilities at Epsom Hospital in January 2019. As a result of the inspection, the total number of domains across the core services rated as 'Good' increased from 64 to 70. The overall ratings for paediatrics and critical care services increased from 'Requires Improvement' to 'Good'. In addition, the overall rating for the 'Well-led' domain for Epsom Hospital increased from 'Requires improvement' to 'Good'.

Register of Interests

The Trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The register can be found at: www.epsom-sthelier.nhs.uk/download.cfm?ver=25085

NHS Pension Scheme

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

The Environment

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18).

David in our HR team took delivery of the NHS staff survey – a vital tool in finding out what our staff think about working here.

Our Estates, Facilities and Capital Projects team have worked tirelessly to deliver a record £47.9 million improvement programme.

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 incorporated a review of the main financial systems and processes, which included significant and in-depth analysis to identify any areas of risk and recommendations for improvement.

Financial risks, including mitigations and controls, are considered at the Trust's Performance Assurance 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 a wide range of data to inform the cost improvement programme, including the Model Hospital, feedback from GIRFT reviews and procurement benchmarking tools.

The Trust is part of an acute provider collaborative in south west London which is looking at opportunities for collaboration to drive quality and efficiencies, with a particular focus on estates and facilities, information technology (IT), workforce and procurement.

The CQC undertook a Use of Resources Assessment in April 2019 which involved reviewing metrics from the Model Hospital 'Use of Resources' section and a narrative prepared by the Trust against the Use of Resources key lines of enquiry. The visit will generate a Use of Resource report and rating, not yet published at the time of writing.

Information governance (IG)

During 2018-19, the Trust has completed the new NHS Data Security and Protection Toolkit. This included achieving 96.21% of all staff completing the mandatory information governance training against a target of 95%.

The Trust's Information Governance Committee is chaired by the Senior Information Risk Owner (the Director of Corporate Services). 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 quarter 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 2018/19 financial year, the Trust reported three IG incidents to the Information Commissioner (ICO). Two incidents related to inappropriate release of information and one to inappropriate access of information. For two of the incidents the Trust has received confirmation from the ICO that they will be taking no further action. A response is waited for the third incident.

Data and cyber security risks are managed operationally by the Trust's IT team, supported by the Information Governance Manager, including ensuring all relevant security alerts and guidance from NHS Digital (CareCert) are actioned. The most significant risks, mitigations and controls are reviewed regularly at the Trust's Performance Assurance and Risk Committee, as well as at Audit Committee, whose chair is the Trust's NED lead on cybersecurity. Cyber security is also part of the internal audit current work plan, and any actions arising from this and other cyber insights are overseen by the Director of Corporate Services as the Trust's Senior Information Risk Officer (SIRO), including via the Information Governance Committee. The Trust has taken all necessary action to ensure compliance with the Data Security and Protection Tooolkit for 2018/19.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The 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'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. The Quality Account is audited by the Trust's External Auditors.

The Quality Account contains information about the quality of our services, including the improvements the Trust has made during 2018-19 against the priorities that it set and determines he Trust's key priorities for next year (2019-20). The report also includes feedback from patients and commissioners (the NHS organisations who pay for our services) on how well they think the Trust is doing.

The Quality Account is divided into four parts:

Part one looks at performance in 2018-19 against the priorities and goals set for patient safety, clinical effectiveness and patient experience. If he Trust does not achieved what it set out to do, it explains why and outline how it intends to address these areas for improvement.

Part two sets out the quality priorities and goals for 2019-20 and explains how the Trust decided on them, how it intends to meet them and how it will track progress.

The proposed 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 develop new pathways and ways of working across care systems to prevent avoidable admissions and support patients with remaining in their own home.
- Priority 5 – To work with key partners and stakeholders to improve the experience of carers and the people they care for through an integrated approach across the healthcare system. This work is to include young carers.

Part three sets out the Trust's 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.

England rugby player Mat Gilbert declared our new Adult Audiology Department officially open.

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.

Counter Fraud

Fraud awareness campaigns have included 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.

Investigations into fraud are conducted in accordance with relevant legislation and are undertaken by accredited LCFs in a professional, objective and fair manner.

Referrals can be received from a number of sources including anonymous calls from concerned members of staff and the public. Where considered appropriate, an investigation is carried out in accordance with a plan agreed with the Chief Financial Officer.

Clinical Audit

During 2018-19, the Trust participated in 43 national clinical audits and 5 national confidential enquiries on the quality accounts list in which it was eligible to participate.

The reports of 14 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 89 local clinical audits in 2018-19 at quality half day meetings and via appropriate divisional management team meetings.

Learning from audits continues to be shared at quality half day meetings, educational meetings and through presentations and posters at the quality 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 2018-19, the Trust reported three 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.

Learning from deaths

In August 2017 the Trust ratified the 'Policy for mortality reporting and mortality peer review process'. This policy provides an organisational framework for the process and management of mortality reviews and reporting within the Trust and details the aims of the mortality review process including identifying and minimising potentially 'avoidable' deaths within the Trust and promoting organisational learning and improvement. The Trust aspires to all deaths being reviewed and progress is monitored through the Reducing Avoidable Death and Harm (RADAH) Committee. A Quarterly Report is also made to the Trust Board giving an update on the progress of mortality peer reviews.

The Trust has designed a report to support staff in identifying deaths that require a level one mortality review based on agreed case selection criteria. The process also identifies the deaths which meet the criteria for completion of Structured Judgement Reviews (SJR). Learning from the level one and SJRs is collated and widely disseminated, and focuses on thematic analysis to identify both good practice and areas of improvement.

To support the mortality peer review process and the timely review of deaths within the Trust, during the year 2018/19 an additional number of clinicians have been trained to complete Structured Judgement Reviews.

Clinical Assurance

The Trust has a Clinical Assurance Panel which meets on a regular basis. The purpose of the Panel is to assure the Trust Board via the Medical Director and Chief Nurse and the two local CCGs that savings plans and major service changes support clinical quality improvement and any potentially negative impacts on clinical quality are tracked and mitigated. Each scheme reviewed the Clinical Assurance Panel requires both an equality and quality impact assessment to be carried out. The equality assessment seeks assurance that the various statutory regulations would be met for each of the Cost Improvement Programme (CIP). Any negative quality impact for both patients and staff are also considers for each CIP.

Performance reporting

The integrated performance report (IPR) details Trust delivery of both national and local standards, reporting performance against the following metrics:

- Safe and effective
    - Mortality
    - Quality measures
    - Reducing avoidable harm
    - Safe staffing
    - Healthcare associated infections
- Caring and responsive
    - Maternity
    - Friends and Family Test
    - PALS and complaints
    - Cancer access
    - Elective care
    - Urgent care
- Well led/resources
    - Workforce
    - Communications and engagement
    - Financial performance

Dr Amir Hassan, Clinical Lead for our A&E departments talks to a film crew from the Sunday Politics TV show.

The IPR is presented to Board on a monthly basis including public board and the public briefing. 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 Committee 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 prepared to provide assurance that plans are in place to improve performance. Trend analysis is included against the majority of indicators, together with benchmarking data where appropriate.

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 to wait for treatment. There are weekly performance meetings to performance at specialty level.

Conclusion

The Trust, like the rest of the NHS, faced significant operational challenges in 2018-19 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 91.7% against the 95% standard, we were consistently ranked within the top 3 trusts in London and in the top 20% nationally.

In the 2017/18 year, the Trust failed to achieve Level 2 in the IG Toolkit, solely based on its performance against the requirement to achieve 95% of staff completing their IG training. The Trust has been particularly focussed on this in 2018/19, and improved its IG training performance to 96.21% and was successful in achieving a pass at the new Data Security and Protection Toolkit.

The Trust is at the leading edge of the integrated care agenda. From April 2019, the Trust becomes the host for delivery of two contracts for community health services in Surrey Downs and Sutton. Both contracts will be delivered through contractual joint ventures (Surrey Downs in partnership with the 3 local GP Federations and the community trust and Sutton in partnership with the local GP Federation, local authority and mental health trust). This is a significant opportunity to reshape the local health economy towards greater home care and hospital admission prevention, and to create a far greater degree of integration.

Whilst the Trust is situated within the South West London Sustainability and Transformation Partnership (STP) area, as a two-site trust it is increasingly playing an active system leadership role as part of the two systems of South West London and Surrey Heartlands Health and Care (ICS) Partnership.

Our 2019/20 system ambitions have been developed collaboratively and include a clear intent to work much more collaboratively, both as a system and across our local integrated care partnerships. We will be moving decision-making from a national to a local level (our devolution agreement), and working in collaboration with local people to achieve much greater benefits for our community and improve the financial sustainability of our system. To this end, we have established an ICS Development Programme and as part of this will be identifying which services should be planned across larger areas and those that are better delivered at a more local level.

Overall, the Trust finished the year in a good position, having delivered its control total for the year and agreed contracts for the 2019-20 financial year. There are no significant control issues.

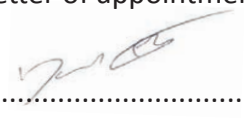
Signed..... Daniel Elkeles Chief Executive Date: May 2019

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

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

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

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



Siged..... Chief Executive

Statement of Directors' Responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

..... Chief Executive

.....Finance Director

Financial review – an overview

In 2018-19 the Trust made an accounting deficit of £31.4 million. However, operating expenditure included a charge to operating expenses of £28.2 million relating to an impairment of Trust assets and £0.3 million in respect of depreciation, meaning that we achieved our financial control total for the year.

An impairment has occurred because, 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-value. 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. Hence not chargeable against the Trust's NHS Improvement Financial Performance Target.

After adjusting for these, the Trust made a deficit of £2.9m against a planned deficit of £13.7m which was the agreed Financial Performance Target set by NHS Improvement (including Provider Sustainability Funding). This was a favourable performance to plan of £10.8m.

A reconciliation between the Trust's accounting deficit and reporting position against our NHS control total is as follows:

Statement of comprehensive income	2018/19	2017/18
	£'m	£'m
Operating income from patient care activities	383.3	357.3
Other operating income	51.1	41.3
Employee expenses	-283.2	-267.6
Operating expenses excluding employee expenses	-192.8	-172.1
Operating Deficit	**-41.7**	**-41.2**
Finance income	0.1	0.1
Finance expense	-1.7	-1.3
PDC dividends payable/refundable	-0.6	-2.5
Other gains/(losses) including disposal of assets	12.4	10.4
Deficit for the year	**-31.4**	**-34.5**
Adjusted NHS financial performance	**2018/19**	**2017/18**
	£'m	**£'m**
Deficit for the year	-31.4	-34.5
Add back all I&E impairments/(reversals)	28.2	20.6
Remove capital donations/grants I&E impact	0.4	0.5
Adjusted financial performance surplus/(deficit) excluding PSF	**-2.9**	**-13.4**
Control total	**-13.7**	**-17.8**
Performance against control total	**10.8**	**4.5**

Provider Sustainability Funding (PSF) is an additional element of payment introduced by NHS Improvement which can be earned by trusts for achieving the financial plan and the A&E operational standard.

As in the previous year, a PSF bonus was available as an additional amount for trusts that achieved their targets.

The Trust received £10.8m of incentive and bonus Provider Sustainability Funding at the end of the financial year, and a total of £23.4 million of PSF in the year as a whole, for delivering its financial and performance targets.

A key driver of the Trust's favourable position to plan (pre-PSF) was the net gains of £11.6 million and £0.8 million from the planned land disposals on the Epsom and Sutton sites respectively.

The Trust achieved a saving of £14.0 million through its cost improvement programme.

The Trust has agreed a new Financial Performance Total with NHS Improvement for 2019-20 of a deficit of £6.7 million (after non-recurrent funding, including PSF) which is a planned deficit of £32.7 million before non-recurrent funding.

Key financial targets for 2018-19

Target	2018-19 performance	Target met?	2017-18 performance	Target met?
Achieve the Financial Performance Total for its overall deficit as set by NHS Improvement	The Trust posted a reported deficit of £2.9 million a favourable variance of £10.8m to the target	Yes	The Trust posted a reported deficit of £13.4 million a favourable variance to the target of £4.4 million	Yes
Do not overshoot the External Finance Limit	Undershot by £27.9 million *	Yes	Undershot by £4.5 million	Yes
Do not overshoot the Capital Resource Limit	Undershot by £0.5 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 £0.6 million	Yes	The Trust kept within the 3.5% CCAR, resulting in dividend payments of £2.5 million	Yes
Meet the requirement of the Public Sector Payment Policy to settle creditors within 30 days	The Trust achieved a settlement rate of 88% for non-NHS and 71% for NHS invoices, by volume, and 95% for non-NHS and 65% for NHS invoices, by value	No	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 has such a large undershoot on its EFL as it has £16.1 million of capital funding which will be used to pay capital creditors in 2019-20 and it must also repay £6.8 million for advance payments of Provider Sustainability Funding and agreed underperformance on patient income contracts.

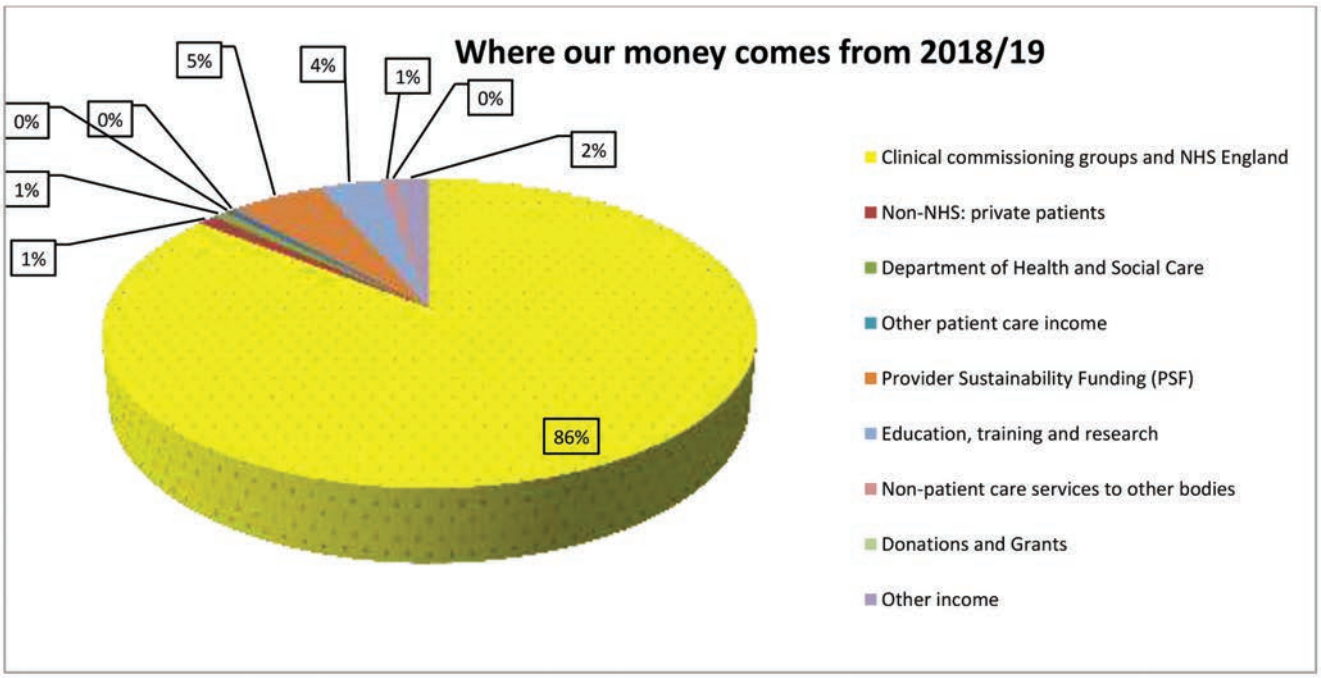
Where our money comes from

Trust income increased by £35.8 million between 2017-18 and 2018-19, mainly due to a £21.7million increases in NHS patient care income due to new community services income of £9.1 million and the remainder due to higher patient activity and patient tariff.

The total income received by the Trust during 2018-19 was £434.4 million of which £383.3 million was for clinical services and £51.1 million related to income for non-patient care, such as research and development, training and education and facilities income (and including PSF 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 2018-19 to 2017-18.

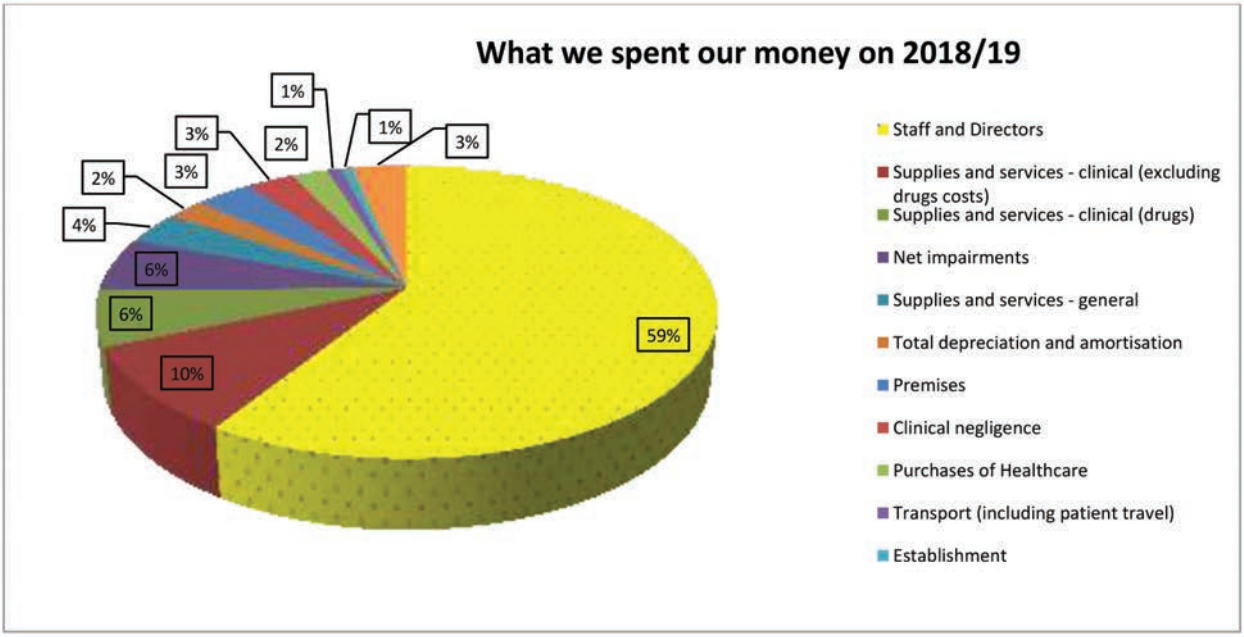
	2018-19 Amount £m	2017-18 Amount £m	Variance £m	Variance %
Clinical commissioning groups and NHS England	372.0	350.3	21.7	6%
Non-NHS: private patients	4.8	4.4	0.4	9%
Department of Health and Social Care	3.6	0.0	3.6	0%
Foundation Trusts	1.6	1.4	0.3	21%
Other patient care income	1.2	1.2	0.0	3%
Total Patient Care income	**383.3**	**357.3**	**26.0**	**7%**
Provider Sustainability Funding (PSF)	23.4	13.8	9.6	70%
Education, training and research	15.9	14.9	1.0	7%
Non-patient care services to other bodies	3.1	1.9	1.2	62%
Donations and Grants	0.1	0.1	0.0	-32%
Other income	8.7	10.6	-2.0	-18%
Total Non Patient Care Income	**51.1**	**41.3**	**9.8**	**24%**
Total	**434.4**	**398.6**	**35.8**	**9%**



What we spend our money on

The Trust spent £476.0 million on operating costs during 2018-19, an increase of £36.3 million from 2017-18. The largest expenditure was staffing at £280.9 million, which accounts for 59% of all expenditure, followed by expenditure on clinical supplies and services at 16%. 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 2018-19 to 2017-18:

	2018-19	2017-18		
	Amount	Amount	Variance	Variance
	£m	£m	£m	%
Staff and Directors	280.9	265.2	15.7	6%
Supplies and services - clinical (excluding drugs costs)	45.7	44.1	1.7	4%
Supplies and services - clinical (drugs)	29.3	30.7	-1.4	-5%
Net impairments	28.2	20.6	7.6	37%
Supplies and services - general	16.8	11.5	5.3	46%
Total depreciation and amortisation	11.0	11.3	-0.3	-3%
Premises	16.8	15.3	1.4	9%
Clinical negligence	14.1	11.5	2.6	22%
Purchases of Healthcare	10.1	8.7	1.4	16%
Transport (including patient travel)	4.3	7.4	-3.1	-42%
Establishment	3.1	3.0	0.1	2%
Other	15.9	10.4	5.5	53%
Total	**476.0**	**439.7**	**36.3**	**8%**



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 for indication of impairment.

The Trust identified assets that showed evidence of impairment and commissioned Deloitte LLP to carry out a valuation of these assets. Their valuation was £43.5 million lower than the Trust's current valuation of these assets, of which £28.2million was charged to the Trust's expenditure for 2018-19, the remainder being charged to the revaluation reserve (which is used to account for any increase and subsequent decrease in the value of an asset).

The impairment, although charged to the Trust's 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 increasingly is falling behind the standards required for providing healthcare in suitable facilities.

Disposal of part of the Epsom Hospital Site

The Trust has been following a strategy of rationalising its estate and disposing of surplus land in order to generate capital to support investment in resolving its backlog maintenance challenge. In addition to generation of capital receipts on sales, this strategy will lead to elimination of backlog maintenance in relation to disposed of buildings.

Following this strategy a plot of land at Epsom hospital was identified as surplus to the Trust's future requirements.

In March 2019 the Trust concluded the sale of this plot to Legal and General for a sale price of £18.5 million. As the sale proceeds are to be received over two years the Trust has discounted these and only recognised £18.2 of sale proceeds in this year's accounts. This resulted in a profit on disposal of £11.6 million after deducting the net book value of assets sold of £5.4 million and disposal costs of £1.2million.

Disposal of part of the Sutton Hospital site

The Trust has been following a strategy of relocating services and staff from Sutton Hospital to its other sites and releasing land for sale. It has previously sold three plots of land at Sutton Hospital to the London Borough of Sutton, in March 2015, March 2017 and March 2018.

In December 2018 the Trust concluded a further sale of land at Sutton Hospital to the London Borough of Sutton for a sale price of £2.2 million, resulting in a profit on disposal of £0.8 million after deducting the net book value of assets sold of £1.4million.

Capital Investment

The Trust delivered a capital investment programme of £49.7 million, which saw over £7.4 million being spent on projects to replace the Trust's boilers and improve energy efficiency at both Epsom and St Helier, also spending £6.5m to complete the addressing critical backlog at St Helier's B and C blocks. A further £3.5 million was spent in improving the Trust's IT systems, over £4.0 million on new medical equipment, £4.6 million in improvements to A&E Departments on both sites, £3.4 million on a new outpatient centre at Epsom and £20.3 million as part of a programme to improve and extend patient facilities.

The Trust has a planned capital programme for 2018-19 of £44.0 million, which will include the following:

- £12.9 million to continue with the project for the new energy centres and energy efficiency measures at both sites,
- £3.3 million on new medical equipment,
- £3.5 million on Information Technology,
- £3.5 million to finish work on ITU / HDU,
- £2.0 million to transfer Community beds and Therapies to Epsom Hospital

The remainder will be spent on other improvements and site reconfigurations across the Trust.

Improving value for money

The Trust made £14.0 million of efficiency savings during the financial year, which equates to 3% of total expenditure (ignoring impairments).

The Trust plans to deliver a further £15.4 million in efficiency savings during 2019-20 by improving the Trust's IT systems, and through a transformation and cost improvement programme.

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 provides advice and support to the Trust and advises on appropriate proactive initiatives whilst carrying out reactive investigations where required.

External Auditors

The Trust's external auditor is KPMG. The total cost of their statutory work in 2018-19 was £55,000, (£59,000 in 2017-18). This included the auditing of the annual accounts and this annual report.

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 2019-20

The Trust has agreed a new Financial Performance Total with NHS Improvement for 2019-20 for a deficit of £6.7million after non-recurrent funding.

An integral part of delivering this plan will be planned efficiency savings of £15.4 million in 2019-20 by improving the Trust's IT systems, and through a transformation and cost improvement programme.

The Trust also has an ambitious capital programme that, subject to funding will see £44.0 million invested on its main sites next year.

The Trust has obtained approval for NHS Loan Capital funding of £4.2m, secured loans to fund its energy projects and is seeking funding for the transfer of Community Hospital beds and Therapies of £7.4m.

Preparation of the Accounts on a Going Concern Basis

The Trust recorded an adjusted retained Financial Performance deficit (including Provider Sustainability Funding) for the year ended 31 March 2019 of £2.9 million, £10.8 million better than the £13.7 million deficit agreed with NHS Improvement at the start of 2018-19.

The Trust received cash funding from NHS Improvement to manage its deficit as well as Provider Sustainability Funding.

For the Financial year commencing 1 April 2019, the Trust has agreed a Financial Performance Target of a deficit of £6.7 million. This plan has been submitted to NHS Improvement and includes Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Emergency Tariff (MRET) funding of £26.0 million 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.

Remuneration and staff report

Directors and Senior Managers Salaries and Allowances: Audited

The table below shows the salaries and allowances for those Senior Managers who attend the Trust Board.

	2018/19						2017/18					
Name and title	(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL(a to e)	(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL(a to e)
	Bands of £5,000 £000	to nearest £100 £00	Bands of £5,000 £000	Bands of £5,000 £000	Bands of £2,500 £000	Bands of £5,000 £000	Bands of £5,000 £000	to nearest £100 £00	Bands of £5,000 £000	Bands of £5,000 £000	Bands of £2,500 £000	Bands of £5,000 £000
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**
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	5-10	0	0	0	0	**5-10**	0-5	0	0	0	0	**0-5**
Chris Elliot Associate Non Executive Director	0-5	0	0	0	0	**0-5**	N/A					**N/A**
Daniel Elkeles Chief Executive	180-185	0	0	0	42.5-45	**225-230**	180-185	0	0	0	47.5-50	**225-230**
Rakesh Patel Chief Finance Officer	140-145	0	0	0	0	**140-145**	130-135	0	5-10	0	0	**140-145**
Dr James Marsh Joint Medical Director	205-210	0	5-10	0	10-12.5	**225-230**	205-210	0	0	0	40-42.5	**245-250**
Dr Ruth Charlton Deputy Chief Executive and Joint Medical Director	215-220	0	5-10	0	15-17.5	**240-245**	215-220	0	0	0	67.5-70	**280-285**
Dan Bradbury Chief Operating Officer	120-125	0	0	0	32-37.5	**160-165**	55-60	0	0	0	15-17.5	**70-75**
Charlotte Hall Chief Nurse	25-30	0	0	0	0	**25-30**	115-120	0	0	0	22.5-25	**140-145**
Arlene Wellman Chief Nurse	105-110	0	0	0	222.5-225	**330-335**	N/A	0	0	0	0	**N/A**
Kevin Croft Director of Human Resources	35-40	0	0	0	7.5-10	**45-50**	110-115	0	0	0	27.5-30	**140-145**
Peter Davies Director of Strategy	120-125	0	0	0	60-62.5	**180-185**	115-120	0	0-5	0	105-107.5	**225-230**
Trevor Fitzgerald Director of Estates Facilities and Capital Projects	115-120	0	0	0	27.5-30	**145-150**	110-115	0	0-5	0	80-82.5	**195-200**
Thirza Sawtell Director of Integrated Care	120-125	0	0	0	0	**120-125**	N/A	0	0	0	0	**N/A**
Lisa Thomson Director of Comunications	105-110	0	5-10	0	70-72.5	**190-195**	95-100	0	0-5	0	7.5-10	**105-110**

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 £130,000 to £135,000 and £115,000 to £120,000, 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 executives did not serve the entire financial year

	From	To
Charlotte Hall Chief Nurse	01/04/2018	24/06/2018
Kevin Croft Director of Human Resources	01/04/2018	13/08/2018
Christopher Elliot Non-Executive Director	01/09/2018	31/03/2019

During the year, Remuneration Committee agreed to set aside the total sum of £30,000 (2017-18 £22,500) to be divided at the end of the year among those members of the Executive Board who had significantly outperformed their personal objectives, as set at the start of the year; or who had taken on additional responsibilities during the year. Any bonus paid is non-consolidated.

Directors and Senior Managers Pension Benefits: Audited

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2018 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2019 £000	(h) Employer's contribution to stakeholder pension £000
Daniel Elkeles Chief Executive	2.5-5	0-2.5	45-50	100-105	606	104	755	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	0-2.5	0	65-70	160-165	1130	133	1312	0
Dr James Marsh Joint Medical Director	0-2.5	0	55-60	140-145	985	109	1152	0
Daniel Bradbury Chief Operating Officer	2.5-5	0	10-15	0	73	28	122	0
Charlotte Hall Chief Nurse	0	0	40-45	120-125	858	0	0	0
Arlene Wellman Chief Nurse	10-12.5	25-27.5	25-30	65-70	282	224	529	0
Kevin Croft Director of Human Resources	0-2.5	0	35-40	90-95	629	31	745	0
Peter Davies Director of Strategy	2.5-5	0	60-65	0	677	137	852	0
Trevor Fitzgerald Director of Estates Facilities and Capital Projects	0-2.5	0-2.5	35-40	80-85	533	84	649	0
Thirza Sawtell Director of Integration	0	0	0	0	0	0	0	0
Lisa Thomson Director of Communications	2.5-5	5-7.5	20-25	50-55	328	96	449	0

The Real Increase in cash equivalent transfer values (CETV)

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

Cash equivalent transfer values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 200833.

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 2018-19 was £217,250, (£212,250 in 2017-18). This was six times (seven times in 2017-18) the median remuneration of the workforce, which was £34,580 (2017-18 median remuneration £31,780).

In 2018-19 no employees (2017-18 none) received remuneration in excess of the highest paid director.

Staff report

The average whole time equivalent staff (WTE) employed by the Trust this year is 5,362 WTE (2017-18 5,187 WTE) in the following staff groups:

	Total	Permanent	Other	Total		Other:	Bank	Agency	Total Other
	2018/19	2018/19	2018/19	2017/18			2018/19	2018/19	2018/19
Medical and dental	**803**	718	85	**786**			85	0	85
Ambulance staff	**96**	96	0	**0**			0	0	0
Administration and estates	**1,192**	1,060	132	**1,145**			109	23	132
Healthcare assistants and other support staff	**1,041**	815	226	**1,083**			195	31	226
Nursing, midwifery and health visiting staff	**1,710**	1,428	282	**1,665**			184	98	282
Nursing, midwifery and health visiting learners	**0**	0	0	**0**			0	0	0
Scientific, therapeutic and technical staff	**306**	236	70	**287**			49	21	70
Healthcare science staff	**214**	214	0	**221**			0	0	0
Total average numbers	**5,362**	**4,567**	**795**	**5,187**			**622**	**173**	**795**
Of which:									
Number of employees (WTE) engaged on capital projects	**73**	32	41	**35**					

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

Pay Bands	Female	Female%	Male	Male%
AfC Band 1	8	0.2%	6	0.1%
AfC Band 2	589	11.4%	167	3.2%
AfC Band 3	446	8.6%	54	1.0%
AfC Band 4	367	7.1%	69	1.3%
AfC Band 5	662	12.8%	107	2.1%
AfC Band 6	710	13.7%	133	2.6%
AfC Band 7	515	9.9%	79	1.5%
AfC Band 8A	173	3.3%	36	0.7%
AfC Band 8B	55	1.1%	22	0.4%
AfC Band 8C	30	0.6%	8	0.2%
AfC Band 8D	11	0.2%	8	0.2%
AfC Band 9	7	0.1%		0.0%
VSM	6	0.1%	9	0.2%
Doctors	402	7.8%	397	7.7%
Other	33	0.6%	71	1.4%
Grand Total	**4014**	**78.20%**	**1166**	**21.80%**

Of these, there are 103 senior managers in the following bands.

Senior Managers	Headcount
AfC Band 8B	49
AfC Band 8C	20
AfC Band 8D	13
AfC Band 9	6
VSM	15
Grand Total	**103**

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

Board Members

Gender	Head count	%
Female	7	39%
Male	11	61%

Sickness Absence Data

Staff sickness absence	Total number 2018-19	Total number 2017-18
Total days lost	43,852	39,567
Total staff years	4,507	4,346
Average working days Lost	9.7	9.1

Staff policies 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 initiatives to support staff health and wellbeing, occupational health care, physiotherapy and advice as appropriate.

Expenditure on consultancy

The Trust spent £1,843k on consultancy services.

Chief Executive Daniel shares a laugh with Serena from our Patient Advice and Liaison Service during their Macmillan coffee morning.

Off Payroll Engagements

The Trust had no off payroll engagements as demonstrated by the tables below.

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019	0
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.	0
No. that have existed for between two and three years at time of reporting.	0
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.	0

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

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	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

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

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)	20

Exit Packages

The tables below show payments made as part of exit packages agreed by the Trust

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			9	24,202	9	24,202		
£10,000 - £25,000			1	12,633	1	12,633		
£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	**0**	**-**	**10**	**36,835**	**10**	**36,835**	**0**	**-**

Other Exit Packages 2018-19

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*	10	37
Exit payments following Employment Tribunals or court orders		
Non contractual payments requiring HMT approval **		
Total	10	37
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary		

Our Nuclear Medicine department at St Helier underwent a half a million pound makeover this year!

Work to create a brand new outpatient department at Epsom is well underway – Matron Clare and Chief Executive Daniel test the new electronic signing in machines.

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

Epsom and St Helier University Hospitals NHS Trust

Annual accounts for the year ended 31 March 2019

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 2019 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 one.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 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 and Social Care Group Accounting Manual 2018/19.

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.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of exiting the European Union, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

We draw attention to note 1.2 to the financial statements which indicates that the Trust has forecast a planned deficit of £6.7m, and is seeking additional support from the Department of Health and Social Care for 2019/20 of £6.7m which has not been confirmed. In past years, the Trust has secured funding from the Department of Health and Social Care 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 1.2, 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 and Social Care Group Accounting Manual 2018/19. 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 and Social Care Group Accounting Manual 2018/19.

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. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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 31 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.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, 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 2019.

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 reported an in-year deficit of £2.9 million against a turnover of £434.4 million. The Trust continues to rely on loan support from the Department of Health and Social Care to support its ongoing operations. The Trust's in year deficit target of £13.7 million was agreed with NHSI to reflect the cost pressures facing the Trust, such as multi-site operations and the condition of the Trust's estate. Although the Trust has plans to improve the underlying financial position, the plans do not demonstrate that the Trust will achieve a breakeven underlying financial position in the foreseeable future. Despite the Trust's financial challenges, in 2018/19 it achieved a financial outturn position that is £10.8 million better than the target set.

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 31, 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 17 March 2019 we wrote to the Secretary of State in accordance with Section 30(1)(b) of the 2014 Act in respect of the Trust's expected 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 2019 identify a cumulative deficit of £28.9m, with £2.9m of that incurred in the 2018/19 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

28 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	383,295	357,281
Other operating income	4	51,081	41,279
Operating expenses	7, 9	(476,049)	(439,731)
Operating surplus/(deficit) from continuing operations		**(41,673)**	**(41,171)**
Finance income	11	147	62
Finance expenses	12	(1,711)	(1,296)
PDC dividends payable		(582)	(2,467)
Net finance costs		**(2,146)**	**(3,701)**
Other gains / (losses)	14	12,392	10,390
Surplus / (deficit) for the year		**(31,427)**	**(34,482)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(15,328)	(5,419)
Revaluations		2,628	8,271
Other reserve movements		-	(163)
Total comprehensive income / (expense) for the period		**(44,127)**	**(31,793)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	278	639
Property, plant and equipment	16	170,742	180,255
Receivables	18	394	407
Total non-current assets		**171,414**	**181,301**
Current assets			
Inventories	17	4,730	3,793
Receivables	18	46,274	35,976
Cash and cash equivalents	20	30,925	12,818
Total current assets		**81,929**	**52,587**
Current liabilities			
Trade and other payables	22	(66,313)	(52,946)
Borrowings	24	(38,658)	(82)
Provisions	25	(1,157)	(675)
Other liabilities	23	(1,596)	(2,684)
Total current liabilities		**(107,724)**	**(56,387)**
Total assets less current liabilities		**145,619**	**177,501**
Non-current liabilities			
Borrowings	24	(89,394)	(79,659)
Provisions	25	(1,856)	(1,967)
Total non-current liabilities		**(91,250)**	**(81,626)**
Total assets employed		**54,369**	**95,875**
Financed by			
Public dividend capital		184,732	182,111
Revaluation reserve		28,848	45,603
Income and expenditure reserve		(159,211)	(131,839)
Total taxpayers' equity		**54,369**	**95,875**

The notes on pages 5 to 39 form part of these accounts.

Daniel Elkeles
Chief Executive Officer
Date 22 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**182,111**	**45,603**	**(131,839)**	**95,875**
Surplus/(deficit) for the year	-	-	(31,427)	**(31,427)**
Impairments	-	(15,328)	-	**(15,328)**
Revaluations	-	2,628	-	**2,628**
Transfer to retained earnings on disposal of assets	-	(4,055)	4,055	-
Public dividend capital received	2,621	-	-	**2,621**
Taxpayers' equity at 31 March 2019	**184,732**	**28,848**	**(159,211)**	**54,369**

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**

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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(41,673)	(41,171)
Non-cash income and expense:			
Depreciation and amortisation	7.1	10,974	11,297
Net impairments	8	28,178	20,613
(Increase) / decrease in receivables and other assets		(225)	(7,561)
(Increase) / decrease in inventories		(937)	(191)
Increase / (decrease) in payables and other liabilties		4,750	4,890
Increase / (decrease) in provisions		368	(64)
Net cash generated from / (used in) operating activities Cash flows from investing activities		**1,435**	**(12,187)**
Interest received		147	62
Purchase of property, plant, equipment and investment property		(40,555)	(26,994)
Sales of property, plant, equipment and investment property		11,449	14,100
Net cash generated from / (used in) investing activities		**(28,959)**	**(12,832)**
Cash flows from financing activities			
Public dividend capital received		2,621	1,950
Movement on loans from the Department of Health and Social Care		37,428	36,533
Movement on other loans		9,248	-
Capital element of finance lease rental payments		(352)	(82)
Interest on loans		(1,396)	(805)
Interest paid on finance lease liabilities		(196)	(107)
PDC dividend (paid) / refunded		(1,722)	(3,214)
Net cash generated from / (used in) financing activities		**45,631**	**34,275**
Increase / (decrease) in cash and cash equivalents		**18,107**	**9,256**
Cash and cash equivalents at 1 April - brought forward		**12,818**	**3,562**
Cash and cash equivalents at 31 March	20	**30,925**	**12,818**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

The NHS the Group Accounting Manual (as directed by the Government Financial Reporting Manual) indicates that unless services provided by a Trust are likely to be transferred outside of the public sector within a year of the opinion date, the financial statements should be prepared on a going concern basis.

There are currently no plans to transfer services currently provided by the Trust outside of the NHS.

The Trust has submitted a 2019/20 plan to NHS Improvement for an in-year deficit of £6.7m. The Trust's financial priorities are to deliver the deficit Control Total of £6.7m and work with Surrey Downs Integrated Care Partnership (ICP) and South West London STP to develop joint Financial Recovery Plans as part of its longer term financial strategy.

In 2019/20 the Trust will implement its financial objectives to include:

- Deliver the control total;
- Develop the Surrey Downs ICP and South West London STP Financial Recovery Plans and deliver cost reductions across both places;
- Deliver recommendations and outcomes from Getting it Right First Time (GIRFT) reviews;
- Utilise the Model Hospital to achieve efficiency gains.

2019/20 healthcare contracts with the main Clinical Commissioning Groups (CCGs) and NHS England have been agreed and signed.

The 2019/20 cash flow forecast is based on delivery of the 2019/20 operating plan. 13 week forecasts are reported to NHS Improvement (NHSI) to support access to working capital loans. Internally, 12 month cash flow forecasts are updated daily and reviewed.

Key risks of material uncertainties that could impact the Trust's cash position are:

- Inability to refinance the Department of Health and Social Care revenue loans maturing in 2019/20;
- Not receiving working capital loans of £6.7m to fund the operating deficit;
- Significant unforeseen capital requirements arising in year due to the age and condition of the Trust's estate that cannot be accommodated within the capital contingency;
- CIP not achieved or unforeseen operational cost pressures resulting in failure to achieve the Control Total and therefore not receiving Provider Sustainability Funding of £7.8m and Financial Recovery Funding of £14.8m;

- Commissioner QIPP not achieved and the Trust therefore incurring 50% risk share on the QIPP shortfall.

The Trust's Cost Improvement Programme, which totals savings of £15.4m, includes the following key work streams:

- Reducing length of stay
- Improving Elective throughput
- Clinical support services savings
- Maximising investments made in IT
- Improving HR processes
- Procurement savings

£6.1m of the Trust's CIP target is unidentified at the date of these accounts.

The Trust is working with our health economy partners in the places that we serve by:

- Adopting an active system leadership role around place based care through integrated care partnerships and at system level through Surrey Heartlands Integrated Care System and within the South West London Health and Care Partnership;
- Discharging our host role for community contracts (Sutton Health & Care and Surrey Downs Health & Care) to a high standard and work in partnership to transform clinical pathways;
- Supporting the CCGs in taking forward the Improving Healthcare Together programme of work;
- Taking forward collaborative initiatives via the South West London Acute Provider Collaborative;
- Leading development and implementation of a Joint Recovery Plan with Sutton CCG and Surrey Downs CCG.

Subject to the uncertainties recorded above, and the intention that the healthcare and other services will continue to be provided by the public sector for the foreseeable future, the Directors consider the Trust will continue to operate as a going concern.

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

Revenue from NHS contracts

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

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

NHS injury cost recovery scheme

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

Note 1.3.2 Revenue grants and other contributions to expenditure

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

The value of the benefit received when accessing funds from the 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 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

Valuation

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

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

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

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

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

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

Subsequent expenditure

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction 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 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable 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 abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	1	95
Dwellings	5	24
Plant & machinery	5	10
Information technology	5	5
Furniture & fittings	5	10

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

Note 1.8 Intangible Assets

Note 1.8.1 Recognition

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

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 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 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.8.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Software licences	5	5

Note 1.9 Inventories

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

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

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

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

Note 1.11.2 Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12 -month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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

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

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

Note 1.11.3 Derecognition

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

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

Note 1.12 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 charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. 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's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases."

Operating leases

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

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is

significant, the estimated risk-adjusted cash flows are discounted using 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 25 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 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, 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

- donated assets (including lottery funded assets),
- (average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- 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 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.

1.18 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are reviewed regularly.

1.18.1 Critical judgements in applying accounting policies

There are no material judgements, except those involving estimates, which are disclosed below.

The Trust has made the following judgements that have an immaterial effect on the financial statements:

1. Ascertaining if an arrangement contains a lease; and if it does so assess whether it is an Operating or Finance Lease.
2. 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 2019. 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.

1.18.2 Sources of estimation uncertainty

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

1. 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. The Trust also assess assets for impairment on an annual basis in intervening years and revalues assets where indicators of impairment are identified.
2. Income recognition – accrued income is estimated based on the level of services provided by the Trust in the year. The Trust makes a provision for bad debts which is an estimate of irrecoverable income based on historical recoverability.

The Trust also makes the following assumptions about the sources of estimation uncertainty that could result in an immaterial adjustment to the carrying amounts of assets and liabilities within the next financial year:

1. The useful economic life of Trust assets is set by: Buildings: Professional third party valuers. 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

2. 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. The element of accruals that requires estimation is immaterial to the Trust's financial statements.
3. 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.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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

The Trust has identified one accounting standard which is not yet effective or adopted which may have a material impact on the Trust's balance sheet and income and expenditures, International Financial Reporting Standard 16 'Leases' (IFRS 16). IFRS 16 is applicable for accounting periods beginning on or after 1 April 2020.

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 owned. 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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000s	£000
Income	**383,295**	357,281	**383,295**	357,281

No other single customer accounted for more than 10% of the Trusts income. Notes 3 and 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 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.

Note 3.1 Income from patient care activities (by nature)	2018/19	2017/18
	£000	£000
Acute services		
Elective income	70,265	68,541
Non elective income	101,297	95,619
First outpatient income	24,388	22,920
Follow up outpatient income	37,600	35,471
A & E income	19,033	17,760
High cost drugs income from commissioners (excluding pass-through costs)	19,048	20,042
Other NHS clinical income	88,783	89,612
Community services		
Community services income from CCGs and NHS England	9,143	-
All services		
Private patient income	5,493	4,401
Agenda for Change pay award central funding	3,613	-
Other clinical income	4,632	2,915
Total income from activities	**383,295**	**357,281**

On 1 January 2019 the Integrated Dorking, Epsom and East Elmbridge Alliance (known as IDEEA), took on responsibility for providing adult community services in the Surrey Downs area. During the year the Trust received income from Surrey Downs CCG for its work as part of this Alliance. From 1 April 2019 this Alliance has been renamed Surrey Downs Health and Care.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	48,587	49,598
Clinical commissioning groups	323,433	300,723
Department of Health and Social Care	3,613	-
Other NHS providers	1,676	1,446
NHS other	-	44
Non-NHS: private patients	4,783	4,401
Non-NHS: overseas patients (chargeable to patient)	194	206
Injury cost recovery scheme	710	768
Non NHS: other	299	95
Total income from activities	**383,295**	**357,281**
Of which:		
Related to continuing operations	383,295	357,281
Related to discontinued operations	-	-

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

	2018/19	2017/18
	£000	£000
Income recognised this year	194	206
Cash payments received in-year	128	176
Amounts written off in-year	352	174

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	729	701
Education and training (excluding notional apprenticeship levy income)	15,165	14,200
Non-patient care services to other bodies	3,057	1,892
Provider sustainability / sustainability and transformation fund income (PSF / STF)	23,391	13,756
Other contract income	8,544	10,499
Other non-contract operating income		
Charitable and other contributions to expenditure	77	114
Rental revenue from operating leases	118	117
Total other operating income	**51,081**	**41,279**
Of which:		
Related to continuing operations	51,081	41,279

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

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,684
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	1,596
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**1,596**

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

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	3,437	3,326
Full cost	(2,358)	(2,018)
Surplus / (deficit)	**1,079**	**1,308**

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

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,405	3,492
Purchase of healthcare from non-NHS and non-DHSC bodies	4,687	5,221
Staff and executive directors costs	280,859	265,180
Remuneration of non-executive directors	61	68
Supplies and services - clinical (excluding drugs costs)	50,291	44,056
Supplies and services - general	16,781	11,500
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	29,252	30,667
Inventories written down	34	30
Consultancy costs	1,843	2,381
Establishment	3,088	3,036
Premises	16,767	15,319
Transport (including patient travel)	4,280	7,383
Depreciation on property, plant and equipment	10,613	10,721
Amortisation on intangible assets	361	576
Net impairments	28,178	20,613
Movement in credit loss allowance: contract receivables / contract assets	243	
Movement in credit loss allowance: all other receivables and investments	-	476
Increase/(decrease) in other provisions	661	-
Change in provisions discount rate(s)	114	-
Audit fees payable to the external auditor		
audit services- statutory audit	55	59
other auditor remuneration (external auditor only)	20	8
Internal audit costs	74	135
Clinical negligence	14,093	11,517
Legal fees	286	580
Insurance	63	40
Research and development	516	688
Education and training	2,863	2,751
Rentals under operating leases	1,068	960
Hospitality	3	5
Losses, ex gratia & special payments	41	33
Other	3,449	2,236
Total	**476,049**	**439,731**
Of which:		
Related to continuing operations	476,049	439,731
Related to discontinued operations	-	-

The external audit fee noted above is gross of VAT as the Trust cannot recover VAT on external audit fees. The recipient of this fee pays this VAT to HMRC: the actual cash they received from the Trust for the audit in 2018/19 is therefore £45,870.

Other auditor remuneration relates to the fee due for the audit of the Trust's quality accounts (£7,000 net of VAT) and for additional assurance service performed (£10,000 net of VAT). The external auditor has performed additional procedures in 2018/19 relating to the audit: a fee for this work has yet to be agreed and this cost will be recognised by the Trust in 2019/20.

Note 7.2 Other auditor remuneration

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

Note 7.3 Limitation on auditor's liability

The contract, signed on 1 February 2018, states that the liability of KPMG LLP, 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 8 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Other	28,178	20,613
Total net impairments charged to operating surplus / deficit	**28,178**	**20,613**
Impairments charged to the revaluation reserve	15,328	5,419
Total net impairments	**43,506**	**26,032**

During the year the Trust undertook an impairment review of its land and buildings. This review included obtaining external valuations for fourteen assets (at the Trust's St Helier, Epsom, and Sutton sites) 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 fourteen buildings book value and caused the impairment noted.

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	224,280	211,321
Social security costs	23,422	21,915
Apprenticeship levy	1,087	1,007
Employer's contributions to NHS pensions	24,974	23,738
Pension cost - other	73	9
Temporary staff (including agency)	13,941	12,525
Total staff costs	**287,777**	**270,515**
Of which		
Costs capitalised as part of assets	4,560	2,907

Other pension costs relate to the employer pension contributuons paid to NEST Workplace Pensions for employees who are not members of the NHS Pension scheme and have not opted out of NEST.

Note 9.1 Retirements due to ill-health

During 2018/19 there was one early retirement from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of this ill-health retirement is £17k (£175k in 2017/18).

The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

Note 9.2 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 for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases

Note 10.1 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.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	118	117
Contingent rent	-	-
Other	-	-
Total	**118**	**117**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	118	96
- later than one year and not later than five years;	118	187
- later than five years.	-	-
Total	**236**	**283**

Note 10.2 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 significant 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;

v) During the year the Trust disposed of part of its Epsom site. As part of this sale the Trust has agreed to lease back for a limited period certain of the buildings included in the sale.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,186	1,077
Contingent rents	-	-
Less sublease payments received	(118)	(117)
Total	**1,068**	**960**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	893	1,082
- later than one year and not later than five years;	1,058	2,600
- later than five years.	21	36
Total	**1,972**	**3,718**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	147	62
Total finance income	**147**	**62**

Note 12 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,487	1,046
Other loans	25	-
Finance leases	196	107
Total interest expense	**1,708**	**1,153**
Unwinding of discount on provisions	3	2
Other finance costs	-	141
Total finance costs	**1,711**	**1,296**

Interest on other loans relates to interest on the Trust's Energy Efficency loans held with The Mayor of London's Energy Efficiency Fund (MEEF) and the London Energy Efficiency Fund (LEEF).

Note 13 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	12,392	11,158
Losses on disposal of assets	-	(768)
Total gains / (losses) on disposal of assets	**12,392**	**10,390**

Gain on disposal relates to profit on disposal of part of the Trust's Sutton and Epsom sites.

Note 15 Intangible assets 2018/19

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**4,722**	**4,722**
Additions	-	-
Valuation / gross cost at 31 March 2019	**4,722**	**4,722**
Amortisation at 1 April 2018 - brought forward	**4,083**	**4,083**
Provided during the year	361	**361**
Amortisation at 31 March 2019	**4,444**	**4,444**
Net book value at 31 March 2019	**278**	**278**
Net book value at 1 April 2018	**639**	**639**

Note 15.1 Intangible assets 2017/18

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**4,821**	**4,821**
Disposals / derecognition	(99)	**(99)**
Valuation / gross cost at 31 March 2018	**4,722**	**4,722**
Amortisation at 1 April 2017 - as previously stated	**3,584**	**3,584**
Provided during the year	576	**576**
Disposals / derecognition	(77)	**(77)**
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 16 Property, plant and equipment 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**38,502**	**191,682**	**970**	**9,057**	**33,987**	**-**	**17,123**	**1,349**	**292,670**
Additions	-	13,333	-	29,080	3,656	-	3,628	-	**49,697**
Impairments	-	(43,506)	-	-	-	-	-	-	**(43,506)**
Revaluations	-	2,625	3	-	-	-	-	-	**2,628**
Reclassifications	-	18,964	-	(19,099)	-	-	135	-	**-**
Transfers to / from assets held for sale	(2,333)	(1,361)	-	-	-	-	-	-	**(3,694)**
Disposals / derecognition	(1,677)	(3,857)	(415)	-	(91)	-	-	-	**(6,040)**
Valuation/gross cost at 31 March 2019	**34,492**	**177,880**	**558**	**19,038**	**37,552**	**-**	**20,886**	**1,349**	**291,755**
Accumulated depreciation at 1 April 2018 - brought forward	**7,393**	**71,107**	**419**	**-**	**21,895**	**-**	**10,259**	**1,342**	**112,415**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	6,116	25	-	2,483	-	1,987	2	**10,613**
Disposals / derecognition	-	(1,951)	-	-	(64)	-	-	-	**(2,015)**
Accumulated depreciation at 31 March 2019	**7,393**	**75,272**	**444**	**-**	**24,314**	**-**	**12,246**	**1,344**	**121,013**
Net book value at 31 March 2019	**27,099**	**102,608**	**114**	**19,038**	**13,238**	**-**	**8,640**	**5**	**170,742**
Net book value at 1 April 2018	**31,109**	**120,575**	**551**	**9,057**	**12,092**	**-**	**6,864**	**7**	**180,255**

Note 16.1 Property, plant and equipment 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017	**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	**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 16.2 Property, plant and equipment financing 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	27,099	101,974	114	19,038	9,245	-	8,640	5	**166,115**
Finance leased	-	-	-	-	2,720	-	-	-	**2,720**
Owned - donated	-	634	-	-	1,273	-	-	-	**1,907**
NBV total at 31 March 2019	**27,099**	**102,608**	**114**	**19,038**	**13,238**	**-**	**8,640**	**5**	**170,742**

Note 16.3 Property, plant and equipment financing 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	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**

The Trust's land is not depreciated but has brought forward accumulated 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 to:

- 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 2018 and 31 March 2019 the Trust applied its revaluation indices as prepared by Deloitte LLP, RICS qualified third party experts, which lead to an increase of £2,628k in the carrying value of its buildings and £0k 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 8 and resulted in a £43,506k fall in the holding value of the Trust's buildings. The Trust's land and building valuation is partly based on a judgement around future construction costs. Although it is impossible to determine the exact impact at the time of the valuation, this judgement includes a consideration of the potential impact - under various scenarios - of the eventual outcome of the UK Government's negotiations to exit the European Union.

During the year the Trust sold surplus land at its Epsom and Sutton sites with a book value of £7,692k. £3,694k of book value first was transferred to assets held for resale (see Note 19) and then sold, and £3,998k of book value was disposed of from Property, Plant, and Equipment. The net profit on disposal of these two transactions is disclosed in Note 14.

Note 17 Inventories

	2019	2018
	£000	£000
Drugs	1,569	1,294
Consumables	3,118	2,454
Energy	43	45
Total inventories	**4,730**	**3,793**
of which:		
Held at lower of cost and NRV	4,730	3,793

Inventories recognised in expenses for the year were £42,564k (2017/18: £44,398k). Write-down of inventories recognised as expenses for the year were £34k (2017/18: £30k).

Note 18 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	30,827	
Trade receivables*		13,419
Capital receivables	8,920	-
Accrued income*		18,414
Allowance for impaired contract receivables / assets*	(2,049)	
Allowance for other impaired receivables	-	(2,063)
Prepayments (non-PFI)	3,397	3,264
PDC dividend receivable	1,827	687
VAT receivable	2,985	2,128
Other receivables	367	127
Total current trade and other receivables	**46,274**	**35,976**
Non-current		
Contract receivables*	505	
Trade receivables*		528
Allowance for other impaired receivables	(111)	(121)
Total non-current trade and other receivables	**394**	**407**
Of which receivables from NHS and DHSC group bodies:		
Current	27,948	28,510

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 18.1 Allowances for credit losses

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**2,184**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,184	(2,184)
New allowances arising	243	-
Utilisation of allowances (write offs)	(267)	-
Allowances as at 31 Mar 2019	**2,160**	**-**

Note 19 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £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	3,694	3,045
Assets sold in year	(3,694)	(3,045)
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 Epsom 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 £3,694k were transferred to non-current assets available for sale. These assets were sold to an operating division of Legal and General in March 2019 leading to a net profit after disposal expenses of £11,600k.

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19 £000	2017/18 £000
At 1 April	**12,818**	**3,562**
Net change in year	18,107	9,256
At 31 March	**30,925**	**12,818**
Broken down into:		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	30,921	12,814
Total cash and cash equivalents as in SoFP	**30,925**	**12,818**
Total cash and cash equivalents as in SoCF	**30,925**	**12,818**

Note 21 Third party assets held by the Trust

The Trust held no cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties (2017/18: £nil)

Note 22 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	16,298	18,733
Capital payables	12,732	4,893
Accruals	25,887	22,923
Receipts in advance (including payments on account)	64	59
Social security costs	3,541	3,114
Other taxes payable	3,238	2,824
Accrued interest on loans*		310
Other payables	4,553	90
Total current trade and other payables	**66,313**	**52,946**
Non-current		
Trade payables	-	-
Capital payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	9,778	16,982
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 24. IFRS 9 is applied without restatement therefore comparatives have not been restated.

The payables note above includes no amounts in relation to early retirements.

Note 23 Other liabilities

	2019 £000	2018 £000
Current		
Deferred income: contract liabilities	1,596	2,684
Total other current liabilities	**1,596**	**2,684**

Note 24 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Scoial Care	38,287	-
Obligations under finance leases	371	82
Total current borrowings	**38,658**	**82**
Non-current		
Loans from the Department of Health and Scoial Care	78,263	78,721
Other loans	9,248	-
Obligations under finance leases	1,883	938
Total non-current borrowings	**89,394**	**79,659**

Interest on other loans relates to interest on the Trust's Energy Efficency loans held with The Mayor of London's Energy Efficiency Fund (MEEF) and the London Energy Efficiency Fund (LEEF).

Note 24.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Finance leases £000	Total £000
Carrying value at 1 April 2018	**78,721**	**-**	**1,020**	**79,741**
Cash movements:				
Financing cash flows - payments and receipts of principal	37,428	9,248	(352)	**46,324**
Financing cash flows - payments of interest	(1,371)	(25)	(196)	**(1,592)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	310	-	-	**310**
Additions	-	-	1,586	**1,586**
Application of effective interest rate	1,487	25	196	**1,708**
Other changes	(25)	-	-	**(25)**
Carrying value at 31 March 2019	**116,550**	**9,248**	**2,254**	**128,052**

Note 24.2 the Trust as a lessee

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

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**2,254**	**1,020**
of which liabilities are due:		
- not later than one year;	371	82
- later than one year and not later than five years;	1,209	938
- later than five years.	674	-
Net lease liabilities	**2,254**	**1,020**
of which payable:		
- not later than one year;	371	82
- later than one year and not later than five years;	1,209	938
- later than five years.	674	-
the reporting date	-	-

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 radiology equipment base and provides guaranteed service levels.

Note 25 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**1,553**	**748**	**77**	**264**	**2,642**
Change in the discount rate	35	79	-	-	**114**
Arising during the year	8	-	-	653	**661**
Utilised during the year	(237)	(82)	-	(88)	**(407)**
Reversed unused	-	-	-	-	-
Unwinding of discount	6	(3)	-	-	**3**
At 31 March 2019	**1,365**	**742**	**77**	**829**	**3,013**
Expected timing of cash flows:					
- not later than one year;	233	95	-	829	**1,157**
- later than one year and not later than five years;	926	351	-	-	**1,277**
- later than five years.	206	296	77	-	**579**
Total	**1,365**	**742**	**77**	**829**	**3,013**

Pensions: 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.

Pensions: injury benefits

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. In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

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) A provision for remedial works at the Trust's Epsom site ii) A provision for the cost of future Employment Tribunals.

Note 25.1 Clinical negligence liabilities

At 31 March 2019, £270,811k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Epsom and St Helier University Hospitals NHS Trust (31 March 2018: £220,675k).

Note 25.2 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
Other	(30)	(29)
Gross value of contingent liabilities	**(30)**	**(29)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(30)**	**(29)**
Net value of contingent assets	**-**	**-**

Note 25.3 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	20,059	9,392
Total	**20,059**	**9,392**

Significant contractual capital commitments relate to works improving the energy efficiency at both the Trust's Epsom and St Helier sites.

Note 25.4 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 2019 £000	31 March 2018 £000
not later than 1 year	1,492	1,568
after 1 year and not later than 5 years	4,477	6,674
paid thereafter	1,492	3,776
Total	**7,461**	**12,018**

Other financial commitments relate to the Trust's radiology managed equipment service, provided by Althea Ltd.

Note 26 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 2018/19. See Note 1.2, Going Concern, for further details.

Note 27 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	38,065	-	-	**38,065**
Cash and cash equivalents at bank and in hand	30,925	-	-	**30,925**
Total at 31 March 2019	**68,990**	**-**	**-**	**68,990**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
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**

Note 28 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	116,550	-	**116,550**
Obligations under finance leases	2,254	-	**2,254**
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	9,248	-	**9,248**
Trade and other payables excluding non financial liabilities	54,723	-	**54,723**
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2019	**182,775**	**-**	**182,775**

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	78,721	-	**78,721**
Obligations under finance leases	1,020	-	**1,020**
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	47,007	-	**47,007**
Other financial liabilities	-	-	-
Provisions under contract	345	-	**345**
Total at 31 March 2018	**127,093**	**-**	**127,093**

Note 29 Fair values of financial assets and liabilities

Note 29.1 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	93,381	47,434
In more than one year but not more than two years	71,026	82
In more than two years but not more than five years	3,569	856
In more than five years	14,799	78,721
Total	**182,775**	**127,093**

Note 30 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	21	17	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	158	610	48	174
Stores losses and damage to property	1	27	-	-
Total losses	**180**	**654**	**48**	**174**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	9	3
Extra-contractual payments	-	-	-	-
Ex-gratia payments	55	15	33	30
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**55**	**15**	**42**	**33**
Total losses and special payments	**235**	**669**	**90**	**207**
Compensation payments received		-		-

Note 31 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £310k, and trade payables correspondingly reduced.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,220k.

Note 32 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The standard has had no impact for the Trust.

Note 33 Related parties

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 2018/19

	Payments to Related Party £'000	Receipts from Related £'000	Amounts owed to Related £'000	Amounts due from Related £'000
Surrey Downs CCG	46	123,258	455	578
Sutton CCG	0	114,378	493	1,399
HM Revenue and Customs	24,509	0	6,779	0
National Health Service Pension Scheme	24,974	0	3,661	0
NHS England	4	71,962	373	16,828
Croydon CCG	0	14,412	58	98
Merton CCG	0	36,923	121	89
Health Education England	9	14,413	9	109
NHS Resolution	14094	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 £77,000 (2017/18 £114,000).

During the year Dr Christopher Elliott joined the Board of Epsom and St Helier University Hospitals NHS Trust. Dr Elliot is also a Director of Sutton CCG. Disclosure is made above of the value of the transactions between the Trust and the CCG: all of these transactions were on an arms length basis.

Note 34 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 £18,200k.

Note 35 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables	75,341	261,389	84,114	241,248
Total non-NHS trade invoices paid in the year	66,603	248,637	78,311	227,389
Total non-NHS trade invoices paid within target	88.4%	95.1%	93.1%	94.3%
Percentage of non-NHS trade invoices paid within target				
NHS Payables	3,088	11,224	3,943	13,232
Total NHS trade invoices paid in the year	2,205	7,309	2,389	6,666
Total NHS trade invoices paid within target	71.4%	65.1%	60.6%	50.4%
Percentage of NHS trade invoices paid within target				

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

Note 36 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	30,838	29,145
External financing requirement	**30,838**	**29,145**
External financing limit (EFL)	56,778	33,671
Under / (over) spend against EFL	**25,940**	**4,526**

Note 37 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	49,697	27,855
Less: Disposals	(7,719)	(4,323)
Charge against Capital Resource Limit	**41,978**	**23,532**
Capital Resource Limit	41,978	23,894
Under / (over) spend against CRL	**0**	**362**

Note 38 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(2,891)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(2,891)**

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,877	3,332	(12,277)	(12,094)	(7,400)	78	(25,788)	(12,687)	(13,361)	(2,891)
Breakeven duty cumulative position	(996)	1,881	5,213	(7,064)	(19,158)	(26,558)	(26,480)	(52,268)	(64,955)	(78,316)	(81,207)
Operating income		327,548	334,761	331,320	343,567	356,010	365,769	372,591	392,161	398,560	434,376
Cumulative breakeven position as a percentage of operating income		0.6%	1.6%	(2.1%)	(5.6%)	(7.5%)	(7.2%)	(14.0%)	(16.6%)	(19.6%)	(18.7%)

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.