

Annual Report and Accounts 2015/16



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Overview

Overview

Introduction

Caring for Croydon together

Caring for London's largest borough means that we are much more than just a local hospital.

Looking back over the past twelve months (2015/16), our focus has been striving to deliver better care for Croydon residents. The Trust was described as having made sustained and "significant progress" following a routine inspection by the Care Quality Commission (CQC). One patient quoted in the inspection report (published October 2015) said that they were "gobsmacked at how much better it is than before."

Overall, the Trust was rated as "requires improvement," but we are already well on the way to addressing the areas raised.

The CQC praised 13 areas of "outstanding" practice across the Trust, including our special care baby unit and the specialist palliative care team for the support provided in the last days or hours of life. The inspectors also rated the Trust as "good" for caring and effective services. All of this is to the credit of our incredible staff.

Throughout the year we have invested in our services, most notably to deliver improved unplanned and emergency care, 7-days a week. Last year, as part of Listening into Action, we asked our staff to come together to discuss what we could do differently to manage higher demand during the busy winter months. As a result, our consultants put forward a new "one stop unit" for rapid medical treatment – without having to wait in A&E – which we have called the Edgecombe Unit. Patients, including the frail and elderly and those whose conditions mean they frequently need urgent care, can now be referred direct to the Edgecombe Unit by their GP or from within the hospital.

In just the first five months of when it opened in November 2015, the Edgecombe Unit has substantially eased the pressure in the Emergency Department and reduced waiting times for other patients. It is also helping to free-up bed capacity to care for patients who need a hospital stay.

As well as creating the Edgecombe Unit, the Trust also began another major project to improve its A&E performance in November, the building of a new, £21.25m Emergency Department (Accident & Emergency) at Croydon University Hospital. Opening in 2017, this state-of-the-art facility has been designed by our very own Emergency Department clinicians to be bigger, brighter and better, to give us the flexibility to cope with changes in demand, and to give people in Croydon the very high standards of care that we work hard to provide.

More NHS workers are now choosing the Trust as their employer. We have 280 more doctors, nurses and therapists working at the Trust than we did in (2012/13), but like many NHS trusts – especially in London where there is limited availability and greater competition – recruiting more permanent staff remains a big challenge. As a consequence of this, we have spent an additional £7m on temporary staff this year compared with last (2015/16 to 2014/15). This is not sustainable in the long-term.

Our greatest challenge over the past year has remained our financial deficit. Throughout the year, the Trust spent more than planned to deliver services and meet rising demand. Like the rest of the NHS, we must make the funding we have go further by being more efficient and minimising waste – but we must do this in a planned way, without compromising our quality of care.

Waiting to treat this many people when they get ill is not the answer. As an NHS Trust, we need to change and grow with our community and respond to what Croydon citizens tell us. That means doing more to keep people well and preventing ill-health, in addition to providing clinical treatment expertise and care when and where it is needed.

Six years ago (2010), Croydon Health Services became an integrated NHS Trust, leading the way in joining together hospital and community services. In the past year (2015/16), we have taken even more pioneering steps to innovate and transform services to deliver more seamless care.

Working with Croydon Council, Croydon Clinical Commissioning Group and other local care providers, we have formed a new alliance to transform the care available for older people and join-up health and social care services in our community.

We are also bringing together our services for parents and children aged under five in the borough, to give Croydon families the “Best Start” in life. Croydon will become one of the first UK boroughs to fully combine services for families and young children, including health visiting, children’s centres and midwifery. With a promotional campaign already well-under way, this will be formally launched in summer 2016.

This is the next step in our journey of continued collaboration in Croydon. We will not only be there when you need us, but working together, we can keep you well for longer.

John Goulston



Chief Executive

Mike Bell



Chairman

Year in numbers

Over the past year the Trust treated and cared for:

- 22,963 day case and 2,976 elective (planned) in-patients
- 33,667 emergency and non-elective in-patients
- 330,974 outpatient contacts (including maternity)
- 286,111 adult community services contacts
- 190,705 children's community services contacts
- 72,294 people in the Emergency Department at Croydon University Hospital, and an additional 45,203 at the Urgent Care Centre (provided by Virgin Care since 11 April 2012)
- 3,997 babies born in the Maternity Unit and Birth Centre

On any given day in Croydon, we see approximately:

- 11 babies born in our Maternity Services
- 1,273 outpatient appointments on a weekday
- 198 people using our Emergency Department
- 938 home visits
- 1,258 health visitor appointments (children and older people)
- 171 Croydon children in local schools



About the Trust & Community

Croydon Health Services NHS Trust (CHS) is more than a single hospital. We provide a full range of clinical services, caring for the Croydon community throughout their lives, from the moment of their birth through to their old age.

In hospitals, at home, in clinics, in schools and in community settings across the borough, the Trust delivers both acute care and a wide range of community services to help keep people well, active and healthy.

The Trust employs 3,944 staff and has a dedicated team of 400 volunteers. More than a third of our staff work within our community services, alongside our partners in primary care and social services, to care for people in-and out-of-hospital.

The Trust runs two hospital sites covering both the north and south of the borough: Croydon University Hospital is our main hospital with a flexible bed base of 424 with capacity to extend at times of high demand.

Services include one of the busiest Accident & Emergency departments in south London, with a new £21.25m facility currently under construction; our transformed maternity services; and specialist care for stroke, heart disease and elective (planned) surgery, including trauma and orthopaedics.

Our secondary base is Purley War Memorial Hospital, which re-opened in 2013 after an £11.15m extensive refurbishment, to offer improved access for people living in south Croydon, providing diagnostic and outpatient services, including ophthalmology services provided by Moorfields Eye Hospital.

The Trust's community services delivered across Croydon include community nursing, health visiting, school nursing, homeless health, sexual health and Children's Hospital At Home. These are delivered in a variety of settings, including the home, at schools and colleges and in our 15 other community sites across the borough.

Local health economy

Croydon faces a number of challenges and pressures in terms of the underlying health and healthcare needs of its population.

The overall population of the borough, and so the number of people who will use the Trust's services, is now currently around 380,000 and is expected to increase by another 80,000 over the next 25 years. Croydon is also a 'young' borough, with the largest population of young people in London.

Although parts of Croydon remain affluent, the borough also has a high level of deprivation; it has become more deprived, overall, over the past five years (2010 – 2015) than other local authorities in England. More specifically, the borough was the 25th most deprived local authority in terms of levels of crime, and 19th in the country for access to services, although it is placed around the median nationally in terms of deprivation in relation to health (155th most deprived of 326). Disability also remains a day-to-day fact of life for many in Croydon,

particularly the over-65s, with the 2011 census showing that around 14% of the population of the borough report some sort of limitation on their day-to-day activities due to a health issue.

Other health-related issues raised by Croydon Council in their 2015 report on the borough include a high proportion of babies being born with low birth weight, high levels of obesity in both children and adults, a high and increasing teenage contraception rate and an increase in the number of emergency admissions of the over-65s due to falls.

Our vision and objectives

Our Vision: “Excellent integrated care for you and your family, when and where you need it”

Our Objectives:

1. To deliver high quality, integrated people-centred services
2. To ensure staff are able, empowered and responsible for the delivery of effective and compassionate care
3. To achieve best practice performance standards
4. To secure value for money and ensure the financial sustainability of the Trust
5. To work with partners to improve the health and wellbeing of the people of Croydon

Delivering on our objectives

The Trust maintains an annual plan which sets out the organisation’s key deliverables in line with Trust objectives. Over 2015/16, we have delivered the following achievements under the following objectives:

1. To deliver high quality, integrated people-centred services

Working to this objective has involved planning and delivering changes to our services and improving patient experience. Among the actions that we have delivered are:

- We are meeting our national targets for all patient groups for our Friends and Family Test scores and our local targets for complaints response times.
- We have put in place action plans to address the recommendations of the CQC following their inspection in 2015.
- We successfully moved our Emergency Department as part of the ED rebuild project and have begun construction of our new, £21.25m facility.
- We have increased our overall compliance to the London Quality Standards from 69% to 79.4% and robust plans are in place to move towards full 7-day working at the Trust.

2. To ensure staff are able, empowered and responsible for the delivery of effective and compassionate care

Working to this objective has involved embedding Listening into Action (LiA), the Trust's comprehensive framework for supporting staff empowerment, across the organisation and the recruitment & retention of skilled substantive staff. Among the actions that we have delivered are:

- We have registered 113 LiA teams across the Trust and delivered 162 team-led improvement actions by the end of 2015/16.
- 85% of substantive staff are now staying with the Trust for one year or more.
- More staff this year would recommend the Trust to their friends and family as a place to receive treatment and to work than did last year.

3. To achieve best practice performance standards

Working to this objective has involved maintaining and sustaining our operational performance and improving our patient flow. Among the actions we have delivered are:

- Achieving the majority of national standards, including diagnostic waits, delayed transfers of care and a report of zero maternal deaths for the year. We have performed particularly strongly on measures of performance relating to cancer services.
- We are working hard to address the challenges of meeting two further standards: A&E four hour waits and Referral to Treatment (RTT) 52-weeks.
- We have developed a number of specialist acute units in surgery, gynaecology and paediatrics to provide more effective specialist care to our local community. These are now operational or will be operational in early 2016/17.

4. To secure value for money and ensure the financial sustainability of the Trust

Working to this objective has involved delivering our financial improvement programme and investing in our IT systems. Among the actions we have delivered are:

- Hosting more clinics and outpatient activity at Purley War Memorial Hospital.
- Developing analytics and tools to support building on directorate business plans for the next year.
- Engaging with colleagues across South West London to establish the SWL Acute Provider Collaborative, a joint-working arrangement to move forward in delivering more effective collaborative working across the region.
- Delivering a further expansion of CRS Millennium across the Trust along with the Sectra PACS diagnostic imaging system.

5. To work with partners to improve the health and wellbeing of the people of Croydon

Working to this objective has involved planning and delivering more integrated care in a non-hospital setting and investing in prevention of poor health. One of the key current projects to

address this is Outcomes Based Commissioning for the over-65s, a new way of targeting and funding healthcare that focuses on the ultimate wellness of the patient rather than specific treatment they receive. So far we have:

- Secured £800k from the Better Care Fund to support out of hospital care and reduce non-elective activity.
- Worked on developing the operational framework for 'Outcome Based Commissioning' for the over-65s for 2016/17.
- Met initial milestones for the Croydon Best Start scheme and created joint operational groups with the Croydon Clinical Commissioning Group and other local providers to work towards moving a range of clinical services closer to home over the next year.



Highlights of the year

Our Care Quality Commission inspection

Croydon Health Services NHS Trust was described as having made “significant progress” following a routine inspection by the Care Quality Commission (CQC) last year. One patient quoted in the inspection report (published October 2015) said that they were “gobsmacked at how much better it is than before.” Another told the CQC that “staff [were] gentle, kind and caring,” and that care at Croydon University Hospital had “improved since their last admission.”

A comprehensive action plan with 188 milestones has been drawn up to address the CQC’s areas of improvement which has been incorporated into the Trust’s Quality, Safety and Experience Programme (QESP).

Delivering on performance

The Trust has strong performance monitoring and review processes in place to support improvements in service delivery. These were further enhanced over the last year with the creation of a new ‘clinical business unit’ structure, which provides both greater autonomy and greater accountability to individual services.

Amongst the areas where we made notable improvements is referral to treatment standards, and in particular cancer waiting times. Although, in common with many Trusts in the England, we did not meet the 95% 4-hour waiting standard for A&E, we are in the process of developing a number of actions to improve our performance on this standard, including improving our overall patient flow, analysing our A&E workforce structure and developing new and improved pathways of care.

Improving our patient experience

The overwhelming majority of our patients are telling us, through the Friends and Family Test, that they are happy with their care with over 90% of those surveyed in every patient group willing to recommend the Trust as a place for treatment to the friends and family. Despite this, the 2014 inpatient survey, released in May 2015, told us that there were aspects of their experience that should be improved.

One of the main projects to improve patient care was the Perfect Ward programme, delivered through our Listening into Action staff empowerment framework. The Perfect Ward looked at the full scope of activity and experience on the ward to see where we could work effectively to release more time to care as well as the environment we create for our patients. This included broadening our visiting hours period, introducing new multi-disciplinary team ward rounds and new ways of working for our pharmacy staff to support patient care and special activities to support our older patients to socialise.

Enhancing the quality of our services

Our CQC inspection in June 2015 identified 13 areas of outstanding practice, including our community nursing team, our Special-Care Baby Unit and our Children's Specialist Asthma and diabetic teams. The inspection also raised a number of specific areas for improvement, which we have addressed as part of our overall drive to enhance the quality of our services. Among these are further work to develop and embed quality and safety monitoring systems and encourage more thorough incident reporting by staff, wide-ranging plans to refurbish and generally strengthen the management of our surgical theatres and efforts to support our staff in receiving up-to-date mandatory training.

We also have delivered targeted improvements on a range of other aspects of our care, including raising awareness with clinical staff of the risk and signs of sepsis in patients; reducing the number of patients who suffer from cardiac arrests while they are in our care; strengthening our commitment to candour with our patients with the appointment of a family liaison support officer; and maintaining the Trust's excellent record on delivering harm-free care to patients.

Empowering our staff

In its findings, the CQC commented how the Trust's use of Listening into Action had helped to deliver many of these improvements. CHS was one of 26 trusts in England to pioneer LiA as a key way of working. Now in its fifth year (2016/17), LiA is no longer 'something that we do'. It is now the way that staff at all levels of the organisation approach continuous improvement initiatives.

Details of our adoption of LiA, and the positive impact that it is continuing to have in enabling staff to drive forward change, was one of four CHS submissions to this year's Health Service Journal Awards (November 2015) that went on to become a finalist in its category. One of our other award finalists was the Trust's successful initiative in reducing painful pressure ulcers for Croydon residents cared for in the community by 45% - almost twice the original target.

This achievement was led by our nursing teams and was celebrated by Optimize, the national co-ordinators for LiA, nationally as the first of '100 Stories of Staff-Led Change' across the NHS through Listening into Action. Further stories from the Trust also featured on the list.

Through LiA we have galvanized staff and generated real momentum. CHS was the first NHS Trust in the country to be awarded LiA accreditation for staff engagement and empowerment (March 2015). This is an improvement journey that we are keen to continue, and through new initiatives like "Let's Do It," we are even more determined to pick-up the pace.

Developing our new Emergency Department

The rebuilding of our Emergency Department began in October 2015, a major work programme that will last until 2017. Designed by our own clinical staff, this state-of-the-art facility will give our doctors and nurses direct line of sight of their patients to improve safety and care; will improve patient experience with brighter, more modern surroundings; will have doors rather than curtains on cubicles to enhance the privacy and dignity of our patients; will be dementia-friendly; and give the Trust the flexibility to meet future changes in demand.

During the rebuilding period we are continuing to maintain a full Emergency Department at Croydon University Hospital, having moved the service into a new, temporary home on the site while the work is being undertaken. This carefully planned move ensured that despite relocating the entire department in one planned phase, we did not need to close our doors to patients at any point and continued to provide emergency care throughout the relocation.



Utilising Purley War Memorial Hospital

As part of the drive both locally and nationally to deliver NHS care closer to home, we have continued our work to make as full and effective use of Purley War Memorial Hospital to deliver a wide range of services to residents in the south of Croydon. We are now fully utilising our outpatient clinic space, with clinics booked into 119 of the 120 available slots each week at the hospital, with services ranging from cardiology, podiatry and rheumatology to antenatal, postnatal and elderly care. The Hospital also provides a walk-in blood test service, X-ray and ultrasound diagnostics, a baby café and, run by our clinical partners, a GP practice, minor injuries unit and ophthalmology service.

Creating new ways of delivering care

The Edgecombe Unit, which opened in November 2015, is a ‘first-of-its-kind’ facility, combining and co-locating four related teams into one single facility in the old Edgecombe ward space. The unit provides a range of ‘one-stop’ care services, including a Rapid Assessment Medical Unit (RAMU) for fast clinical assessment and medical treatment; an Ambulatory Emergency Care Unit (AECU) which provides urgent hospital care for patients who can then return home without admission to hospital as an inpatient; an eight-bed Acute Care of the Elderly (ACE) unit which provides short-stay hospital care for older patients with complex needs; and our long-standing COPD Hospital Outpatient Treatment (HOT) clinic which cares for COPD patients who are experiencing a sudden escalation in their condition and so avoids a need for an inpatient stay at hospital. The Edgecombe Unit takes these patients either from our Emergency Department or directly from GP referrals, ensuring that they get the right specialist care more quickly and removing pressure from our Emergency Department.

Refreshing our Lifeblood Suite

In January 2016 the Trust opened our refurbished the Neil Hawkins Lifeblood Suite. Named after the former Chairman of the Friends of Croydon University Hospital who had played a major part in the planning and funding of the project, it was formally opened by his widow and the Mayor of Croydon. The Lifeblood suite sees over 3,000 patients per year, providing a comfortable and restful environment for treatments for blood conditions such as leukaemia and sickle cell anaemia; the unit is now over four times its previous physical size, is lighter, brighter and provides enhanced privacy for those undergoing treatment.

Joining up our services with our partners

Croydon CCG and Croydon Council have identified care for older people as a priority for introducing Outcome Based Commissioning (OBC). OBC is designed to improve outcomes for patients and break down the organisational barriers that can often cause a person’s care to be fragmented and frustrating. By joining-up services across health, social care and the voluntary sector we can care for the “whole person” – this means looking after physical health and mental well-being.

A relatively new concept in the NHS, OBC places the incentive on keeping people well, and the delivery of outcomes that patients have defined as the most important to them rather than the current funding system which rewards health services by activity. Over the last year we have been working with our partners towards 'Outcome Based Commissioning' (OBC) for the over 65s, which together we are planning to deliver in 2016.

As well as our OBC work, in order to help us to deliver more seamless care for thousands of older people living in Croydon, the Trust has formed an Accountable Provider Alliance (APA) with four partner organisations; Croydon Council Adult Social Care, Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust and Age UK Croydon.

The APA is currently developing a new model of care which has five initiatives to begin implementation in 16/17.

Choosing Croydon

Croydon Health Services NHS Trust should be the healthcare provider of choice for the Croydon community to provide the majority of their acute and community care needs. In 2015/16 we engaged with mums-to-be and local GPs to provide more information on our maternity service, our refurbished facilities and our Crocus home birth team; as a result, bookings by local mums with our maternity team have increased by 6% from 2014.

More patients using our services means that we are able to more effectively and efficiently utilise our resources, as well as ensuring that the Trust continues to generate funding to invest and develop our services and ensure we are a financially sustainable organisation.

To encourage more of our community to choose Croydon as the hospital that they want to treat them, we are analysing our services to see where we have the most capacity to grow and we are developing our plans to engage further with GPs, patients and members of the public to let them know more about the high quality services that the Trust can provide to them, as well as listening to them about how we can make it easier for them to access these services.

Finance and Going Concern

In 2015/16 the Trust reported an adjusted retained deficit of £34.5m. The Trust is forecasting a deficit of £39.8m in 2016/17 which is a realistic forecast based on increased costs associated with service developments, current levels of vacancies and increased levels of resilience.

The Service Developments will require additional staff that will potentially come at a premium if posts are unable to be filled under the new national capped rates. Due to the levels of vacancies that the Trust is already suffering, additional resourcing will put a greater strain on an already limited pool of staff.

The Trust will also incur additional employer costs as result of changes to National Insurance (NI) costs and pay uplifts resulting from the national pay award. The gross increase to the Tariff offsets the additional costs for inflation, NHS Litigation Authority Medical Insurance and NI adjustment however incremental drift is a cost pressure as it is not met by this increase.

Profitability alone does not ensure the Going Concern status of an organisation. The critical factor that management use to determine the Going Concern status of Croydon Health Services Trust is whether we can maintain sufficient working balances, to ensure our creditors are paid. The Trust's Better Payment Practice figures showed a weakening in the Trust's ability to pay suppliers within 30 days in 2015/16. The Trust mandated the use of Purchase Orders in 2015/16 which for a short while slowed the authorisation process at the Trust. However, the real cause of the weakening position was the fact that the Trust suffered cash shortages throughout the year. The Trust was reliant on its working capital facility of £21.3m which attracts interest of 3.5% until February when its application for a revenue support loan of £26.4m at an interest rate of 1.5% was approved. The Trust effectively was loaned £26.4m to pay back its working capital support facility and given an additional £5.1m to pay a backlog of creditors, some of which related to prior financial years. Having replenished its working capital facility the Trust drew down an additional £3.2m of support to pay creditors in March 2016. This took the total revenue support received in 2015/16 to £29.6m.

In 2016/17 the Trust will continue to rely on its working capital facility to pay creditors. Our planned deficit of £39.8m would suggest that we will need to submit our application for revenue support earlier in the financial year. NHS Improvement has provided the Trust with an assurance that the Department of Health (DH) will make sufficient cash financing available to the Trust, either through an Interim Revolving Working Capital Support Facility or an Interim Revenue Support Loan, over the next 12 months such that the Trust is able to fund all essential operational liabilities.

The Trust continues to receive cash support from the DH in the form of a capital investment loan which will be drawn down over the course of the next two financial years to fund the on-going refurbishment of the Emergency Department at a total cost of £21.25m. The support of the DH in this regard gives us additional support to the Trust's going concern status.

The Trust therefore has a reasonable expectation that adequate resources will be available to continue in operational existence for the foreseeable future.

Looking Forward to 2016/17

The next year is planned to be one of maintaining and building on this year's improvements and delivering further positive change in terms of the services we provide, the experiences of our patients and our overall financial position.

Over the coming year the Trust will continue to build on the successes of the 2015/16 Quality Improvement Plan through the delivery of the Trust's Quality, Experience and Safety Programme (QESP), which encourages, supports and embeds sustainable best practice throughout the Trust. The QESP is led by the Director of Quality Assurance and Governance, with clinical leadership provided by the Director of Nursing, Midwifery and Allied Health Professionals and the Medical Director. This will support working towards delivering care which meets quality and safety standards, fulfilling our pledges set out in our Quality Account and providing an excellent experience for patients, every day of the week.

In addition to the day-to-day demands of providing high quality and financially sustainable healthcare, national and local healthcare commissioners have been clear that health provision needs to significantly change over the next five years. The number of older people in Croydon is increasing, which is putting increasing pressure on health services as a whole. There must be greater investment in prevention and, through pathway redesign, more integrated care provided in the community setting, rather than in hospitals.

To address the significant financial and quality challenges across South West London, commissioners are in the process of refreshing the 5 Year Strategic Plan for South West London to help address these goals. Among the issues that are expected to be covered are reconfiguration of healthcare, greater integration and the transformation of Out of Hospital services, in conjunction with Primary Care co-commissioning.

2016/17 is an important transition year with the emphasis on Croydon Health Services delivering as effective and efficient services as possible whilst at the same time establishing a Croydon provider alliance with South London and Maudsley NHS Foundation Trust, social care and primary care and working together on being ready to commence Outcomes Based Commissioning for 2016/17. CHS will need development support to enable the Trust to deliver against this exciting and exacting agenda.

CHS will ensure that the population we serve receive high quality, safe and compassionate care, irrespective of what time or day they require it. As an Integrated Care Organisation, providing both hospital and community services, we will be shifting our focus of care towards prevention and early intervention to provide safer, more effective and more economic healthcare.

Performance



Performance Analysis

Performance against key statistics

To support the delivery of key performance standards services at Croydon Health Services there is an established Performance Management Framework; all performance reporting is now aligned with the Care Quality Commission's (CQC) five domains around Responsive, Caring, Effective, Safe and Well-led services. Around each of the five domains there are a suite of indicators set out in the Trust Development Authorities Accountability Framework Escalation and Oversight model with the addition of other national and local indicators identified as a priority by key stakeholders.

Trust performance is reported through a suite of integrated quality, safety, access and finance dashboards. The dashboards, supported by detailed quality, performance and financial reports, are presented to the Trust Board Sub-Committees and the Executive Management Board following Directorate monthly and quarterly Strategic Performance Reviews.

All Directorates have business plans with objectives aligned to the delivery of the Trust's five corporate objectives and key priorities, set out in our Annual Plan and Annual Quality Account. These include key performance indicators (KPIs) which are reflected in team and personal objectives as part of the performance appraisal process. Directorates also have Operational Agreements in place and are aware of their responsibilities to improve and deliver high quality patient care and achieve best value for money in its use of resources through effective capacity and demand planning.

Delivery of the Trust objectives is monitored by the Trust Board via sub-committee, executive director and directorate governance structures and at ward level by matrons through the Trust's Quality Rounds programme and through the Clinical Business Unit (CBU) structure. The CBU structure was implemented in 2015, strengthening the organisational effectiveness of services across the Trust by providing groups of services with increased autonomy in, and accountability for, their own development and performance.

Specific improvement actions from Quality Rounds are agreed with ward sisters/charge nurses and monitored weekly through the rounds, and the quality dashboards, which are discussed within CBUs and co-ordinated at directorate quality governance meetings. When identified, cross-cutting themes generate wider actions adopted by all Directorates, which are highlighted in action plans and monitored at bi-weekly Matrons and Support Services Operational Meetings.

Externally, quality reviews and audits are undertaken by commissioners and regulators such as Croydon CCG and the CQC. Monthly performance assessments also take place against key performance indicators by both commissioners in accordance with our contractual obligations and by the NHS Trust Development Authority (NHS Improvement from 1 April 2016), and benchmarked against local/national comparators and other Trusts where applicable.

National Cancer Waiting Times

Cancer is one of the most common health conditions in the UK; according to estimates by Macmillan Cancer Support, approximately 2.5 million people in the UK are currently living with cancer, with the number increasing by 3.2% every year. While different forms of cancer have different rates in terms of likely recovery and long term impact on health, early detection and swift treatment are universally key to ensuring that individuals diagnosed with cancer have the best chance of beating the disease. Throughout 2015/16 the Trust has worked with its clinical workforce to optimise the clinical pathways for suspected cancer sufferers, ensuring that they are consistently seen and treated quickly.

The Trust continues to be benchmarked against other South West London (SWL) Acute Trusts as part of the Cancer Network Programme and the official figures across the region show that the Trust is performing consistently well when compared with other acute and specialist Trusts in delivering on all National Cancer standards in 2016.

The Trust's summary position for London Cancer waits for 62 Day Waits performance in Q4 (2016) was at 80.50% broadly in line with the national position of 82% in Q4. The Trust was one of only three providers to meet the 62 Day Standard for the Quarter and one of two Trusts to meet all Cancer waiting Time Standards for Q4 2015/16.

Referral to Treatment Waiting Times

The Trust has developed its management of Referral to Treatment (RTT) over this past year and sustained strong overall performance against the three elements of the 18 week Referral to Treatment (RTT) targets and a 38% reduction both in backlog and long waiting patients.

Although the measurement of Admitted and Non-admitted 18 Week Waits are no longer national targets, the Trust continues to monitor performance to help make sure that patients are seen as soon as possible. The Trust reported 80.10% of admitted patients were seen within 18 weeks against a target of 90% and 92.80% of Non-admitted patients seen within 18 weeks against previous national targets of 95%. The Trust's waiting times performance is measured on the percentage of patients on an incomplete pathway which CHS continues to meet over and above the 92% standard, reporting 94.53% as its end of year position.

Directorates are increasingly taking more direct ownership of their waiting lists, and are undertaking continual capacity and demand analysis to ensure compliance across all Referral to Treatment standards into 2016/17.

A&E waiting times

The four hour waiting time was not delivered consistently during 2015/16. The new model of care introduced in November 2015, incorporating the Trust's Edgecombe Unit, has helped to manage activity levels over the winter, which were higher than those for the same period in 14/15.

The number of admissions from A&E has also fallen by 20% following the introduction of the new unit.

The actions taken in 2015/16 provide the foundation for continuing improvement, focusing on the following five key aspects:

- Improving patient flow - Work will include a revised discharge group and implementation plan to help patients leave hospital more swiftly when they are ready to return home; reduction in specific clinical pathways to reduce Length of Stay and make more beds available more quickly; a revised model for managing our site overall; developing and building on streaming pathways to ensure quicker allocation of attendees to the most appropriate services, including work with London Ambulance Service, rapid response and GP's referrals to acute medicine and the surgery teams.
- Workforce – Nursing staffing levels have been reviewed in the Emergency Department, with a revised structure implemented in Feb 2016; a medical workforce review for ED is underway and recommendations planned in May; a community staffing review to support patient flow and emergency pathways is underway.
- Emergency pathway – Implementation of Assessment areas, with business cases to be agreed with Croydon Clinical Commissioning Group for a Gynaecological Assessment Unit (GAU), Surgical Assessment Unit (SAU) & Paediatric Assessment Unit (PAU); development of stage 2 of the Edgecombe Unit; and full implementation of internal professional standards & escalation policy by June.
- Resilience – The Trust is undertaking a complete bed capacity modelling exercise, with an realignment of resources by due by the end of April; the implementation of programme for next stages of Emergency Department decant, including the planned opening of the new resuscitation suite in autumn 2016 and the move to new build in 2017 has also commenced.
- Whole systems response - The Trust will be continuing to work with stakeholders elsewhere in the NHS and the wider health and care system to improve system resilience and collaboration on key themes, such as early intervention and urgent care.

The ED has put a process and measures in place to enable the Ambulance Handover times to be recorded in real time to reflect the timeframes and the activity undertaken. The weekly data is discussed at the weekly Emergency performance meeting, as well as at board level.

Improving quality, effectiveness and safety for patients

Quality Experience and Safety Programme

The main driver for delivering improvements to service quality at the Trust has been the Quality, Experience & Safety Programme (QESP). Established in January 2015, the primary aim of the programme was to build upon the previous CQC Inspection Quality Improvement Plan to improve the quality of patient care, patient safety and patient experience across the Trust and embed 'Best Practice' processes and procedures.

In order to achieve this, a schedule of weekly strategic and operational meetings was established to drive forward actions resulting from a range of initiatives such as the Matrons' Quality Rounds, Executive Walk Rounds and Mock Inspections.

Following the CQC announcement that they would be carrying out an inspection of the whole Trust (Acute and Community), from 16 to 19 June 2015, the QESP's focus was expanded to encompass the preparations for the inspection, the inspection itself, the factual accuracy checks of the draft report and the Quality Summit.

Following this the QESP has overseen the development of a comprehensive CQC Quality Improvement action plan to respond to each of the 4 'must do' actions and the 31 'should do' actions (see below). Each of the 'must do' and 'should do' actions has a designated Executive and Project Lead and detailed action plans have been developed. These action plans include the high level milestones, risks & mitigations, assurance required to evidence delivery and a project summary for audit purposes.

The action plans are updated regularly with progress and exceptions are reported through the QESP Delivery Group for action as required. The QESP reports monthly to the Quality & Oversight EMB, the Quality & Clinical Governance Committee and the Trust Board.

Care Quality Commission Report

In June 2015, the Trust took part in a scheduled inspection by the Care Quality Commission (CQC) to evaluate the standards of care provided both in hospital and, for the first time, by our community services. Following an exhaustive evaluation of our services and processes, the CQC formally awarded the Trust a 'requires improvement' rating on the national evaluation scale in October 2015, acknowledging that the Trust had made significant improvements since the previous inspection in September 2013.

A "Good" rating was given for the domains of Effective and Caring with the remaining domains of Safe, Responsive and Well Led given the rating of 'Requires Improvement'.

At a service level Urgent & Emergency Services, Maternity & Gynaecology and Services for Children & Young People were all given an overall rating of 'Good'. All other services in the hospital and community were given an overall rating of 'Requires Improvement' (see table below)

Care Quality Commission rating of Croydon Health Services NHS Trust
Last rated 7th October 2015

Overall Trust rating	Requires Improvement
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Croydon University Hospital

Are services	
Safe?	Requires Improvement
Effective?	Good
Caring?	Good
Responsive?	Requires Improvement
Well led?	Requires Improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Requires improvement	Good	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Intensive/critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity & gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement

Community services

Are services	
Safe?	Requires Improvement
Effective?	Requires Improvement
Caring?	Requires Improvement
Responsive?	Requires Improvement
Well led?	Requires Improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Community adults	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community children & young people	Good	Requires improvement	Requires improvement	Good	Good	Requires improvement

The CQC identified 13 areas of outstanding practice at Croydon University Hospital and in the community services provided by the Trust. These were:

- Engagement undertaken by the Specialist Palliative Care team with staff and the public on the development of the ‘care of the dying person care plan’.
- The Trust’s involvement in the LEGACY study for secondary breast cancer, in collaboration with the Royal Marsden and Institute of Cancer Research.
- The care provided by the diabetes team for children and young people.
- The breast-feeding support given by the Special Care Baby Unit.
- The urogynaecology and pelvic floor reconstruction unit.
- The maternity service work on developing antenatal courses to support women with limited English.
- The personalised and holistic care provided by adult community services.
- The 24-hour, 7-days-a-week community nursing cover.
- The Trust’s community nursing service at St Giles special school.
- The work and approach of Children’s Specialist Asthma Service.
- The Chatterbox language development service for pre-school children.
- The Children’s Specialist nurse diabetic service.
- The Willow Bereavement Service to provide counselling for terminally ill children and their siblings.

The Trust was also given 4 ‘must do’ actions and 31 ‘should do’ actions by the CQC as guidance to improve services. The ‘must do’ actions, and the response that we have taken to address these, are:

- Continue to improve and embed systems to monitor the quality and safety of care provided (Trust wide).
 - In September 2015, the Trust appointed its first Director of Quality Assurance and Governance. This is a new role to increase the prominence of continued quality improvements at Board level and embed robust monitoring arrangements throughout the Trust. This will help to spread best practice from one ward or clinical area to another, and ensure areas of improvement are quickly identified to deliver better care for patients and service users.
- Improve clinical governance and risk management in the surgical services (CUH).
 - The Trust revamped its clinical management structures in June 2015, to put clinicians at the forefront of continued service improvement. Three new Clinical Directors were appointed. All are consultants by background and are supported by an experienced senior nurse and manager to oversee the performance of services in their directorate. They report directly to the Chief Operating Officer and Deputy Chief Executive.
 - All directorates, including the surgical directorate, will appoint a new governance lead to strengthen its governance processes, and will setup a new performance dashboard to systematically review quality and performance data. This will be used to monitor progress and lead continued improvements where they are needed.
- Implement promptly plans to refurbish theatres and to put in place an equipment replacement programme (CUH).
 - Plans for the refurbishment of the nine main surgical theatres at Croydon University Hospital are currently being developed.
 - Theatre managers and clinicians meet monthly to review all new theatre equipment coming in. More than £1m has been spent on new theatre equipment over the last 15 months, including £130,000 on new anaesthetic machines, and more than £90,000 on new operating tables.

- Ensure that 90% of staff receive up-to-date safeguarding and mandatory training (CUH).
 - The number of staff completing refresher safeguarding and mandatory training has already increased by as much as 12% in some areas since the CQC inspection. Each directorate has been asked to produce a clear action plan to get 90% or more of staff the required levels of training by the end of January 2016.

These, along with the 31 'should do' actions have been incorporated into the Trust's QESP programme.

Quality initiatives and improvements

There have held a number of initiatives that have been successful over the past year in improving quality and raising awareness of important quality issues amongst staff, patients and members of the public. The following represent an overview of some of the many actions the Trust has taken to improve the quality of our care; a more detailed summary can be found in the Trust's Quality Account.

Patient Safety Week & Sign up to Safety

In September we held our first patient safety week with over 475 pledges being made by staff as part of our 'Sign up to Safety' campaign has been a success and we have achieved many of our pledges made. We used this week to raise awareness on key safety areas that included Sepsis, Acute Kidney Injury, Diabetes Medication Incidents and Harm-Free Care.

Combatting Sepsis

We have introduced a Sepsis Task Force that has led on an education programme for all staff around Sepsis, one of the most harmful and least publicly recognised medical conditions affecting patients in the UK. The task force also reviews all incidents where a patient has been diagnosed with Sepsis. There has been additional training for staff in key areas and all staff have been supplied with the Sepsis card which highlights the key areas for Sepsis consideration. In the coming year changes will be made to the electronic patient record system to flag up actions to be taken when a patient is showing signs of Sepsis. This will include the pilot of a Sepsis box for use in ward areas.

Reviewing Mortality

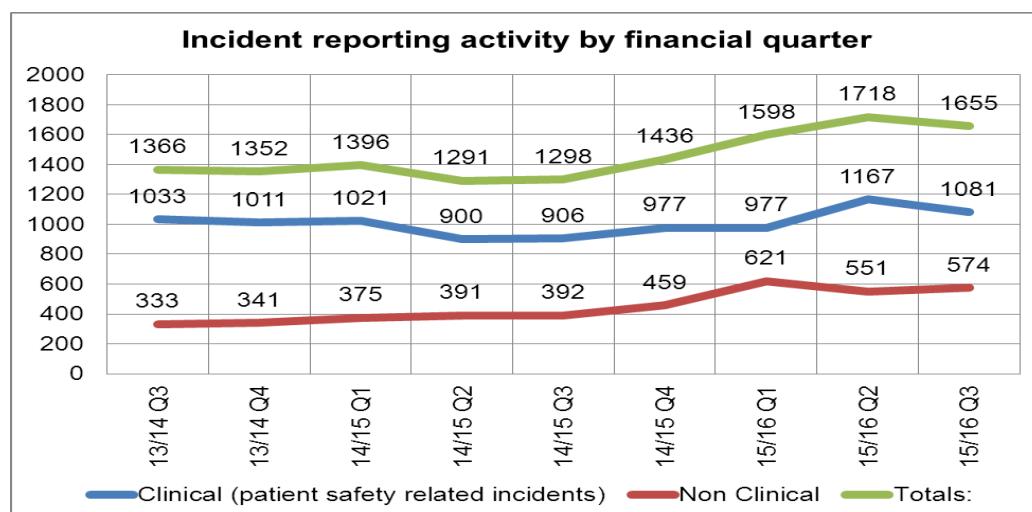
The Trust has set up a Mortality and Morbidity Group, a multi-disciplinary group that reviews every death that has occurred within the hospital and assessed against the Hogan scale for degree of harm. The group is represented by all service areas and also adults and paediatrics. The Group reports monthly to the Patent Safety and Mortality Group and sub-committee of the Quality and Clinical Governance Committee.

Reducing cardiac arrests

The Resus team traditionally have responded to emergency calls if a patient experiences a sudden collapse, cardiac arrest or deterioration in their condition. By combining an education, clinical and technological approach the Resus team at CUH has been able to enhance patient safety for the people of Croydon and reduce in-hospital cardiac arrests by 56% in the past two years. The team was invited to present on their successes to the leading international conference on these clinical issues, and their work has been shared widely with health services across the world to help encourage other hospitals to address this important issue.

Learning from past incidents

The Trust has seen a welcome increase in incident reporting over the past year and this continues to be a focus for the organization. Anonymous reporting has been introduced over the past year to reassure staff around reporting incidents and the Trust constantly review the level of harm incidents reported. The Trust has reported one Never Event in the past year.



This year we have held a “What we learnt last year” event which reviewed how we had learnt from previous incidents and events. We have introduced patient safety newsletters and kept a central repository for these in the library for reference. We have also introduced the **three key safety messages** each week , where all staff are sent three brief pieces of insight that have been identified from learning from events that have occurred –either complaints, incidents or inquests.

Other actions to improve our learning from incidents have included:

- Creating a shared learning hub on the intranet for all staff to have easy access to the resources that make a difference in patient care, safety and experience.
- Opportunities for shared learning mainstreamed through the Trust’s ‘Trust Focus’ all-staff briefing and the Medical Director’s section on grand rounds.

- Datix incident reporting system was upgraded to make incident reporting easier for staff.
- A Podcast on how to use Datix was created on the shared learning hub.

Being open

We have a Family Liaison Support Officer in place who provides the link with staff and patients around ‘duty of candour’, our legal duty to be frank, open and honest with patients when things go wrong. Ensuring that all NHS organisations address this issue was one of the main recommendations from the Francis report on care at Mid Staffordshire hospital. The Family Liaison Support Officer also provides training to staff and has developed leaflets for patients and staff on duty of candour.

Managing patient nutrition

Following the re-establishment of the Trust’s ‘Nutrition Task Force’ in June 2015 to monitor nutrition and hydration standards across the organisation and ensure compliance with national guidance, we have seen a reduction in nutrition-related incidents.

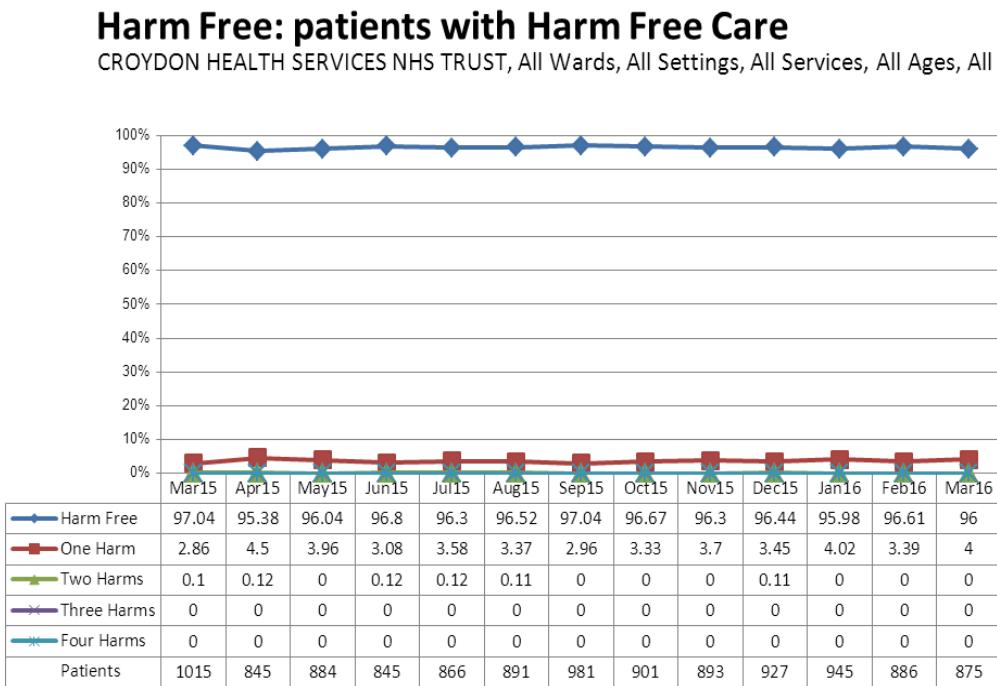
Achievements have included

- Development of a Trust wide nutrition and hydration action plan.
- Nutrition and hydration incidents are being reported more efficiently (by 20%).
- Nutritional Study days organised, covering all aspects of nutrition assessment and Malnutrition Universal Screening Tool (MUST) management in the acute setting.
- Bespoke training provided to wards.
- Weekly audits to assess compliance with MUST.
- Overhead bed boards now in use across all wards to identify specific dietary needs
- Coloured jugs and labels now used on wards to identify nutritional needs and when are being used.
- LiA project led by the Matrons to improve communication at ward level regarding nutritional needs of vulnerable patients.

Harm-free care

The Trust continues to outperform the national average for delivery of harm free care with 96.67% of patients experiencing harm free compared to 94.17% nationally.

Graph showing Harm-Free care in Croydon Health Services Jan 2015 –Jan 2016



During 2015 the incidence of pressure ulcers continues to reduce in all areas with the biggest reduction demonstrated in nursing homes. Trust incidence data shows an overall reduction in pressure ulcers of all grades of over 800 across the year which equates to a 45% reduction. Pressure ulcer prevalence data shows the Trust is out performing the national average by 40%.

This has been achieved by:

- A Trust wide action plan that is monitored via the multi-agency pressure ulcer strategy group
- A follow up Big Conversation to develop further plans. This was attended by the Trust, nursing home managers, NICE representative and the CCG.
- Development of a single pressure ulcer pathway for use by all health professionals and healthcare settings in Croydon.

The Trust's success on addressing pressure ulcers was so significant that the Trust staff who developed the action plan were nominated last year for a Health Service Journal award.

The Trust also remains significantly below the national average for falls prevalence. A national falls audit, undertaken in May 2015, showed that the Trust out-performed most of the London Trusts against which it was benchmarked. The Trust performed well against

other Trusts on a number of specific areas of falls minimisation including: number of falls per 1000 bed days; delirium assessments completed; medication reviews; mobility assessments undertaken and proportion of patients whose call bell is within reach.

For the next year, issues that the Trust falls group have highlighted for improvement are:

- Recording of lying and standing blood pressure
- Continence assessments
- Vision assessment

Infection Control

Overall 2015-16 has been a challenging year in terms of infection control, however, the Trust management, staff and infection control team have managed the challenges well.

July 2015 saw a higher than usual incidence of C.difficile cases, with 8 cases occurring in a 13 day period, against a usual incidence level of 1-2 per month and a C.difficile-specific action plan was implemented. This included:

- Enhanced infection control measures, including a matron-led weekly infection control walkabout, weekly commode spot checks along with regular audits of PPE use and antibiotic prescribing, with senior nursing staff reviewed these findings.
- Deep cleaning and, on some wards, use of hydrogen peroxide vapour to aid cleansing.
- Enhanced infection control training for staff who manage patients with diarrhoea.

These actions effectively addressed the increase in cases, which dropped back to two in August 2015 and remained well controlled for the remainder of the year. The actions implemented in the C.difficile specific action plan will continue and ensure rates remain as low as possible. Despite the spike of cases in July, overall the Trust had 20 cases of hospital-acquired C.difficile against a planned trajectory of 16 or less for the year.

There was one hospital acquired MRSA bacteraemia. The Trust screens all emergency admissions for MRSA and offers decolonisation to those found positive. In addition, the infection control team review all individuals who have MRSA on a weekly basis, work closely with ward teams on treatment, screening and documentation of these patients and other patients who are at higher risk of infection.

This year Croydon University Hospital has seen more cases of confirmed flu this winter than previous years. From November 2014 to 08th April 2015, we have seen 202 patients with confirmed influenza at CUH. 123 of these were due to Influenza A H1N1, 59 were due to Influenza B and 20 were due to Influenza A (not typed). The current flu vaccine (for winter 2015/16) contains these three types of flu.

The high number of cases put tremendous pressure on the requirement for side rooms and infection control staff time. The infection control team worked closely with operational teams to ensure patients admitted with flu were safely kept separate and any other patients who

had contact with them were followed up and given antiviral medicine as a precautionary measure.

To support this work, the Trust produced printed guidelines for handling flu patients for staff, the communications department produced posters for main entrances to further educate patients, staff and visitors, and staff flu immunisation was widely promoted throughout the winter.

In July and August 2015, four midwifery staff were confirmed with whooping cough. The midwifery, infection control, occupational health and communications teams, along with the Trust's Medical Director, Director of Infection and Prevention and Control and Director of Nursing, worked closely with Public Health England to address this issue. Women using the service and staff were offered precautionary treatment and immunisation and, as a result, no mothers or babies contracted whooping cough.

Patient Experience

Patient Feedback

The Friends and Family Test continues to show that the overwhelming majority of our patients have a positive experience of care at the Trust. Of those who completed a Friends and Family Test over the past 12 months, 93.8% of inpatients, 94.4 % of maternity service users, 92.6% of A&E service users and 94.1% of outpatients would recommend the Trust's services to their friends and family. The 2014 Inpatient Survey (published in May 2015), however, showed that patient's felt that particular aspects of their experience, such as having their conditions and medications explained to them and being involved in decisions about their care, were not up to the level that they should expect of their care and the Trust has been working to address these issues.

The Trust also participates in the national Patient-Led Assessment of the Care Environment scheme, known as PLACE. The Trust is evaluated once a year by teams, including local people, go into hospitals to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviour. In 2015 the Trust performed strongly, with the PLACE teams scoring the Trust above the national average on the food provided to patients (90.65% score; national average of 88.48%) and on par with the national average on cleanliness (90.56% score; national average of 90.57%). Although not quite meeting the national average scores on the remaining three areas, the Trust still performed solidly with a 84.02% score in condition, appearance and maintenance; 75.69% on patient privacy, dignity and wellbeing; and 70.38% on the new domain of dementia.

Improving Patient Experience

Perfect Ward

One of our major projects to support the improvement of patient experience was the ‘Perfect Ward’ programme, delivered through our Listening into Action framework. With the mission of “Working together to create the perfect ward, resulting in a safe and effective patient journey from admission to discharge”, the Perfect Ward Sponsor Group held a big conversation attended by over 80 members of staff on 15th October 2015.

The team was proposed out of the need to work differently to proactively manage the patient journey from admission, improve patients’ experience of their inpatient stay and deliver safe timely discharges on a daily basis. Winter pressures put a huge strain on the whole organisation, therefore identifying the blocks and barriers and embedding new operational ways of working for patients admitted to the wards was required. The Perfect Ward has delivered substantial improvements to the patient experience of their journey through the hospital. These include the following actions and the resulting impact.

- Flexible visiting hours: Relatives who had complained about restricted visiting hours can now visit patients due to increased flexibility visiting hours from 12-8pm. This has greatly improved patients’ experience and accessibility to friends and family.
- Introduction of Multi-disciplinary ward rounds with doctors and nurses leading to greater effectiveness and more timely communications between professionals as well as with patients about treatment plans. This is also impacting the timeliness of diagnostic tests for inpatients in a positive way.
- Introduction of a new model of care with Pharmacy technicians supporting medication administration rounds to assist nurses and ensure speedier medication rounds. Early indications are showing great benefits of the role for both patients and the nursing staff.
- Dementia activities such as reminiscence tea parties and matinee movies for elderly people cared for in hospital to spark a memory or conversation leading to greater positive patient experiences of their inpatient stay.

Other Patient Experience projects

The Trust has developed and delivered a number of other patient experience projects over the last year, including:

- Bedside music – a professional singer visited dementia and stroke wards, singing to patients and have also purchased a new classic record player to play music in ward day rooms. The singing has had a comforting and uplifting effect on patients, stirring memories and raising spirits.
- Dementia reminiscence boxes and scrapbooks for patients where developed by the team to spark memories and start conversations. The boxes and books help stimulate conversation and the one-to-one contact with patient experience staff and volunteers offers companionship for patients that may not have any visitors.

- Hand massages – The team trained the house keepers to perform hand massage on the patients. The massages are therapeutic and relaxing for the patients, helping to make them to feel more comfortable.

Length of stay and discharge from hospital

Length of stay and efficient discharge from hospital are an important part of patient experience. A report on the discharge of elderly patients released this year by Healthwatch Croydon showed that one in four said we could have been much clearer in how we communicated with them around discharge, although 82% said that they waited in our discharge lounge for less than an hour before going home.

As part of the Emergency Care Recovery Programme, the Trust has continued to drive forward improvements to patient flow, reducing “exit block” within the system and ensuring that our patients are treated in the right place at the right time, every time.

Patient flow in its entirety has been the main focus of the programme in the last year with a complete redesign of the “Front End” model of emergency care through the development of the Edgecombe Unit, which hosts a range of co-located short stay and ambulatory services.

The creation of this unit has driven both a 30% reduction in admissions to the Trust and, overall for 2015/16, a 5% reduction in the average length of stay that our inpatients have in hospital, despite the 10% increase in attendances to the Trust through the months of January and February alone.

The Programme now enters into its second year with a greater focus on ward processes and demand management within ED in order to ensure that patients are only admitted when necessary and once admitted are then discharged in the most effective and timely manner possible.

The majority of patients (82%) now wait less than an hour in the Discharge Lounge to go home after a hospital stay. Through Trust-wide initiatives like ‘Safer:Faster’, the Trust is working hard to reduce unnecessary delays for patients by booking transport and medicines to take home in advance and ensuring patients are reviewed by their medical team by 10am on the day they are due to leave.

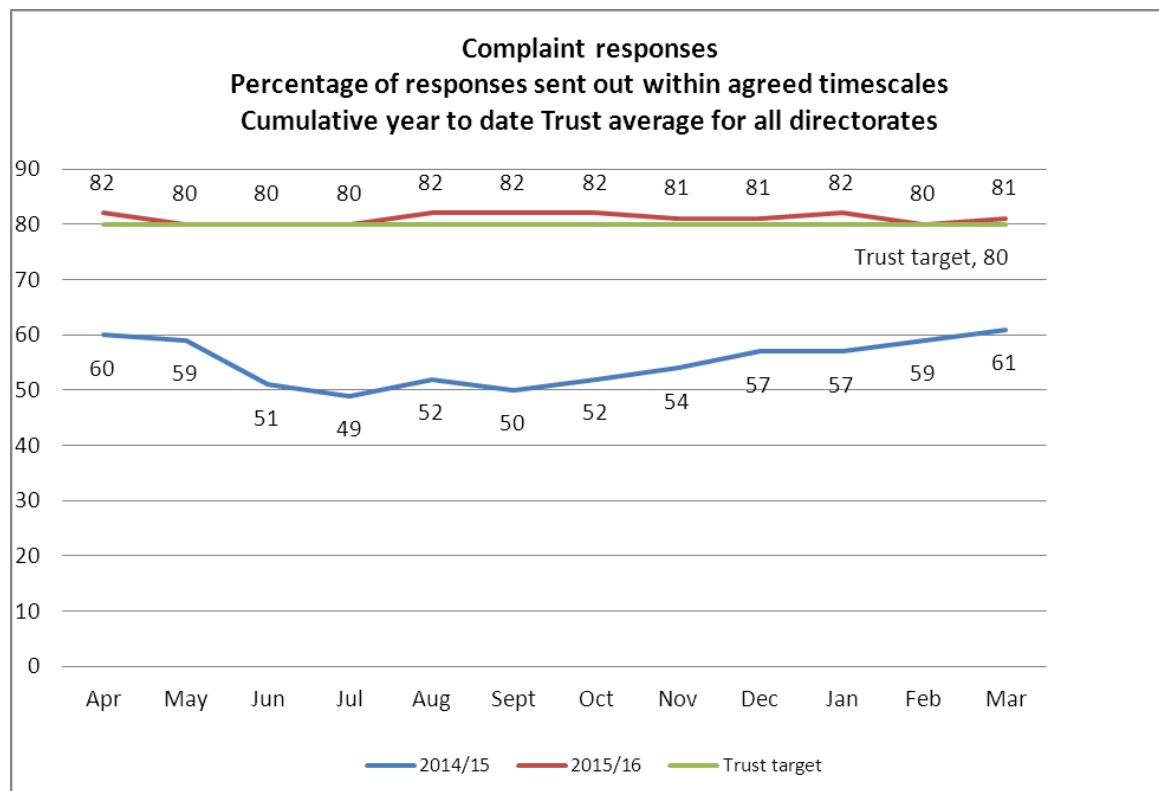
The Trust has also introduced special 'discharge advocates' on four elderly care wards to bridge the gap between busy clinical staff and patients and their families, explaining discharge decisions more clearly. Pending a full evaluation of the success of this programme, the Trust hopes to introduce discharge advocates more widely across the organisation.

Responding to and learning from complaints

The Trust has made a number of changes and improvements in how it responds to patient complaints by adopting the principles set out in ‘My expectations for raising concerns and complaints’, the guidelines for expectations of good complaint handling produced by the Parliamentary and Health Service Ombudsman (PHSO), Local Government Ombudsman and Healthwatch England.

During 2015/16 the complaints team received 499 formal complaints. There has been a decrease of complaints compared to 2014/15 by 15%. The decrease is due to how complaints are now handled; by agreement with the complainant, in many cases their concerns can be resolved earlier and informally without the need to utilise the formal complaints process.

The Trust must acknowledge complaints within 3 working days of receipt and at present we achieve an average of 96%. We are committed to responding to 80% of formal complaints within an agreed timescale with the complainant. We achieved and maintained 80% throughout 2015/16, a significant improvement from 61% in 2014/15.



In-depth complaints training is now available to all staff; this enables staff to explore the fundamental elements they need to provide to deliver a positive experience to both patients and their families when investigating and responding to complaints.

During 2015/16 the Trust has taken significant steps to improve how we record actions and learning from resolved complaints and share these with staff and complainants to ensure change is recorded, embedded and the needs of service users are outcomes based.

Actions and learning are now captured on closure of a complaint to ensure that evidence is held of what we have done and where appropriate, is shared with the complainant ('you said, we did' approach).

Throughout the year complaints have fed into staff education and learning, reflective practice across multi-disciplinary teams and changes to local practice and procedures where lessons have been learnt. A regular complaints newsletter is now being produced and circulated to staff, and a current complaint is highlighted bimonthly in the Chief Executive's all-staff 'Trust Focus' briefing.

The Trust also shares positive feedback and due recognition to help motivate staff and ensure they receive credit for providing good care.

Patient Advice and Liaison Service

During 2015/16 the PALS team received 1790 contacts. There has been a decrease in PALS contacts by 10%. Analysis of patient feedback has shown that this decrease is due to staff addressing concerns as they arise.

A Well-Led and Responsive Organisation

Well-Led Pilot

In 2015, the Trust was selected as one of three across England to pilot the Well-Led Framework for Governance Reviews developed by the NHS Trust Development Authority (NHS TDA).

Following the Trust Development Authority's (TDA) field work and their assessment of the Trust's own self-assessment, the TDA provided a report and action plan with 38 recommendations under the four headings of:

- *Strategy and Planning*
- *Capability and Culture*
- *Process and Structures*
- *Measurement*

In summary the key themes/areas that were identified for development at CHS were:

- Governance Arrangements, Framework and Risk Management
- Board, Committee and Sub-Group Effectiveness and Structure
- Leadership Development including NED Challenge and ED Support
- Stakeholder Engagement and Management
- Transformation and Sustainability

A significant amount of work has been undertaken throughout 2015/16 to progress these themes, including:

- A Director of Quality Assurance & Governance was appointed in September 2015 with responsibility for both clinical and corporate governance to provide leadership at Board level.

- The Trust's Audit Committee approved the separation of the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) into two separate documents. The Board Assurance Framework has been significantly revised to provide additional assurance to the Trust Board that the risks to the strategic objectives are being managed
- The Risk Management Strategy has been revised and a Risk Management Framework has been developed.
- Work has been undertaken to develop a Trust Assurance Map which details how the Trust receives its assurance in respect of effective systems and controls.
- Board/Committee Forward Plans have been developed and action trackers are in place for all Board, Board sub-committee and Executive Management Board meetings.
- A Governance review of committees was undertaken and weekly Executive Management Board meetings to provide additional scrutiny of Trust Board papers prior to presentation at the Trust Board have been introduced.
- Annual reports for each Board sub-committee have been produced and were presented to Trust Board.
- A series of Board development days focusing on Board leadership and effectiveness has been undertaken, as well as days to focus on further development of strategic planning. A Board Development Away has also been undertaken.

Listening into Action

The Trust continues to use the comprehensive, outcome-oriented Listening into Action (LiA) approach to engage staff, put them at the heart of change and empower them to make positive changes for patients and service users.

Building on the successes of wave 3 last year, the Wave 4 LiA teams delivered improvements by focusing on creating the Perfect Ward for patients from admission through to discharge, improving staff roles in Outpatients to better serve the needs of patients, and improving recruitment and retention in theatres. Some of the outcomes of these LiA teams include;

- Introduction of multidisciplinary ward rounds on the two LiA Perfect Wards leading to greater effectiveness and more timely communications between professionals as well as with patients about treatment plans.
- Patient safety newsletter introduced to focus attention on key patient safety issues and new patient safety developments as they impact the Trust.
- Creating a shared learning hub on the intranet for all staff to have easy access to the resources that make a difference in patient care, safety and experience.
- All Trust newsletters with learning elements which were previously held by individuals have been centrally archived through the Trust library services to ensure retention of knowledge and accessibility.
- Opportunities for shared learning mainstreamed through Trust Focus and Medical Director's section on grand rounds.

- Introduction of the pharmacy technician role to release more time for nurses to care for patients.
- Improved entertainment for patients on our LiA Perfect Wards – including increased activities for patients with dementia.
- Further improvements to the Outpatients service and environment to enhance the experience of service users.

The LiA enabling teams have also delivered notable changes to the experience of staff working in the Trust as we continue to remove barriers getting in the way of staff providing high quality care and supporting them to make a real difference. The Wave 4 enabling teams - staff health and wellbeing, diversity and inclusion, Community IT and shared learning are delivering improvements to staff and the working environment that is positively impacting the quality of services delivered at CHS.

- Improving how staff learn lessons from incidents and complaints to ensure they can be better avoided in future
- Launched ‘creating a mentally healthy workplace’ training programme for leaders and managers.
- The Trust has introduced a number of after work exercise classes such as Yoga, Tabata, and Pilates to improve staff health and wellbeing. The uptake of these classes has been substantial with all the classes booked to capacity.
- The Trust supported the provision of free staff health checks to staff in September 2015 and February 2016.
- Improvements to catering services which has positively impacted staff health and wellbeing including a new range of healthy meal options.

To celebrate and share our successes, and inspire other members of staff to get involved in LiA, the LiA organised a ‘Pass It On’ event in March 2016 which was attended by over 130 members of staff and celebrated the achievements of the 7 Wave 4 teams. In addition, the Trust continued to embed LiA by launching ‘Let’s Do It’ team improvement actions to empower staff and embed an ethos of continuous improvement at team level. The goal of having 100 registered ‘Let’s Do it’ teams has been exceeded with over 150 evidenced improvement actions delivered. These actions include improvements to quality and safety of patient care, patient experience, environment, information, systems, processes, clinical equipment and staff wellbeing/morale.

In October 2015, we launched the LiA Champions as role models who actively support staff and teams with the LiA approach to continuous improvement of care provision and service delivery. Our LiA Champions actively seek opportunities for improvement at all levels of services delivered to patients and other service users.

Engaging with our Local Community

Effectively listening and ensuring that the views of patients, service users and other stakeholders are reflected in our plans is a critical aspect of how we provide and improve our services. In February 2016, the Trust held a patient feedback and listening event attended by over 50 members of the local community and service users. It was an opportunity for us to provide a progress report on over 50 actions and suggestions put forward by our stakeholders at another listening event held in March 2015. Some of these actions and suggestions have led to significant improvements some of which include:

- Wide array of new and improved meals served to inpatients in the hospital. Feedback received so far includes: "absolutely delicious, beautifully presented" and "very nice." The new meals were also given a 'taste test' with our local community at our Big Conversation event in the spring of 2016.
- Introduction of a new look food menu with expanded range of multi-cultural options and choice for vegetarians to make it easier for the patients to choose what they find appealing to eat.
- The Introduction of a new Nutrition alert system to ensure there is appropriate response and adequate support for patients refusing food.

At the event, further improvement actions were identified by patients and service users which we are taking forward in 2016 and will feedback on at another event later in the year. We continue to see the benefit of the positive impact of LiA on patients and service users experiences of the Trust as we listen and respond to their opinion of our services.

Research

Research is a core part of the NHS, enabling it to improve the current and future health of the people it serves. Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment availabilities, and active participation in research can lead to successful patient outcomes.

In 2015-2016, 67 clinical research studies were being conducted in the Trust; 35 of which were funded by the Clinical Research Network. 18 studies were concluded by December 2015 of which 63% were completed as designed within the agreed time and to the agreed recruitment target. This is an improvement from last year's 44%.

Among the research projects we undertook last year were:

- The second year of the EU-funded WELCOME study. The Trust's COPD and research teams and consortium partners are preparing to run a trial prototype of a telehealth vest later this year. The aim is to develop the system for remote monitoring of COPD patients to aid their self-care and develop it further into a commercial product.
- A second EU-funded project known as AEGLE completes its first year in April 2016. This is a major analytics programme that will analyse patient data to try improve the treatment of diabetes. The system is being designed and tested at present with the infrastructure being put in place.

- The OPTIMAL project, funded by Innovate UK, is completing its first year in 2016. Working with the discharge team it will look to streamline the discharge of patients in order to reduce readmission rates within 30 days. This would save the Trust money by reducing penalties incurred when patients are readmitted within 30 days.

The Urology and Gynaecology team have been awarded a £420,000 grant from The Health Foundation. This will fund a project looking reducing the rate of obstetric anal sphincter injury (OASIs) when giving birth. The project will provide materials and a training programme to clinicians that highlight the risks factors, the long-term impact of OASIs and the methods of prevention.

Our Workforce

Staff Pledges

The Staff Pledges were introduced in December 2014 as a direct result of staff feedback from a LiA Big Conversation where staff came to discuss customer service. The pledges are about staff commitment to making a difference every day by committing to always introduce themselves. The pledges are:

- Always let patients know who you are, in line with the 'Hello my name is' initiative;
- If someone needs help or looks lost always stop to help;
- If you can't help, always ensure that you refer them to someone who can; and
- If bad behaviour is witnessed always feel empowered to challenge it.

Listening to staff

The Trust had encouraging results for a third year in the NHS Staff Survey 2015, which was conducted nationally in autumn 2015 and published in February 2016, with results for the majority of findings on par or better than the national average.

Among the findings were that our staff feel amongst the most enfranchised of any NHS organisation, with 72% feeling that they are able to contribute to improvements at work – a testimony to the organisation's efforts over the past two years to create an environment where staff feel engaged and empowered to deliver improvements to our patients.

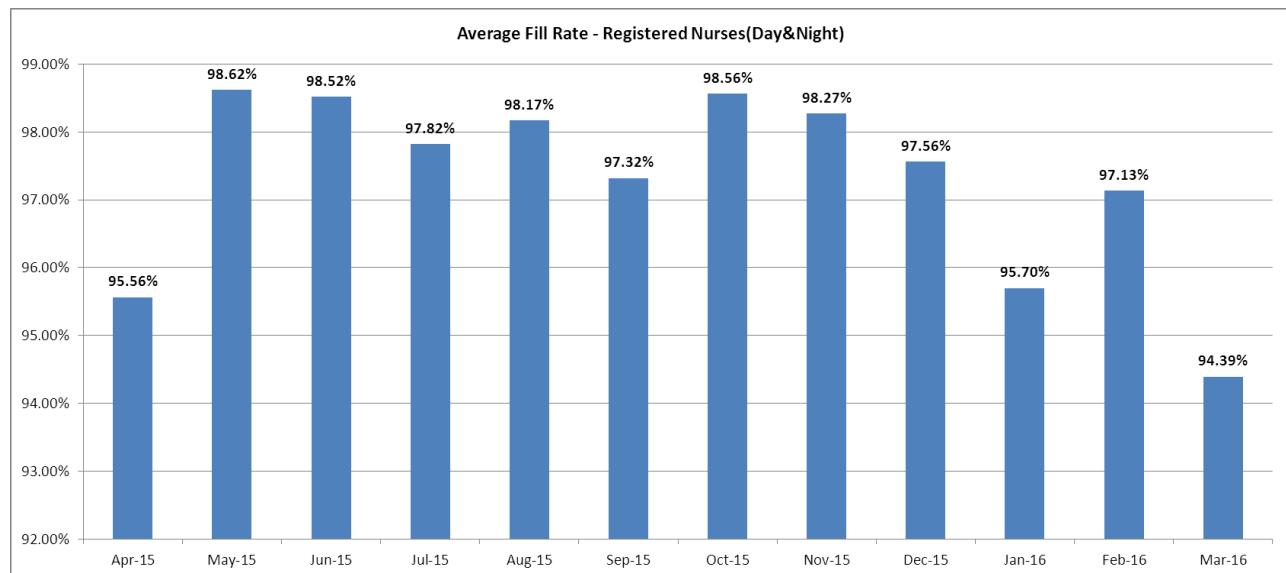
To ensure that it engages effectively with its staff, the Trust also undertakes an annual 'pulse check', which was conducted in February 2016, six months after the national staff survey. This year's pulse check found continued improvement in all aspects of staff engagements, staff recommending the Trust as a place to work and a place to receive care.

Safe staffing

All hospitals in England are still required to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

CHS continues to display daily nurse staffing levels on each ward on a daily basis for each shift and the Trust continues to monitor staffing levels on a daily basis, ensuring that this includes the care needs of patients on that day. This enables us to escalate areas where additional resources may be needed and respond quickly. A comprehensive report on safe staffing is produced for the board every six months.

The graph below shows the average fill rate for registered nurses across the in-patient wards and is an assimilation of day and night shifts. CHS remains comparable with our peers. The reduction in January 2016 is due to the opening of escalation wards in response to higher admission rates across the winter months.



Recruitment and retention

Nurse recruitment remains one of the key challenges facing the Trust. Croydon Health Services is not alone in facing this challenge and the nurse recruitment situation across London is formally acknowledged. A recent survey by the Royal College of Nursing (RCN) shows that across London the average vacancy rate for qualified nurses is 17%.

The CHS vacancy rate Key Performance Indicator (KPI) that the Trust works to is 11.5%, and the Trust is currently reporting a vacancy factor in nursing of 19.62% which equates to 264 WTEs across all qualified nursing grades. However, to put these figures in perspective it should be noted that the Trust now employs 150 more nurses than it did in 2012/13.

In recognition of this challenge, the Trust has created a role of Workforce Matron who will work with their peers and Human Resource specialists to develop new and innovative approaches to nurse recruitment .

The Trust's recruitment campaign, 'Could You Be A Croydon Nurse', is continuing by utilising concerted recruitment drives at graduate nursing recruitment fairs alongside a distinctive visual, online and social media presence. Consideration is currently being given to extending recruitment into non EU countries.

Croydon Stars: Annual Staff Awards

Recognition of outstanding service and commitment by our staff is an important part of ensuring that our workforce understand that their work is valued. The Croydon Stars scheme is open year-round, with patients, carers and colleagues able to nominate staff for outstanding conduct across four categories: Amazing Achievement, Incredible Customer Service, Tremendous Teamwork and Landmark Leadership. Each person or team then receives a personal acknowledgement from our Chief Executive and their nomination is put on a long list for our annual awards night.

The Croydon Stars awards take place in late spring every year, where nominations from the previous 12 months are shortlisted and then reviewed by a panel of staff, where winners from each category are selected. The shortlist nominees are all invited to and acknowledged at the awards dinner, with the winners receiving certificates presented by the Chairman of the Trust. As well as those nominated for awards, the Croydon Stars event also provides the opportunity for the Trust to publicly thank members of staff who have a history of long service to the organisation, in some cases going back more than 40 years.



Ensuring equality

The Trust is in the process of developing our Equality, Diversity & Inclusion (EDI) Strategy to meet the requirements of the Equality Act 2010, and standards set out by NHS England. The Strategy sets out our priorities for delivering the equality and inclusion agenda over the next few years.

Our aim is to ensure that the diverse needs of our patients, communities, service users and staff are met, and that we improve their experience when using our services. We are committed to working with our partners and stakeholders to tackle health inequality in Croydon. We also want to ensure that our staff have a positive experience and view Croydon Health Services NHS Trust as an attractive place to work.

Our Equality, Diversity & Inclusion Strategy permits us to embed the principles of equality, diversity and inclusion at the heart of the services that we provide. It will also allow us to link the overall principles into our key strategies, policies, patient and staff engagement, and in our employment practices. In our attempt to improve engagement we will be developing management and staff working groups to monitor the delivery of the Strategy.

Croydon is a very diverse borough and improving patient and staff experience is extremely important to us. We acknowledge that this also presents a number of challenges for the Trust and our partners. Our overall aim is to ensure that the Delivery Plan contains robust actions to deliver the Strategy over the next two years, and contributes to addressing inequalities.

Freedom to Speak Up/Whistleblowing

All of our staff should feel able to raise concerns if they have them, and know that they will be listened to and supported. This is crucial if we are to continue improving how well we look after our patients and staff, and for people to have confidence in their local NHS services. We have – and always will – take all concerns about patient safety extremely seriously as well as any allegations of bullying or a lack of support for our employees.

Every NHS trust and NHS foundation trust will be required to have appointed a Freedom to Speak Up Guardian during the coming financial year (2016/17). Trusts are expected to have plans in place by September 2016, based on local needs and how confident staff already are about raising concerns and speaking up.

Trade Union engagement

The Trust welcomes the continued commitment of recognised trade unions to working in partnership to ensure that our common objectives are achieved. During the national NHS industrial action that took place in October and November 2014, this partnership approach worked well to ensure that patient safety was not compromised. The Trust and the unions recognise their responsibility to encourage all staff to make use of appropriate channels to ensure active communications throughout the organisation.

Managers and trade union representatives recognise their interdependence and agree that matters affecting their interests shall be considered jointly, both by consultation and negotiation through the Joint Staff Consultative Committee (JSSC), which acts as the overarching body of the organisation and is concerned with all employee relations issues.

In addition to the JSSC a Trust-wide Medical and Dental Negotiating Group (LNC) also exists. The LNC covers only those matters which are matters exclusive to Medical and Dental (M&D) employees and the JSSC deals with other employment matters which cover all staff such as general HR policies and procedures.

Emergency Planning and Business Continuity

Emergency Preparedness Resilience Response (EPRR) plans and preparation

Croydon Health Services now employs a full time EPRR Manager who oversees the EPRR remit as laid down by the EPRR Core Standards 2015 and the Civil Contingencies Act 2004. Our last assessment for Core Standards from NHS England (London) in November 2015 gave us a full Green Rating on all standards.

All plans are reviewed and updated in line with new legislation as well as being reviewed annually for updates within Croydon Health Services NHS Trust; Business Continuity Planning also remains a priority within the Trust as laid down in legislation with yearly planning within all directorates.

The Trust participated in a successful EMERGO exercise, funded by Public Health England, in September 2015 which tested multiple teams within the trust with regards to Major Incident Response.

There was also bespoke planning and exercising within the critical care unit which was successful and will link into planning and exercising within our other high level patient care areas in 2016/17

Responding to incidents and issues

The Trust declared a Major Incident on the 3rd March 2016 due to a burst water main on site. A Major Incident Team was assembled to ensure that services would continue as fully as possible; while we were able to assess and treat all ‘walk-in’ patients to our Emergency Department, we received an ambulance divert from NHS England as we could not safely receive ambulance patients into the Emergency Department during this time. The Major Incident was stood down after approximately 4 hours with a resolution of the situation which was delivered by our Estates Team.

The Trust also effectively managed a Whooping Cough outbreak in 2015. Multiple teams worked together to ensure that patients and staff were effectively treated, protected and communicated with, in conjunction with continual communication with NHS England (London) and Public Health England.

The Industrial Action has also tested our Business Continuity Planning and response again from multiple teams both clinical and managerial in the planning and response which has been a multi-layered team response on all occasions.

Managing our Estate

Major improvements

2015/16 saw the Trust embark on a £21.25m capital investment in a new and expanded Emergency Department. The Department has been temporarily relocated whilst the construction of the new Department takes place and is looking to move back into the new facility in spring 2017.

In addition this year the Trust undertook a number of other major capital improvement programmes to enhance our estate and deliver a better clinical working environment for our patients, visitors and staff. The projects delivered by our Estates and Facilities team include:

- The creation of the £750k acute assessment, ambulatory and geriatric care Edgecombe Unit in London Wing
- A new Lifeblood Suite for cancer patients
- Refurbishment and upgrade of the Hydrotherapy pool
- New theatre lighting in the Obstetrics theatres

In addition the Trust has continued its investment in replacing engineering services and reducing its backlog maintenance with a further investment of over £1m in Pharmacy, Mayday House, Maternity and the Fanthorpe Building.

2015/16 also saw the Trust continue to improve its asset utilisation and to rationalise its estate with a consolidation of services on the Purley War Memorial Hospital site and the closure of Purley Clinic which has offered up savings for investment in front line services.

The Procurement and EBME teams have also delivered £1.8m of investment into new medical equipment to help our staff to deliver high quality clinical care. Major items of investment in new equipment purchased this year include:

- Investment of £460K into Theatres equipment including stack systems, rigid scopes, anaesthetic machines and monitors for Main Theatres.
- Investment of £376K into the expansion for new procedures within the Endoscopy Unit.

- Replacement of mobile Image Intensifiers and X-ray C-arms for use within the Theatres at a cost of £140K.

The spring of 2016 saw the Trust embark on three further major capital projects in the relocation of the Trust Child Development Centre from the Crystal Centre to the Tollgate school site, the development of a new Dental Department as well as the final phase of the Cardiac Business case in the Cardiac Outpatients Department. All three schemes will be open to patients in the autumn of 2016.

Sustainability Report (highlights)

As an NHS organisation and as a spender of public funds, we have an obligation to reduce our environmental impact. This approach reduces the Trust's impact on the environment and saves money as fewer resources are consumed. Sustainability has become increasingly important as the impact of people's lifestyles and business choices are changing the world in which we live. We acknowledge our responsibility to becoming more sustainable to the environment by working hard to minimise our carbon footprint.

In 2014/15 the Trust installed two Combined Heat and Power (CHP) engines onto its site. This significantly changed the proportions of gas and electricity used by the Trust as the CHP engines generated 71.7% of the electricity requirements in 2015/16 using natural gas, vastly reducing imported electricity. This year the Trust's total spend on energy was £1,664,692, a reduction of nearly £400,000 compared to 2014/15.

By working on reducing leakages, the Trust has also reduced its overall consumption of water by 16%, from 158,607 m³ in 2014/15 to 132,279 m³ in 2015/16. The full sustainability report can be found in Appendix B of this document.

Developing our ICT systems

2015/16 was a year of consolidation for Trust IT. Following the huge achievement of installing Cerner Millennium in late 2013, the staff within the Trust continued to become adept with the new system and exploit the efficiencies that it allows. The Trust is now in an excellent position to use this technology platform to make further improvements during the coming year.

As part of the Cerner Phase 2 initiative, the IT Team implemented Nursing care plans, Maternity, Surginet and Critical care. We also replaced the aging picture archiving and communication system (PACS), used to access x-ray and other diagnostic images, with a new hardware and software solution. The Trust is now in an excellent position to use this technology platform to make further improvements during the coming year.

A new Experience Centre has been developed, with much improved IT training facilities. This will be used to help staff improve their Cerner skills as we adopt new functionality and modules that will improve our patient care.

Looking ahead to 2016/17, the IT Team will focus on a series of infrastructure upgrades, a refresh of PC operating systems, and an increased emphasis on IT use in Community settings – notably the introduction of a new health record system to replace ePEX and the

development of mobile working technologies.

Financial Review

2015/16 Financial Performance and Progress

The table below sets out Croydon Health Services NHS Trust's Financial Targets, and its performance against these, in the 2015/16 Financial Year:

Target	Performance	Target met?
Breakeven on revenue and operating costs	The Trust has a deficit of £32.4m (£34.5m after technical adjustments). The Trust has returned three successive deficits and has therefore failed the breakeven duty.	No
Keep within the capital resource limit (CRL) of £12.819m	The Trust remained within the CRL, and generated an underspend of £0.075m	Yes
Remain within the external financing limits (EFL) of £34,862	The Trust remained within its EFL, and over achieved on this by £0.465m	Yes
Keep within a Capital Cost Absorption Rate (CCAR) of 3.5%	The Trust kept within the 3.5% CCAR. This has resulted in dividend payments of £5,486m to the Department of Health.	Yes

Where our money comes from

Trust income has increased by £5.0m between 2014/15 and 2015/16 and the total income received by the Trust during the year was £255m, of which: £238m was income for clinical services (from both other NHS and non-NHS), and £17m related to income for non-patient care services such as training and education.

Our income is classified as follows:

£226.8m (89%) – NHS Clinical Income

£9.6m (4%) – Education, training and research

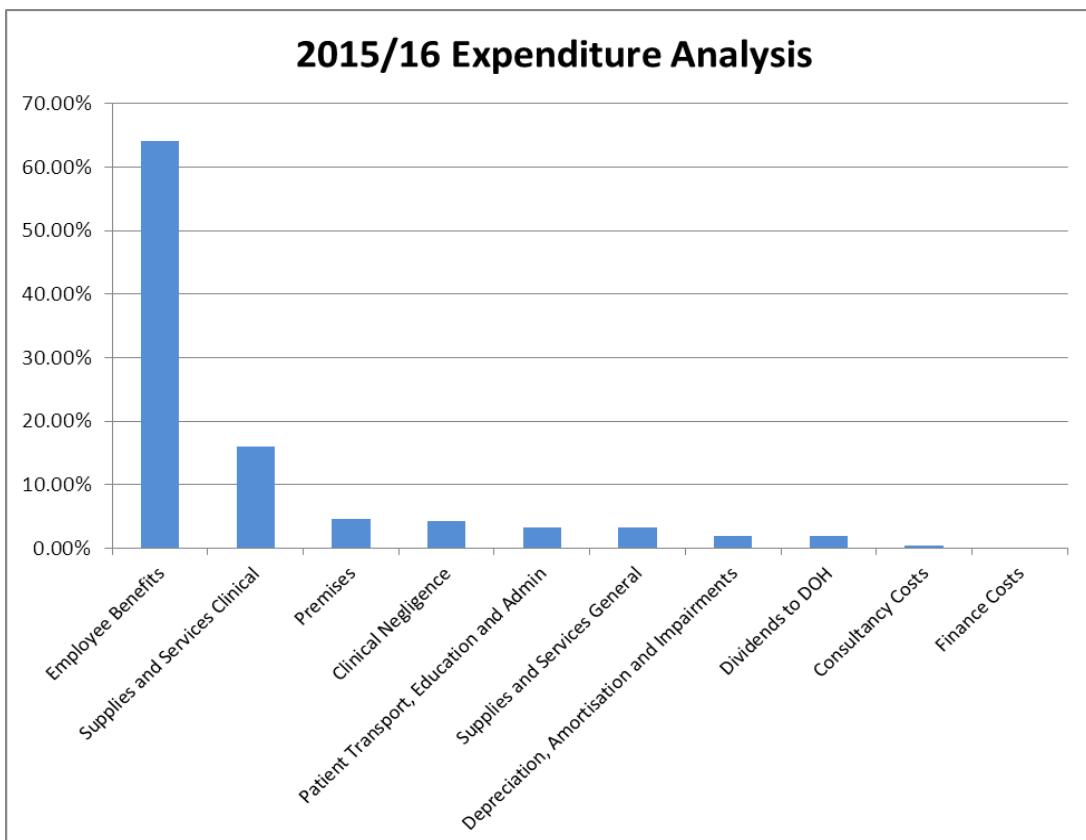
£2.4m (1%) – Non-patient care services
£11m (4%) – Non NHS Clinical Income
£5.3m (2%) – Other

What we spent our money on

The Trust spent was £287.8m during the financial year, an increase of £14.2m from the previous financial year. The largest spend was on staffing at £184.2m.

The Trust also spent:

£46.1m on supplies and services in relation to direct patient care
£9.5m on patient transport, education and training and administrative costs
£1.2m on consultancy costs
£12.2m to the NHS Litigation Authority
£9.7m on other supplies and services
£13.2m on premises, which includes IT costs
£5.5m on dividends to the Department of Health; and finally, £5.7m on depreciation and impairment reversals of our capital assets
£0.4m of interest costs on loan finance from DOH



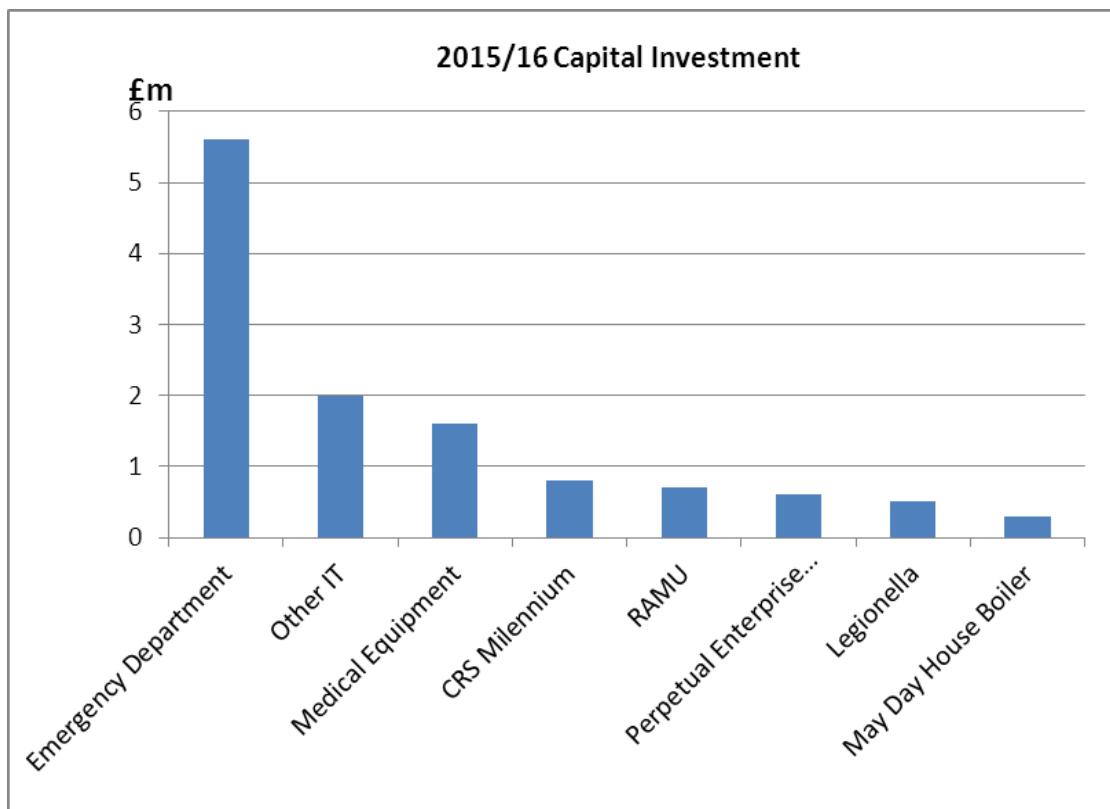
Getting best value for money

The Trust has made £8.8m of efficiency savings during the 2015/16 financial year, which equates to 3% saving against actual turnover. These savings have been reinvested in patient care.

Capital investment

During the 2015/16 the Trust invested £12.744m in capital schemes against a CRL of £12.819m. Major Trust schemes included:

- Emergency Department Redevelopment project, £5.6m
- Edgecombe Unit, £0.7m
- CRS Millennium re-procurement and CRS Millennium Phase 2 patient care system, £0.8m
- Perpetual Enterprise Agreement Software Licences, £0.6m
- Legionella-avoidant Pipe Replacements, £0.5m
- Mayday House Boilers, £0.3m
- Medical equipment, £1.6m and other IT, £2m



The capital programme for 2016/17 continues with the on-going investment in patient care and wellbeing, with substantial budgets set aside for:

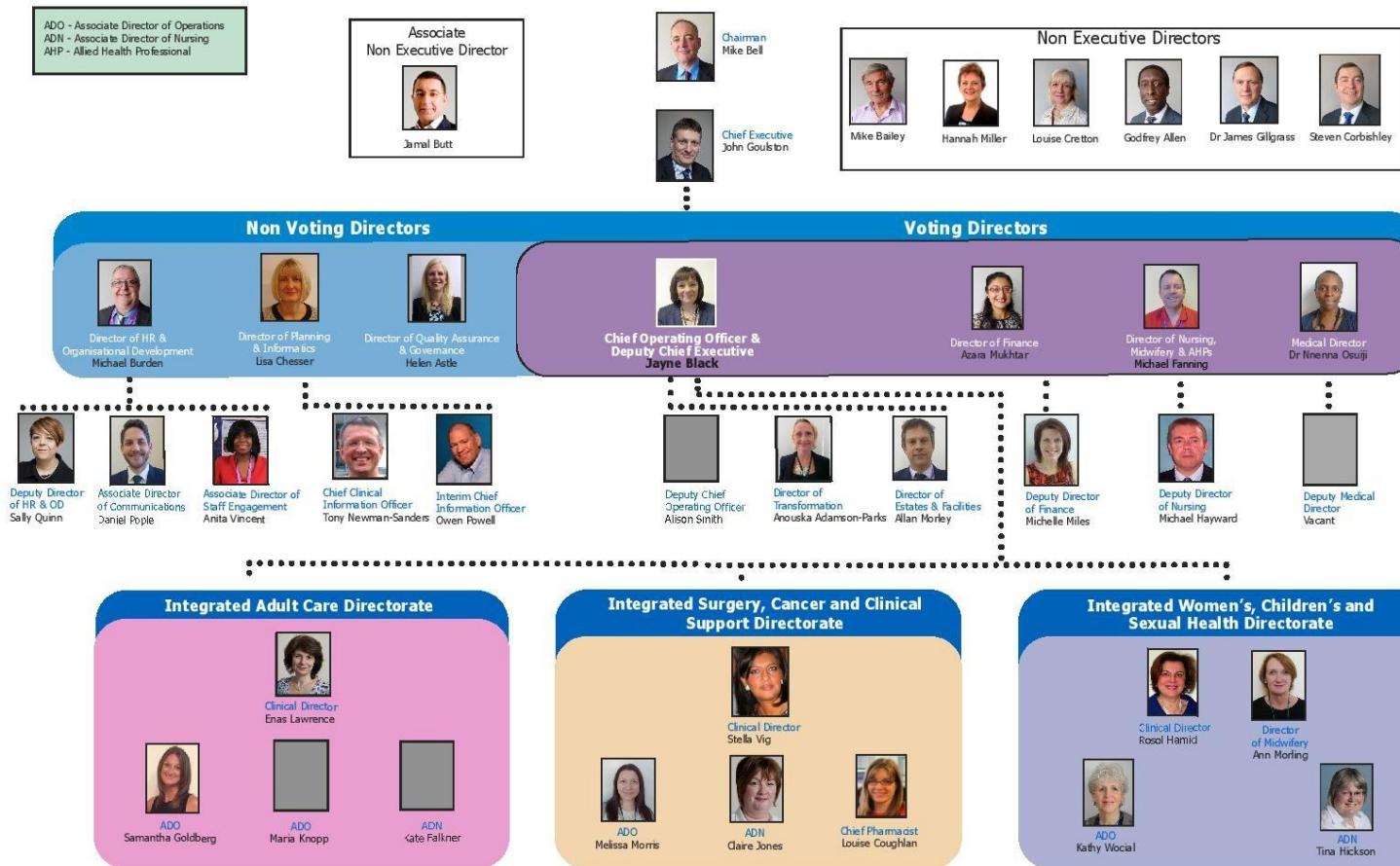
- The refurbishment of the Croydon Heart Centre and Dental Unit was delayed in 2015/16; both of the contracts awarded late in March 2016. The projects will commence in late April 2016 and are expected to be completed by March 2017.
- The on-going refurbishment of the Emergency Department which is expected to be completed by Spring 2017/18.
- The redevelopment of the Tollgate School which will house the Child Development Centre which is earmarked for completion in August 2016.

Trust Board

Board structure (as of 31 March 2016)

Managing Croydon Health Services

Croydon Health Services 
NHS Trust



Updated 31 March 2016

Attendance at Public Board Meetings

Name	Designation	From	To	2015/16 Board Attendance
John Goulston	Chief Executive	1-Mar-13	Present	6 of 6
Azara Mukhtar	Director of Finance	18-Mar-13 (seconded until 31-Jul 13)	Present	6 of 6
Steve Ebbs	Medical Director	10-Sep-13	1-Sep-15	3 of 3
Nnenna Osuji	Medical Director	01-Sep-15	Present	2 of 3
Michael Fanning	Director of Nursing & Allied Health	08-Dec-14	Present	6 of 6
Jayne Black	Chief Operating Officer and Deputy Chief	01-Nov-14	Present	5 of 6

Non-Voting Executive Directors

Name	Designation	From	To	2015/16 Board Attendance
Michael Burden	Director of HR & OD	01-May-13	Present	6 of 6
Lisa Chesser	Director of Planning & Informatics	01-Apr-14 (seconded until 28-Feb-2015)	Present	3 of 6
Helen Astle	Director of Quality Assurance & Governance	07-Sep-15	Present	3 of 3

Non-Executive Directors

Name	Designation	From	To	2015/16 Board Attendance
Michael Bell	Chairman	02-Jan-13	Present	6 of 6
Steven Corbishley	Non-Executive Director and Chair of Audit Committee	01-Apr-13	Present	5 of 6
John Thompson	Non-Executive Director and Chair of Finance & Performance Committee	14-Jan-13	15-Jul-15	1 of 2
Godfrey Allen	Non-Executive Director and Chair of Quality & Clinical Governance	14-Jan-13	Present	6 of 6
Dr James Gillgrass	Non-Executive Director	01-Jan-14	Present	4 of 6
Louise Cretton	Non-Executive Director	01-Jan-14	Present	6 of 6
Mike Bailey	Non-Executive Director	01-Jul-14	Present	5 of 6
Hannah Miller	Non-Executive Director	01-Oct-15	Present	2 of 3
Jamal Butt	Associate Non- Executive Director	01-Apr-13	Present	5 of 6

Committee Structure

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

- The Audit Committee exists to oversee the establishment and maintenance of an effective system on internal control throughout the organisation. It ensures there are effective internal audit arrangements in place to meet mandatory NHS internal audit Standards and provides independent assurance to the Board. The Committee reviews the work and findings of External Audit and provides a conduit through which their findings can be considered by the Board. it also receives the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) at every meeting.

It also reviews the Trust's Annual Statutory Accounts before they are presented to the Trust Board, ensuring that the significance of figures, notes and important changes are understood. The committee maintains oversight of the Trust's Counter Fraud arrangements.

- The Finance & Performance Committee's main responsibilities are to review the Trust's financial and operational performance against annual plans and budgets and to provide overview of the Trust's medium and long-term financial models. It also reviews in-year delivery of annual efficiency savings programmes and monitors the effectiveness of the trust's financial and operational performance reporting systems.
- The Quality and Clinical Governance Committee is responsible for providing the Board with assurance on all aspects on the quality of all aspects of clinical care. The committee oversees the Trust's on-going compliance with the Care Quality Commissions' recommendations following its hospital inspection in September 2013.
- The Remuneration Committee is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for the termination of contracts. The committee ensures that appropriate performance management arrangements are in place for Executive Directors and work with the chief executive to relate performance judgements to pay.

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

Membership of the Audit Committee

The membership of the Trust's Audit Committee for 2015/16 was the following non-executive directors:

- Steven Corbishley – Chair
- Louise Cretton
- Godfrey Allen
- John Thompson (stepped down as Non-Executive Director on 15 July 2015)

Directors' interests

Name	Interest Declared
Godfrey Allen Non-Executive Director	None
Helen Astle Director of Quality Assurance & Governance	<ul style="list-style-type: none"> • Director of Perceptika Ltd • Associate of Capsticks Solicitors Governance Consultancy • Principal Consultant (Governance & Assurance) – NHS South, Central and West Commissioning Support Unit
Dr Mike Bailey Associate Non-Executive Director	<ul style="list-style-type: none"> • Partner in Clock House Medical Practice, Epsom Surrey.
Michael Bell Chairman	<ul style="list-style-type: none"> • Director of MBARC Limited – a research and consultancy company working with a range of public sector bodies including central and local government and various NHS Organisations. MBARC are also currently managing a number of project funded by pharmaceutical companies including Bayer MSD and ViiV Healthcare.
Jayne Black Chief Operating Officer/Deputy Chief Executive Officer	None
Michael Burden Director of Human Resources	<ul style="list-style-type: none"> • Member of the NHS Pension Scheme Advisory Board
Jamal Butt Associate Non-Executive Director	<ul style="list-style-type: none"> • Head of Business Development at Celesio UK
Lisa Chesser Interim Director of Planning & Information	None
Steve Corbishley Non-Executive Director	None
Louise Cretton Non-Executive	None

Director	
Michael Fanning Director of Nursing Midwifery & Allied Health Professionals	<ul style="list-style-type: none"> • Director Michael Fanning Consulting Limited
Dr James Gillgrass Non-Executive Director	<ul style="list-style-type: none"> • Trustee of the Post Graduate Medical Centre, Croydon University Hospital; • Daughter (Emma Gillgrass) is a locality manager at the Wandsworth Clinical Commissioning Group • Member Croydon Opportunity and Fairness Commission. • Member of the Care Committee of the Whitgift Foundation.
John Goulston Chief Executive Officer	<ul style="list-style-type: none"> • Member of the Croydon Health & Well Being Board – 1/4/2015 to present • Member of the Croydon Local Strategic Partnership (LSP) Board and the LSP Chief Executives Group - June 2012 to present. • Member of the Health Innovation Network Board (formerly known as the Academic Health Science Network, South London) – October 2013 to present. • Member of the London Cancer Alliance, Members Board - April 2013 to 31 March 2016. Members of the Royal Marsden Partners' Vanguard Board from 1 April 2016 • Member of the South West London Pathology Partnership Board from 1 April 2014. • Chair of the London Procurement Programme Steering Group from 1 April 2015 • Chair of the Croydon Accountable Care Alliance from August 2015
Hannah Miller Non-Executive Director	<ul style="list-style-type: none"> • Director Hannah Miller Limited • Associate Atlantic Customer Solutions Limited • Senior Associate Social Care Institute for Excellence • Independent Chair Hounslow Adult Safeguarding Board • Trustee Croydon community Against Trafficking (unpaid) • Commissioner Croydon Opportunity and Fairness Commission (unpaid)
Azara Mukhtar Director of Finance	<ul style="list-style-type: none"> • Croydon Health Services NHS Trust Board Member of South West London Pathology Partnership Board.
Dr Nnenna Osuji Medical Director	None

Disclosure of personal data related incidents to the Information Commissioner's Office

The Trust has disclosed four separate personal data related incidents to the Information Commissioner's Office this year.

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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.

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.



John Goulston
Chief Executive
Date: 31 May 2016

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 the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, 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.

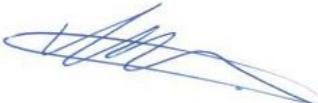
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They 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.

By order of the Board



John Goulston
Chief Executive
Date: 31 May 2016



Azara Mukhtar
Finance Director
Date: 31 May 2016

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

We have audited the financial statements of Croydon Health Services NHS Trust (the Trust) for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the Act). The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- the table of exit packages and related narrative notes;
- the analysis of staff numbers and related narrative notes; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Directors of Croydon Health Services NHS Trust, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes: an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual

Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Croydon Health Services NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for adverse value for money conclusion

Our review of the Trust's arrangements identified a number of matters:

- The Trust delivered a deficit after technical adjustments of £34,500,000 in 2015/16, which was significantly higher than the Trust's original budget forecast of a deficit of £22,500,000.
- In addition, the Trust's financial plan for 2016/17 shows a further substantial deterioration, with a forecast deficit of £39,800,000 as at 18 May 2016. This forecast is dependent on delivery of savings of £20,000,000, of which only £1,000,000 had fully developed implementation plans in place at the end of April. This forecast is also subject to an additional income risk in excess of £5,000,000.
- The Trust has not agreed a medium term financial plan beyond 31 March 2017.

These reflect weaknesses in the Trust's processes for identifying sustainable ways of delivering services in the medium and long term, in line with the Trust's strategic priorities, and managing delivery of its savings plans.

These issues are also evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management, and in managing risks effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

- The Care Quality Commission (CQC) inspected the Trust in June 2015 and, in September 2015, reported that the Trust "requires improvement. In line with its strategic plan, the Trust has not yet completed all the work required to address the issues raised by CQC and has not yet been subject to a further inspection by CQC.

This reflects weaknesses in the Trust's arrangements for clinical governance and risk management in the surgical directorate, ensuring that theatres and medical equipment are adequately maintained, and ensuring that all staff receive appropriate levels of training.

This issue is also evidence of weaknesses in proper arrangements for acting in the public interest through demonstrating and applying the principles and values of sound governance and planning, organising and developing the workforce effectively to deliver the Trust's strategic priorities.

Adverse value for money conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, because of the significance of the matters described in the basis for adverse value for money conclusion paragraph, we are not satisfied that, in all significant respects, Croydon Health Services NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the following matters where we are required to report by exception if:

- in our opinion the governance statement does not comply with guidance issued by the NHS Trust Development Authority; or
- we refer a matter to the Secretary of State under section 30 of the Act 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 Act; or
- we make a written recommendation to the Trust under section 24 of the Act.

Certificate

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

Paul Grady
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP
01 June 2016

2015/16 Annual Governance Statement

1. Scope of Responsibility

The Trust Board is collectively accountable for governance at Croydon Health Services NHS Trust. As the Trust's Accountable Officer and Chief Executive, I have responsibility for maintaining a sound system of governance and internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible as set out in the Accountable Officer Memorandum. The Executive Team is collectively responsible for maintaining the systems of internal control and directors are accountable to me for ensuring effective governance arrangements in their individual areas of responsibilities. These areas of responsibility are detailed in the Trust's Scheme of Delegation.

1.1 Accountability

In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the Chairman on behalf of the Trust. The Trust reports formally to the Trust Development Authority reporting routinely on financial, operational, strategic and quality matters.

1.2 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; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Croydon Health Services; 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 Croydon Health Services NHS Trust for the year ended the 31st March 2016 and up to the date of approval of the Annual Report and Accounts.

2. The Governance Framework of the Organisation

2.1 Board Committee Structure

The Trust Board

The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and is accountable through its Chairman to the TDA and the Secretary of State for Health. The role of the Board is largely supervisory and strategic and it also has the following key functions:

- Formulating and agreeing the Trust's strategy to deliver safe, high quality, patient-centred care.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.

- Shaping culture and establishing the values of the Trust and promoting these in the way that the Board does business and interacts with the rest of the organisation and external stakeholders.

The Director of Quality Assurance and Governance, who was appointed in September 2015, is also the Trust Board Secretary and provides senior leadership in corporate governance. The Board approves an annual schedule of business in the form of a Trust Board Forward Plan which identifies the key reports to be presented each month and quarter. Exception reports to the Board ensure that the Board considers the key issues and makes the most effective use of its time.

The Trust Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions were updated in June 2015 and outline the accountability arrangements and the scope of responsibility of the Board of Directors, Executive Directors. The Board has been fully involved in agreeing the strategic priorities of the Trust.

The Board receives regular minutes and reports from each of the nominated committees that report into it and it has received an annual report from each of its Committees.

The Trust Board met in public on 6 occasions in 2015/16 and was noted to be quorate at all the meetings. The papers are published on the Trust website. The Trust held its Annual General Meeting on 9th September 2015.

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

- The **Audit Committee** exists to oversee the establishment and maintenance of an effective system on internal control throughout the organisation. It ensures there are effective internal audit arrangements in place to meet mandatory NHS internal audit Standards and provides independent assurance to the Board. The Committee reviews the work and findings of External Audit and provides a conduit through which their findings can be considered by the Board. It also receives the Board Assurance Framework and the Corporate Risk Register at every meeting.

It also reviews the Trust's Annual Statutory Accounts before they are presented to the Trust Board, ensuring that the significance of figures, notes and important changes are understood. The Committee maintains oversight of the Trust's Counter Fraud arrangements.

- The **Finance & Performance Committee**'s main responsibilities are to review the Trust's financial and operational performance against annual plans and budgets and to provide overview of the Trust's medium and long-term financial models. It also reviews in-year delivery of annual efficiency savings programmes and monitors the effectiveness of the trust's financial and operational performance reporting systems.

The **Quality and Clinical Governance Committee** is responsible for providing the Board with assurance on all aspects on the quality of all aspects of clinical care. The Committee oversees the Trust's on-going compliance with the Care Quality Commissions' recommendations following its hospital inspection in September 2013.

- The **Remuneration Committee** is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for the termination of contracts. The committee ensures that appropriate performance management arrangements are in place for Executive Directors and work with the chief executive to relate performance judgements to pay.

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

During 2015-16, the Committees met as follows:

Board Committees	No. Meetings	Quorate
Audit	7	Y
Remuneration	2	Y
Finance and Performance	11	Y
Quality and Clinical Governance	10	Y
Charitable Funds	4	Y

2.2 Board Performance and Effectiveness

The Trust Board met a total of 6 times in public in 2015/16 - April, June, July, October, December 2015 and February 2016. Attendance was monitored throughout the year and there were 7 authorised absences from Non-Executive Directors, 4 authorised absences from the Executive Directors.

In order to assess its own effectiveness, the Trust undertook a Well Led Board self-assessment and received the final report in May 2015. Croydon Health Services was one of four NHS Trusts to self-assess itself against the NHS Trust Development Authority's pilot on the Well Led Board Framework. Activities carried out by the NHS TDA (April- May 2015) included:

- Review of responses to the Board Survey and the Trust's Pulse Check Staff survey;
- Review of the Trusts Self-Assessment against the Well led Framework, including documents and evidence provided by the Trust;
- Observations of the Trust Board (Parts 1 and 2) and its Committees (Audit Committee, Finance and Performance Committee, Integrated Board and Quality & Clinical Governance Committee);
- Board members interviews;
- Staff Focus Groups; and
- Stakeholder interviews with Croydon CCG, the London Borough of Croydon and the health and Overview and scrutiny Committee.

Following this, the TDA has provided the Trust with additional guidance to further develop its governance and leadership. An action plan was drawn up following the receipt of the report to address the recommendations.

A significant amount of work has been undertaken throughout 2015/16 to progress the recommendations identified from the Well Led report and a highlight of these is included below.

- Director of Quality Assurance & Governance was appointed in September 2015 with responsibility for both clinical and corporate governance to provide leadership at Board level.
- The Trust's Audit Committee approved the separation of the Corporate Risk Register and Board Assurance Framework into two separate documents. The Board Assurance Framework has been significantly revised to provide additional assurance to the Trust Board that the risks to the strategic objectives are being managed.
- The Risk Management Strategy has been revised and a Risk Management Framework has been developed.
- Board/Committee Forward Plans have been developed and action trackers are in place for all Board, Board sub committees and Executive Management Board meetings.
- A Governance review of committees was undertaken and the introduction of weekly Executive Management Boards meetings to provide additional scrutiny of Trust Board papers prior to presentation at the Trust Board.
- Annual reports for each Board sub-committee have been produced and were presented to Trust Board.
- Board development days undertaken to further develop strategic planning.
- A series of Board development days focusing on Board leadership and effectiveness has been undertaken. A Board Development Away has also been undertaken.

The Board's Register of Interests was maintained during 2015/16 and is included as a standing agenda item at each Trust Board meeting. In February 2016, the Trust's Interests, Gifts and Hospitality Policy was updated and ratified.

The Chairs of each of the committees routinely present verbal reports to the Board. Approved minutes of each Committee meeting are also presented at the Public Trust Board meetings. In addition, the Quality and Clinical Governance Committee, the Finance and Performance Committee and the Audit Committee presented their annual reports to the Trust Board covering their 2015-16 activities highlighting key issues and decisions at their meetings.

Fit and Proper Person

In order to meet the requirements of the Fit and Proper Persons requirements, the Trust is required to provide evidence that appropriate systems and processes are in place to ensure that directors are, and continue to be, fit and that no appointments meet any of the unfitness criteria set out in schedule 4 of the 2014 Regulations. Declarations are received annually by the Director of Human Resources and Workforce Development ensuring that individuals meet the requirements of the regulation.

2.3 Highlights of the Board Committee Reports

Each Committee of the Board concluded that they had effectively discharged their responsibilities throughout 2015-16 and that there was nothing they were aware of that had not been disclosed appropriately. In particular:

Quality and Clinical Governance Committee

The Quality and Clinical Governance Committee reviewed and updated its terms of reference, and considered annual reports and standing items at each monthly meeting. These included key issues from complaints, infection control and the Friends and Family test. Each month a clinical directorate presented their quality report and every two months the committee received the Trust wide quality report which presented information set out under the CQC 5

quality domains. The Committee receives regular reports on CQC regulatory requirements, the Quality Strategy, management of incidents, including duty of candour and clinical audit.

Audit Committee

The Audit Committee undertook a full programme of work and organised its meetings and agendas so as to be able to discharge its responsibilities throughout the year as set out in the Audit Committee Handbook. It reviewed and updated its terms of reference. The Committee received progress reports from internal and external audit, the draft Annual Accounts, the Annual Report, the Annual Governance Statement and the draft Quality Accounts. At each meeting, the Committee received reports on the Corporate Risk Register and the Board Assurance Framework and progress against internal audit recommendations. A number of 'deep dives' into key issues and risks were received as well as progress reports from Counter Fraud and Finance. The Chairs of the Finance & Performance and the Quality & Clinical Governance committees are members of the Audit Committee.

Finance and Performance Committee

The Committee reviewed and updated its terms of reference. In both the areas of Finance and Performance, effort was given to presenting data in a way that made information understandable, useable and relevant to the Trust strategy and the requirements of interested stakeholders. Careful monitoring of Trust performance continued on the A&E standard, Referral to Treatment and cancer waits as well as monthly reports received from the Financial Recovery Board. In addition the Committee received regular reports on the Emergency Department rebuild, the Emergency Care Recovery programme and the development of the operation plan for 2016/17.

2.4 Quality Governance

Quality Account

The Trust is required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended) to prepare the Quality Account for each financial year. The formulation of the Quality Account has been led by the Head of Patient Safety and Risk on behalf of the Director of Quality Assurance and Governance to meet all relevant Department of Health requirements. It provides a 'look-back' against identified priorities and overall progress and improving quality (safety, effectiveness and experience). It also provides a look forward to future priorities. The account also includes a section on mandated topics, for example clinical audits and reports against the achievement of national standards. The progress of preparation and finalisation of the Quality Account is monitored monthly by the Quality & Clinical Governance Committee.

2.5 CQC Regulatory Requirements

Croydon Health Services received an inspection from the Care Quality Commission in June 2015 and was awarded an overall 'requires improvement' rating. The CQC acknowledged that the Trust had made significant improvements since the previous inspection in September 2013.

Care Quality Commission rating of Croydon Health Services NHS Trust
Last rated 7th October 2015

Overall Trust rating	Requires Improvement
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Croydon University Hospital

Are services	
Safe?	Requires Improvement
Effective?	Good
Caring?	Good
Responsive?	Requires Improvement
Well led?	Requires Improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Requires improvement	Good	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Intensive/critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity & gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement

Community services

Are services	
Safe?	Requires Improvement
Effective?	Requires Improvement
Caring?	Requires Improvement
Responsive?	Requires Improvement
Well led?	Requires Improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Community adults	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community children & young people	Good	Requires improvement	Requires improvement	Good	Good	Requires improvement

The Quality, Experience & Safety Programme (QESP) was established in January 2015 by the Director of Nursing, Midwifery and AHPs. The primary aim of the programme was to build upon the previous CQC Inspection Quality Improvement Plan to improve the quality of patient care, patient safety and patient experience across the Trust and embed 'Best Practice' processes and procedures.

In order to achieve this, a schedule of weekly strategic and operational meetings were established to drive forward actions resulting from a range of initiatives such as the Matrons' Quality Rounds, Executive Walk Rounds and Mock Inspections.

Following the CQC announcement that they would be carrying out an inspection of the whole Trust (Acute and Community), 16 to 19th June 2015, the QESP's focus was expanded to encompass the preparations for the inspection, the inspection itself, the factual accuracy checks of the draft report and the Quality Summit. Following this the QESP has overseen the development of a comprehensive CQC Quality Improvement action plan to respond to each of the 4 'must do' actions outlined below and the 31 'should do' actions:

Must do

- Continue to improve and embed systems to monitor the quality and safety of care provided (Trust wide).
- Improve clinical governance and risk management in the surgical services (CUH).
- Implement promptly plans to refurbish theatres and to put in place an equipment replacement programme (CUH).
- Ensure that 90% of staff receive up-to-date safeguarding and mandatory training (CUH).

Each of the 'must do' and 'should do' actions have a designated Executive and Management Lead and comprehensive action plans have been developed. These action plans include the high level milestones, risks & mitigations, assurance required to evidence delivery and a project summary for audit purposes. The action plans are updated regularly and progress and exceptions are reported to the fortnightly QESP Delivery Group for action as required. The QESP reports monthly to the Quality & Oversight EMB, the Quality & Clinical Governance Committee and the Trust Board.

2.6 Quality Strategy

The Quality Strategy is an integral part of a dynamic healthcare organisation and leads quality improvement. It is through the delivery of the Quality Strategy that the Trust has developed programme of continuous improvement, innovation and the delivery of high quality care. The Quality Strategy 2015-18 was ratified by the Trust Board in December 2015 and sets out clearly defined quality goals under the 5 CQC domains and the aspirations in providing quality care throughout the organisation which are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

Throughout out 2015-16, the Quality Strategy has been monitored through the production of a bi-monthly Quality Report which includes national and local priorities. In addition, each Directorate provides a quarterly Quality Report which is presented to the Quality & Clinical Governance Committee.

The Trust Board continues to receive a monthly performance report which provides up to date information on key quality indicators set out under the 5 CQC domains.

2.7 Management of incidents – including duty of candour

Incident reporting

Following the publication of the Francis Report in February 2013, the Trust has been clear in its expectation that staff report near miss and unexpected adverse events using the Trust's web-based (Datix) incident reporting system.

Use of this reporting system enables the Trust to use its data by regularly interrogating the information recorded, carrying out investigations and trend analysis and interpreting outcomes in relation to patient experience and safety.

The Trust's Datix system is electronically linked to the National Reporting and Learning System (NRLS) and patient safety incidents are uploaded to this central reporting and analysis centre. Local investigation of all adverse events is supported within the Trust to ensure that appropriate challenge to existing practice is encouraged and good practice identified is rewarded. Periods of reflective practice in supervision and learning from investigations through regular learning events (known as clinical governance) are some of the ways in which learning is shared throughout the organisation.

During 2015-16, 6905 adverse events and near misses (4466 clinical incidents and 2439 non clinical) were reported by Trust staff using the Trust's reporting system; of which 124 were reported and investigated as serious incidents. Of the serious incidents reported 40 were de-escalated as following investigation the Trust identified that the incident no longer met the Serious incident criteria or were not attributable to CHS (pressure ulcers).

The Trust reported one Never Event in March 2016.

Major Incident

During this period the Trust reported one which related to an Estates Incident.

Serious incidents are investigated using root cause analysis (RCA) investigation techniques. Investigation panels are convened to bring together appropriate colleagues to complete the investigation including a colleague who has been trained in RCA techniques.

Serious incident final reports are also subject to an internal quality assurance programme, with sign off by an executive directors usually either the Medical Director or the Director of Nursing, Midwifery and Allied Health Professionals prior to being sent on to the Clinical Commissioning Group for external scrutiny of the report and appropriateness of the actions before final closure of the serious incident.

Duty of Candour

The Trust continues to demonstrate openness and honesty with patients and their families in line with the CQC Regulation 20 Duty of Candour statutory obligation.

As stipulated in the regulation, the Trust is committed to carrying out duty of candour Being Open stage 1 and 2 conversations with patients and families within a 10-day time frame.

The Trust appointed a family liaison officer in September 2015 to support the duty of candour process and to act as link person between patients and their families. A patient information leaflet is now accessible on the Trust's website in addition to the staff leaflet available on the Trust intranet explaining duty of candour process.

New starters continue to receive Duty of Candour training as part of their induction as well as additional master classes, if requested. During training Trust staff are fully briefed on the Trust's Duty of Candour obligation to ensure they receive the necessary information to assist them in delivering an open and honest service to patients and their families.

Compliance against Duty of Candour is monitored weekly at the Executive Review Meeting and reported in the Trust Quality Report and to Patient Safety and Mortality Committee.

2.8 Clinical Audit

Participation in national clinical audits and confidential enquiries has enabled the Trust to benchmark the quality of the services that we provide against other NHS Trusts, and hence highlight best practice in providing high quality patient care and drive continuous improvement across our services.

During 2015-16, 39 national clinical audits and three national confidential enquiries covered NHS services that Croydon Health Services NHS Trust provides.

2.9 Statutory Functions

Compliance with Equality and Diversity and Human rights legislation

The Trust has developed an Equality, Diversity & Inclusion Strategy, and Delivery Plan for 2016-2018. The Delivery Plan will ensure that the Trust has the appropriate actions in place to meet our obligations under the Equality Act 2010, in particular the Public Sector Equality Duty. In addition the Strategy sets out our commitment to Human Rights legislation. The Access to Equality & Diversity Committee is responsible for monitoring the Strategy and the Delivery Plan, and we are also in the process of setting up Staff Working Groups to support the Committee, and the work that will be carried out across the Trust.

Compliance with NHS Pension scheme

As an employer with staff entitled to membership of the NHS Pension scheme, the Trust has control measures in place to ensure all employer obligations contained within the Scheme regulations are complied with.

Compliance with climate change adaptation reporting to meet the requirements under the Climate Change Act 2008

The Trust continued to work towards its pledge of reducing carbon emissions by 30% from 2013/14 levels by 2019/20. Carbon emissions per employee have dropped by 16.4% from baseline levels. One of the main focus areas, energy emissions have dropped by 17.1% since the baseline year and by 5.3% from 2014/15 levels.

The Trust has robust carbon reduction plans in place in order to comply with the organisation's obligations under the Climate Change Act and the adaptation reporting requirements.

3 Risk Assessment

The Executive Director for Quality Assurance and Governance has executive responsibility for the system of risk management within the Trust. While the Director of Quality Assurance and Governance has a lead role in terms of reporting arrangements, all directors have responsibility

for the management of risk within their own area of direct management responsibility, and corporate and joint responsibility for the management of risk across the organisation.

Structures and systems are in place to support the delivery of risk management across the organisation. Trust Board Committees are in place to ensure effective governance. The Risk Assurance and Policy Group meets monthly to review the directorate risk registers with each clinical and corporate directorate presenting a deep dive into their risks every 6 months. The Risk Assurance and Policy Group is chaired by the Director of Quality Assurance and Governance.

The Corporate Risk Register is presented monthly to the Quality and Oversight Executive Management Board and Trust Board, and every 2 months to the Audit Committee. The Board Assurance Framework is presented 2 monthly to the Audit Committee and the Trust Board.

The Board Assurance Framework is closely linked to the Corporate Risk Register which reflects significant risks as both a corporate and directorate level.

3.1 Board Assurance Framework

At the beginning of 2015, the Trust moved from a combined Corporate Risk Register and Board Assurance Framework (CRAF) to a separate Board Assurance Framework (BAF) and a Corporate Risk Register (CRR).

The Trust identified its major strategic risks in 2015 which are monitored and managed through the Trust Board Assurance Framework. The Trust's principal risks and mechanisms to control the strategic risks are identified through the Board Assurance Framework and were updated in December 2015. These risks are reviewed and updated through the Trust's governance structure and are assessed for completeness of actions, review of control mechanisms and on-going assessment and review of scores.

3.2 The Trust's Principal Risks

Strategic objective	Principal Risk	Controls/Assurances
SO1 - To deliver high quality, integrated people centred services	<p>1. If the Trust does not ensure the correct systems and processes are in place to support nurse revalidation, this may have an impact on the number of nurses and midwives available to work as registered practitioners to provide consistent, safe, high quality care. (New)</p> <p>2. If the Trust does not address all the recommendations from the CQC Hospital Inspection (June 2015), this may impact negatively on the Trust's subsequent hospital inspection rating.</p> <p>3 If the Trust is unable to retain competent, capable staff and managers, this will have an impact on the Trust's ability to provide consistent, safe, high quality care. (Revised)</p>	<ul style="list-style-type: none">• Revalidation report presented to Quality & Oversight EMB, Quality & Clinical Governance Committee and Trust Board (Nov/Dec 2015)• Monthly progress reports to Nursing & Midwifery• Monthly QESP reports to the Quality & Oversight EMB and the Quality & Clinical Governance Committee 'Reasonable' assurance for the CQC internal audit in 2015 Positive CQC inspection report (June 2015)• Positive informal review with the CQC (February 2016)• Bi monthly Quality Report• Quarterly Directorate Reports to the Quality & Oversight EMB and Quality & Clinical Governance Committee• Weekly Nursing Resourcing meeting with matrons which reviews Core Skills Training (CST)• Monthly PDR reports to the directorates• Monthly Performance reports to the Finance & Performance Committee

		<ul style="list-style-type: none"> • Monthly Performance reports to the Trust Board • Know How We are Doing scorecards monitored by the senior nursing team to monitor quality performance indicators • Quality Report to Quality & Clinical Governance Committee and Trust Board to monitor quality and nurse staffing levels
	4. If current resources in the safeguarding team remain insufficient to ensure compliance with the Care Act, this may result in insufficient monthly and local reporting of vulnerable adults to the local authority and external agencies and result in a backlog of patients being at risk.(New)	<ul style="list-style-type: none"> • Annual Safeguarding Report to Quality & Clinical Governance Committee and Trust Board • Quarterly Assurance Framework Report to the CCG on the NHSE Assurance and Accountability Framework
SO2 - To ensure staff are able, empowered and responsible for the delivery of effective and compassionate care	5. If the Trust does not ensure that staff have an annual appraisal this potentially may have an effect on the development and competency of the workforce due to Core Skills Training (CST) not being updated and Continuous Personal and Professional Development (CPPD) not being allocated accordingly. (Revised)	<ul style="list-style-type: none"> • Monthly work reports to the Directorates, People & Organisational Development Committee, Finance & Performance Committee, Trust Board
	6. Inconsistency in the approach and style of management and leadership across the Trust that can have a negative impact on the workforce in terms of staff engagement and staff turnover. (Revised)	<ul style="list-style-type: none"> • Listening into Action annual PULSE checks • Staff FFT quarterly scores
SO3 - To achieve best performance standards	7. If the Trust does not meet the performance targets for the 4 hour waits the impact will be that patients are not referred to the Trust for treatment (New)	<ul style="list-style-type: none"> • Monthly Performance reports to the Quality & Oversight EMB, Finance and • Performance • Committee and Trust Board • Monthly reports to the TDA • Daily reports to the NHS TDA & NHS England
	8 If the Trust does not meet the performance targets for RTT the impact will be that patients are not referred to the Trust for treatment(New)	<ul style="list-style-type: none"> • Monthly Board performance Reports • Monthly reporting to the TDA/CCG • Backlog trajectory is on target to be achieved for patients waiting past 18 weeks
	9. If the Trust does not meet the performance targets for Cancer waits the impact will be that patients are not referred to the Trust for treatment (New)	<ul style="list-style-type: none"> • Weekly 100 day waits escalation report to the CEO • Monthly Board performance reports to Trust Board, EMB and directorate Quality Boards • Directorate quarterly Performance meeting with the Chief Operating Officer
SO4 - To secure value for money and ensure the financial sustainability of the Trust	10. If the Trust is unable to demonstrate financially and clinically sustainable plans, this may result in the organisation entering 'failure regime' or equivalent.	<ul style="list-style-type: none"> • Monthly finance meetings with the TDA to review in the detail the financial position • Monthly Finance reports to Finance Performance Committee and Trust • Weekly FRB meeting
	11. If the organisation does not have sufficient cash flow to meet operational requirements, and will need to apply for short term loans via the ITFF process	<ul style="list-style-type: none"> • Monthly meetings of the Working Capital Group • Daily reconciliations of cash receipts/invoices against forecast cash/flow anticipated receipts • Flags within accounts receivable system to ensure outstanding invoices are tracked against recovery actions • Meetings minuted, attended by managers and significant issues discussed and raised at Trust Board • Performance use of RAG indicators measures against internal KPIs/risk indicators • The TDA has provided a letter of support to state that from 3/6/15 it will make sufficient cash financing available to the organisation over the next 12 month period to enable the Trust to meet its current liabilities
	12. If the organisation does not deliver its annual operating plan then it will fail to deliver the TDA approved control total.	<ul style="list-style-type: none"> • Oversight Financial Recovery Board which alternates between income and expenditure with escalation from directorates and cross directorates work streams • FRB monthly escalation report to Finance & Performance Committee and Board • Internal and External Audit Reports • Annual report on financial control • Clinical Coding undertaking deep dives into areas flagged as risk areas • QIPP milestones tracked weekly by the PMO office reports

		<ul style="list-style-type: none"> presented to directorates and performance meetings Monthly financial performance reports to directorates which include positions on income, costs and QIPP position and forecasts Risks and mitigations to the control total reviewed each week alternating between income and expenditure at the Financial Recovery Board
	<p>13. The Trust currently has an annual ceiling for nursing agency spend (10%) as a percentage of total nursing staff spend. Overspend above the cap will impact on the Trust financially and on its reputation with the NHS Trust Development Authority (TDA). (New)</p>	<ul style="list-style-type: none"> TDA return, working within the ceiling Reports to Finance & Performance Committee and Finance Recovery Board
SO5 - To work with partners to improve the health and well-being of the people of Croydon	<p>14. If the Trust does not maintain effective relationships with external stakeholders it will not meet the needs of the population of Croydon.(Revised)</p>	<ul style="list-style-type: none"> Monthly Quality Report to Trust Board, Quality & Oversight EMB and Quality & Clinical Governance Committee, Report to the Monthly Clinical Quality Review Group Updates on APA to Trust Board

3.3 Compliance with Information Governance and Data Security

Information forms a key component of the current Government's Information Revolution for the NHS. This restates the NHS's intention to ensure effective decision making, inform and empower patients through the provision of accurate, accessible and coherent information.

Information Governance (IG) describes how information is handled in health and social care. The Health and Social Care Information Centre (HSCIC) Information Governance Toolkit (IGT) annually measures compliance of NHS organisations against a number of requirements which are 45 requirements for Acute Trusts.

Croydon Health Services NHS Trust's submission score for the 2015-16 HSCIC Information Governance Toolkit v13 on March 31st 2016 was 67% with all requirements being level 2 compliant.

The Trust is committed to ensuring that its information is managed to the highest standards and in accordance with the Health and Social Care Act 2014, Care Standards Act 2000, The Data Protection Act 1998, The Freedom of Information Act 2000, Central Government policies and guidance from the Information Commissioner's Office.

The Trust complies with the Information Commissioner's Office checklist for reporting, managing and investigating information governance incidents. The Trust declared 5 information governance incidents through the HSCIC IG Toolkit in 2015-16, 3 serious level 2 incidents (classified as disclosed in error) and 2 level 1 incidents (disclosed in error). The ICO also issued an undertaking that committed the Trust to a particular course of action in order to improve its compliance. Completion of these actions were confirmed by the ICO in April 2016 with further management of Staff IG training and legacy records destruction.

The Trust reported 4 serious incidents involving personal data to the Information Commissioners Office (ICO) as per their reporting criteria reported between April 2015 and March 2016:

Code	Description	No.
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	2
C	Lost in Transit	0

D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	0
K	Other	1

4 The Risk and Control

Framework

The Director of Quality Assurance and Governance is also the Senior Information Risk Owner (SIRO) and provides the processes, systems and central co-ordination of all risk and governance activities. The Director of Quality Assurance and Governance ensures that there is a strategy process and tools in place to enable the Trust to consolidate risk management and governance within an efficient and systematic framework that is embedded within the organisation. This includes maintaining and developing the Board Assurance Framework to ensure that the Trust Board are provided with accurate and intelligent information on which to base their decisions.

The Trust's Risk Management Strategy was updated in February 2016 and was ratified in April 2016 at the Trust Board. The Strategy now entitled the Risk Management Framework provides a practical guide to completing the risk register, a process for strengthening the way in which risks are reported and a means by which frontline staff can raise risk issues.

A programme of Risk Management Training including Risk Assessment and Root Cause Analysis training is in place and is provided to staff across the Trust. Risk Management is also included in the induction programme for new starters.

Executive Directors, Associate Directors and Heads of Service have a responsibility to lead with a strong risk management approach in all aspects of the Trust's activities.

Managers at all levels of the organisation have a responsibility to manage risks at a local level and to develop an environment where staff are encouraged to identify and report risk issues proactively. Each directorate maintains a risk register and key risks are reflected in the Corporate Risk Register, which is reviewed every monthly for consideration by Board Directors.

Managers are expected to ensure that their staff report immediately any near miss incidents, adverse incidents and serious incidents, using the Trust's Incident reporting system and to implement recommendations following the incident to reduce the likelihood of the incident occurring.

4.1 Performance against national priorities as set out in the TDA Accountability Framework 2015/16

- **18 Week Referral to Treatment (RTT):** The Trust has significantly developed its management of RTT as a performance target. In the last year it has seen a significant reduction both in the backlog and number of 'long waiters'. The Trust has almost eliminated the 52 week 'waiters' and has been successful in reducing the back log by 38% and has sustainably maintained the incomplete RTT performance target.. There is still further work to be done but with robust processes and infra structures now being developed and implemented and the Trust is in an excellent position to achieve RTT as part of business as usual.

- **Cancer Waits:** The Trust has regularly delivered a strong performance in meeting all cancer waiting time standards. The Trust achieved consistently the 62 day cancer target and in March 2016 achieved all 8 cancer targets.
- **4 hour Access Standard in A&E:** The Emergency Care Recovery Programme was established in August in order to ensure improved patient flow against the Emergency Pathway and support the delivery of the 95% target in a safe and sustainable way. Despite the significant amount of work undertaken through the 4 work streams of set up to help deliver set out below the Trust did not achieve the ED performance against the tripartite agreed trajectory, however it is widely accepted that the Trust has consistently performed over and above the 86% national average and more so throughout the winter period despite the 10% surge in activity to ED that has been witnessed.
- **Control of Infection (C.difficile target):** Overall, 2015-16 has been a challenging year in terms of infection control, however, the Trust management, staff and infection control team have managed the challenges well.

July 2015 saw a higher than usual incidence of C.difficile cases, with 8 cases occurring in a 13 day period, against a usual incidence level of 1-2 per month and a C.difficile-specific action plan was implemented. The actions put in place effectively addressed the increase in cases, which dropped back to 2 in August 2015 and remained well controlled for the remainder of the year; the actions implemented in the C.difficile specific action plan will continue and ensure rates remain as low as possible. Despite the spike of cases in July, overall the Trust had 21 cases of hospital-acquired C.difficile against a planned trajectory of 16 or less for the year.

There was one hospital acquired MRSA bacteraemia. The Trust screens all emergency admissions for MRSA and offering decolonisation to those found positive.

In addition, the infection control team review all individuals who have MRSA on a weekly basis, work closely with ward teams on treatment, screening and documentation of these patients and other patients who are at higher risk of infection.

This year Croydon University Hospital has seen more cases of confirmed flu this winter than previous years. From November 2015 to 08th April 2016, we have seen 202 patients with confirmed influenza at CUH. 123 of these were due to Influenza A H1N1, 59 were due to Influenza B and 20 were due to Influenza A (not typed). The current flu vaccine (for winter 2015/16) contains these three types of flu.

To support this work, the Trust produced printed guidelines for handling flu patient for staff, the communication department produced posters for main entrances to further educate patients, staff and visitors, and staff flu immunization was widely promoted throughout the winter.

4.2 Review of Economy, Efficiency and Effectiveness of Resources

The Trust was set a control total of £22.5m by the NHS Trust Development Authority (now NHS Improvement) and reported a deficit outturn of £34.5m having worked on a series of mitigating actions and some fortuitous one off benefits.

The key areas of the overspend are linked to increased levels of Non Elective Activity, which is not fully reimbursed under Payment by Results rules, and an increase in costs to undertake these increased levels of activity. Increased agency staffing usage compared to

plan and slippage in the savings schemes to deliver cash releasing reductions which would have reduced the run rate.

The Trust increased its levels of spend on agency staff by £7m compared to 2014/15 (£22.5m in total). This increase was mainly due to the need to recruit qualified nurses costing circa £3.6m. NHS Improvement has issued new capped rates which trusts are requested to meet for all staffing groups. The Trust also reports compliance on a weekly basis to NHS Improvement.

Increased resilience spend as compared to the September 2015 plan had an adverse variance of £2.2m due to the increased levels of staffing required, many of which were at a premium. A&E, due mainly to the medical staffing, had an adverse variance of £2.1m principally related to temporary staffing. Wards, other than those classed for resilience, had an adverse variance of £2.4m due to the increase in temporary staffing premium and 1:1 care. In addition to this, the Trust suffered with increasing Theatre costs due to the level of vacancies being covered and the agency premium associated with this specialist area

The Trust has recognised the above issues and has addressed them in 2016/17 budget setting by starting the budget setting process on the actual establishment used in Month 7 (October) and adding back vacancies which were not covered in Month 7. The Directorates then undertook a cost pressure review which has been added to the base budget for 2016/17. From this starting point, the Directorates are able to see clearly where the Clinical and Non Clinical Pathways can be redesigned. This will go towards the Cash Releasing Efficiency Savings (CRES) of £10m for 2016/17. In addition to CRES, the directorates have been tasked with delivering a further £10m of cost containment savings.

Having reviewed the working of the Financial Recovery Board in 2015/16, a revised Financial Improvement & Transformation Board (FITB) has been instituted for 2016/17. This Board will focus on 4 workstreams being workforce, clinical pathways, productivity and enabling programmes which will focus on change management on the key areas of overspend in 2015/16 together with the key drivers of change and transformation. The Lord Carter of Coles recommendations will be encompassed in each of the workstreams. The Programmes would report on a weekly basis with the clinical pathways and productivity workstreams reporting on the same week due to their synergies. In week four of the month the overall financial position would be reported and this would include the business as usual activity of the directorates covering income, expenditure, CRES, cost containment and emerging cost pressures as well as the impact of the four programmes of work. This would also allow dedicated time for the finances of the directorates to be reviewed in detail. The executives would attend every week with the other attendees changing depending on the topic being discussed.

4.3 Compliance with Counter Fraud Legislation

The management of the Trust takes seriously the potential threat and losses associated with possible fraudulent activity. The Trust has complied with the Secretary of State's Directions on countering fraud in the NHS and nominated a professionally accredited Local Counter Fraud Specialist (LCFS) who undertakes a programme of work designed to raise awareness amongst staff of possible fraud and to carry out investigations of any suspicions of fraud. LCFS provide reports to each Audit Committee of the progress of on-going investigations. The annual work plans of our LCFS cover a wide range of activities and follow the recommended plans produced by NHS Protect. Included within these plans are specific exercises, known as proactive reviews, which seek to identify the risk of fraud. Our LCFS has undertaken a number of these exercises under the direction and overall management of NHS Protect.

Staff are encouraged, through our counter fraud and whistle-blowing policies, to raise and refer any concern about fraud to the LCFS who will undertake an appropriate investigation. This encouragement is reinforced through the regular awareness presentations given by the LCFS to Trust staff

5. Review of the Effectiveness of Risk Management and Internal Control

As Accounting Officer, I have responsibility for reviewing the effectiveness 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 Trust who have responsibility for the development and maintenance of the internal control framework.

My review is also informed by the following sources of information:

- CQC Inspection - June 2015
- Internal audit reports (risk management, corporate governance, CQC, external visits)
- Board Assurance Framework
- External reviews (JAG accreditation, UKAS accreditation)
- Reports from Board Sub-Committee (Annual reports)
- Reports from executive directors (verbal and minutes of meetings)
- Croydon Staff Survey
- Picker National Inpatient Survey
- Well-Led Board
- Quality, Experience and Safety Programme
- Quality Report

6. Significant Issues

6.1 Finance

The Trust reported a deficit of £34.5m, which was £12m worse than the stretch £22.5m control total agreed with the TDA. There were a number of issues which led to this position and these have been addressed as part of the 2016/17 budget setting process as well as additional changes to the governance processes of the Trust.

2015/16 has seen significantly more granular information being available to the directorates to understand the drivers of the financial position. However this has resulted, in certain cases, of a subset of information being presented which led to mixed messaging as to the impact of actions on the overall financial position of the Trust. In 2016/17 the data sets to monitor the actions and programmes of work will be agreed for both business as usual and Trust wide workstreams. Information flows into FITB, the Finance & Performance Committee and Board will be clearly rooted in the overall income or expenditure plans of the Trust with the financial performance being monitored via only the relevant originating sources e.g. the Finance or the Information departments. This will ensure that any subset information is firmly rooted in the overarching Trust income, activity and cost plans. This

should ensure full understanding of the wider organisational picture without a repeat of the subset issues the Trust faced in 2016/17. Furthermore, the four workstreams will ensure strengthened leadership and accountability to ensure that plans are shepherded through to completion.

In addition to this, there has been more focussed budget setting in 2016/17 to include a much greater level of understanding for all known cost drivers, i.e. over establishments, service developments, agency planning, and horizon scanning for up and coming Business Cases. This has led to a very detailed analysis of each cost centre to be reviewed and agreed prior to the overarching directorate sign off. This process will provide greater clarity on all aspects of the budget setting for 2016/17 and will allow a greater level of accountability to be achieved. The clinical directorates have been fully involved in the activity planning to again ensure that a full understanding is in place at the beginning of the financial year. This will aid and support challenges, both internally and externally in 2016/17, and avoid some of the confusion and double counting issues which occurred in 2015/16 and which delayed prompt action being taken to address the worsening financial position.

There was significant turnover of staff and use of interims in 2015/16 across both operational management, finance and other corporate areas which resulted in loss of directorate and corporate memory. This was mitigated to some extent by clear audit trails of budget sign off etc but did impact on speed of corrective action. In 2016/17, the majority of operational management and finance business partner posts are now permanently recruited to and, together with the strengthened systems instituted in 2015/16; this will lead to a more consistent and focussed concentration on the delivery of the plans.

Lastly, the Trust has strengthened its business case review and approval processes to ensure that all aspects of the business cases are fully understood and approved prior to implementation and that commissioner approval has been sought and received prior to implementation. This would include the activity recording issues as well as the income, cost, quality and operational impact of any changes.

6.2 Care Quality Commission Must Do Actions

Croydon Health Services received an inspection from the Care Quality Commission (CQC) in June 2015 and was awarded an overall 'requires improvement' rating. The CQC acknowledged that the Trust had made significant improvements since the previous inspection in September 2013. However the Trust received 4 Must Do actions which are monitored by the Quality Experience and Safety Programme Delivery Group. The Group meets monthly to review, monitor and report on progress against all the CQC actions, along with any issues affecting delivery. The 4 Must Do actions are:

- **Continue to improve and embed systems to monitor the quality and safety of care provided (Trust wide).** Progress to date has included a review of the governance structure and a revised programme management structure with a re-designed Financial Improvement Transformation Board. Two of the clinical directorates are in the process of appointing Governance Facilitators to co-ordinated governance more effectively within their directorates. All directorates review their risk registers as part as business as usual and provide monthly reports at their performance meetings and their individual quality boards. Incident reporting continues to increase across the Trust. The Trust's Quality Strategy was approved by the Trust Board in December 2015 linking together with the quality objectives set out in the Quality Account and the Annual Plans

- **Improve clinical governance and risk management in the surgical services (CUH).** The Directorate is making significant progress with this action and held a surgical away day to agree the key actions required to embed robust governance processes across the directorate. A standard terms of reference and agenda is used across the directorate and all surgical specialties use the same format for their clinical governance meetings. Clinical Business Units have been established to provide leadership to embed governance within the specialties.
- **Implement promptly plans to refurbish theatres and to put in place an equipment replacement programme (CUH).** The Trust has an effective Strategic Theatres User group which is currently overseeing the refurbishment options for the theatres. The business case is currently under development in preparation for submission to NHS Improvement (NHSI). Further work is required to prepare the outline and full business case for approval by the NHSI and a consultant has been appointed to undertake this work.
- **Ensure that 90% of staff receive up-to-date safeguarding and mandatory training (CUH).** Currently the Trust Core Skills Training (CST) overall compliance is 85%. Work continues to increase the level of compliance through face to face meetings with staff, detailed directorate action plans which are monitored by the human resources department with formal letters being sent to non-compliant staff. The Trust also introduced a revised ATR (Application to Recruit) form which will only allow managers to recruit to vacant posts if their directorate is compliant with its core skills training. With regard to safeguarding adults' mandatory training, a permanent safeguarding adults lead has been appointed who is working closely with the Mental Capacity lead at Croydon Council to deliver joint training.

6.3 Never Event

The Trust reported 1 Never Event during 2015-16. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers, are available, at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. The Never Event related to a retained swab which had been left in a patient following surgery.

7. Head of Internal Audit Opinion

7.1 Overall Opinion

Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. We have issued reasonable assurance opinions on most areas of work that we have undertaken during the year. We have, however, provided limited assurance reports on Inter Hospital Transfers and Data Quality, CRS Millennium and Financial Management and actions are being taken to address deficiencies.

7.2 Risk Management

The previously combined Board Assurance Framework (BAF) and Corporate Risk Register was separated into a BAF and Corporate Risk Register at the beginning of 2015/16. The BAF was substantially revised in the latter half of the year.

Internal Audit considers that these changes are starting to make a difference with risk management beginning to be embraced by directorates. In Internal Audit's opinion, whilst the revised BAF can be considered still under development and consequently capable of improvement, it does represent a positive step forward.

Overall, Internal Audit provided reasonable assurance that the Trust has effective risk management arrangements in place.

8. Conclusion

With the exception of the internal control issues that I have outlined in this Statement, my review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have or are being addressed.

Accountable Officer:



John Goulston
Chief Executive
Date: 31 May 2016

Remuneration and Staff Report

Remuneration policy

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

During 2015/16, the committee was chaired by Non-Executive Director Louise Cretton.

Other members during the 2015/16 year were:

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

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

The committee's role is to ensure that the Executives are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.

Annual data comparison will continue to be made with other Trusts of a similar size to ensure that Croydon Health Services continues to pay what is generally considered to be the market rate. No part of the Chief Executive's or Director's remuneration is subject to their performance (in other words they do not attract any kind of performance bonus).

None of the Voting Directors have fixed term contracts. Their contracts can be terminated by either side giving, in the case of the Chief Executive, six months' notice, and for the Executive Directors, three months.

Salary and pensions of senior managers

2015-16						
Name & Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) Total (a to e) (bands of £5,000)
	£'000	£'00	£'000	£'000	£'000	£'000
John Goulston, Chief Executive Officer	180 to 185	0	0	0	35.0 to 37.5	215 to 220
Azara Mukhtar, Director of Finance	125 to 130	0	0	0	37.5 to 40.0	165 to 170
Jayne Black, Deputy Chief Executive & Chief Operating Officer	125 to 130	50 to 51	0	0	22.5 to 25.0	155 to 160
Michael Burden, Director of Human Resources & Organisational Development	105 to 110	0	0	0	67.5 to 70.0	175 to 180

Stephen Ebbs, Medical Director (Resigned 31-Aug-2015)	70 to 75	0	0	0	-5 to 0	70 to 75
Nnenna Osuji, Medical Director (From 01-Aug-15)	130 to 135	0	0	0	130 to 132.5	260 to 265
Helen Astle, Director of Quality Assurance and Governance (From 07-Sep -15)	65 to 70	0	0	0	60 to 65	125 to 130
Michael Fanning, Director of Nursing, Midwifery and Allied Health Professionals	110 to 115	0	0	0	430.0 to 432.5	545 to 550
Lisa Chesser, Director of Planning & Informatics	110 to 115	0	0	0	47.5 to 50.0	155 to 160
Michael Bell, Chairman	40 to 45	0	0	0	0	40 to 45
Godfrey Allen, Non-executive director	5 to 10	0	0	0	0	5 to 10
John Thompson, Non-executive director (Resigned 15-Jul-15)	0 to 5	0	0	0	0	0 to 5
Steven Corbishley, Non-executive director (non-paid Non-executive director)	NA	NA	NA	NA	NA	NA
Dr James Gillgrass, Non-executive director	5 to 10	0	0	0	0	5 to 10
Louise Cretton, Non-executive director	5 to 10	0	0	0	0	5 to 10
Jamal Butt, Associate Non-executive director	5 to 10	0	0	0	0	5 to 10
Mike Bailey, Non-executive director	5 to 10	0	0	0	0	5 to 10

Hannah Miller, Non-executive director (From 01-10-15)	0 to 5	0	0	0	0	0 to 5
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2014-15						
Name & Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) Total (a to e) (bands of £5,000)
	£'000	£'00	£'000	£'000	£'000	£'000
John Goulston, Chief Executive Officer	180 - 185	0	0	0	25 - 27.5	205 to 210
Azara Mukhtar, Director of Finance	125 - 130	0	0	0	10 - 12.5	135 to 140

Karen Breen, Deputy Chief Executive & Chief Operating Officer (Resigned 31 August 2014) The salary for 2014-15 is part year only.	50 - 55	0	0	0	0 - 2.5	55 to 60
Sharon Jones, Acting Chief Operating Officer for the interim period from 1 August 2014 to 31 October 2014. The salary for 2014-15 is part year only.	40 - 45	0	0	0	5 - 7.5	45 to 50
Jayne Black, Deputy Chief Executive & Chief Operating Officer (Appointed 1 November 2014) The salary for 2014-15 is part year only.	50 - 55	0	0	0	132.5 - 135	185 to 190
Zoe Packman, Director of Nursing, Midwifery and AHPs (Resigned 24 November 2014). The salary for 2014-15 is full year; however from 1 November 2014 to 31 March 2105, 50% of the salary has been recharged to LAS)	90 - 95	0	0	0	27.5 - 30	115 to 120
Michael Burden, Director of Human Resources & Organisational Development	100 -105	0	0	0	-15 - -12.5	90 to 95
Stephen Ebbs, Medical Director	190 - 195 ¹	0	0	0	1,097.5 - 1,100	1,285 to 1,290

¹ Included within Stephen Ebbs salary were 2013/14 arrears of £11,335 paid in 2014/15.

Edward Adams, Director of Corporate Governance (Resigned 27 November 2014). The salary for 2014-15 is part year only.	45-50	0	0	0	0	45-50
Lisa Chesser, Director of Planning & Informatics (Seconded from Trust Development Authority on 1 st April and permanently appointed to CHS on 1 st March 2015)	100 - 105	0	0	0	32.5 - 35	130 to 135
Michael Bell, Chairman	40-45	0	0	0	0	40-45
Godfrey Allen, Non executive director	5-10	0	0	0	0	5-10
Mary Clarke CBE, Associate Non-Executive Director (Resigned 31 August 2014)	0-5	0	0	0	0	0-5
John Thompson, Non executive director	5-10	0	0	0	0	5-10
Steven Corbishley, Non executive director-(non-paid non executive director)	NA	NA	NA	NA	NA	NA
Dr James Gillgrass, Non-executive director	5-10	0	0	0	0	5-10
Louise Cretton, Non-executive director	5-10	0	0	0	0	5-10
Jamal Butt, Associate Non-executive director	5-10	0	0	0	0	5-10
Mike Bailey, Associate Non-executive director (appointed 1 May 2014) The salary for 2014/15 is part year only	5-10	0	0	0	0	5-10

Pension benefits 2015/16

Name	Title	Real increase / (decrease) in pension at pension (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Cash Equivalent Transfer Value at 31 March 2016	Real increase/ (decrease) in Cash Equivalent Transfer Value	Employer's Contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston	Chief Executive	0 to 2.5	2.5 to 5	60 to 65	180 to 185	1,240	1,301	46	26
Azara Mukhtar	Director of Finance	0 to 2.5	-2.5 to 0	30 to 35	95 to 100	499	525	20	19
Nnenna Osuji	Medical Director	5.0 to 7.5	10.0 to 12.5	25 to 30	70 to 75	283	372	86	15

Helen Astle	Director of Quality Assurance and Governance	2.5 to 5.0	5 to 7.5	5 to 10	15 to 20	56	101	44	9
Jayne Black	Deputy Chief Executive and Chief Operating Officer	0 to 2.5	2.5 to 5.0	45 to 50	140 to 145	876	916	29	19
Michael Burden	Director of Human Resources & Organisation Development	2.5 to 5.0	7.5 to 10.0	45 to 50	145 to 150	910	989	68	16
Stephen Ebbs	Medical Director	-2.5 to 0	-2.5 to 0	105 to 110	320 to 325	2,465	0	-2,494	11
Lisa Chesser	Director of Planning & Informatics	0 to 2.5	0 to 2.5	5.0 to 10	0 to 5	89	120	30	16

Michael Fanning	Director of Nursing, Midwifery and Allied Health Professionals	17.5 to 20.0	55 to 57.5	45 to 50	140 to 145	544	904	354	16
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Pay multiples

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

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

	2015/16	2014/15
Band of Highest Paid Director's Total Remuneration	£180k to £185k	£220k to £225k
Median Total Remuneration of all staff	£25,175	£27,399
Remuneration Ratio	7.35	8.12
Number of employees who received remuneration in excess of the highest paid director	0	0
Remuneration for these staff ranged from:	0	NA

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

Staff

Number of senior staff (by band)

The Trust employs the following senior staff in the organisation:

Band	Headcount	WTE
Associate Specialist	14	13.05
Band 8A	143	135.46
Band 8B	34	33.17
Band 8C	25	24.44
Band 8D	11	10.88
Band 9	4	4.00
Consultant	185	173.06
Very Senior Manager	9	9.00
Specialty Doctor	24	19.35
Staff Grade Practitioner	4	3.21
Total	453	425.62

Staff numbers

The Trust employs a total of 3,944 permanent and temporary staff in the following staff groups.

Staff grouping	Headcount
Medical and dental staff	483
Administration and estates staff	1,046
Health care assistants and other support staff	604
Nursing, midwifery and health visiting staff	1,357
Scientific, therapeutic and technical staff	454
Grand Total	3,944

Staff composition

Trust Total	%
Female	79.3
Male	20.7
Grand Total	100

Directors (Board level)	Headcount	%
Female Executive	5	31.25
Female Non-Executive	2	12.5
Male Executive	3	18.75
Male Non-Executive	6	37.5
Total Female	7	43.75
Total Male	9	56.25

Sickness absence data

Staff Sickness Absence	Number
Total Days Lost (15/16)	24,049
Total Staff Years (average number)	3,266
Average working Days Lost (total day lost/staff years)	7.4

Staff disability policies

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

These include:

- To interview all applicants with a disability who meet the essential criteria for a post and to consider them on their abilities.
- To take action to ensure that all employees have attained the appropriate level of disability awareness, in order for the Trust to meet its commitments under the symbol.

- To ensure that reasonable adjustments are considered at all stages of the recruitment and selection process, in order to accommodate the particular needs of any disabled person, as defined in the Disability Discrimination Act 1995 and Disability Discrimination (Amendment) Act 2005.
- Make all reasonable adaptations and changes to the workplace/job to accommodate employees who are deemed disabled.

Reasonable adjustments might include but not limited to:

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

Expenditure on consultancy

The Trust spent £1.2m on consultancy. Consultants were hired to undertake work in relation to staffing strategy and theatre implementation. The Trust also recruited consultants to undertake an in depth critical analysis of Trust strategy.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Departments and their arm's length bodies must publish information in relation to the number of off payroll engagements – at a cost of £58,200 per annum (i.e. more than £220 per day and more than six month) – that are/were in place within their organisation.

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months	Number
Number of existing engagements as of 31 March 2016	28
Of which, the number that have existed:	
For less than one year at the time of reporting	13
For between one and two years at the time of reporting	13
For between 2 and 3 years at the time of reporting	1
For between 3 and 4 years at the time of reporting	1
For 4 or more years at the time of reporting	0

All existing off –payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the correct amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months	Number
Number of existing engagements , or those that reached six months in duration, between 1 April 2015 and 31 March 2016	76
Number of new engagements which include contractual clauses giving Croydon Health Services NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	76
Number for whom assurance has been requested	76
Of which:	
Assurance has been received	38
Assurance has not been received*	3
Engagements terminated as a result of assurance not being received, or ended before assurance received.	35

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	1

Note

* Two of the contractors have left the Trust post reporting date; the remaining one contractor who has not provided the assurance is being actively managed by the respective director.

Exit packages

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payment have been made	Cost of special payment element including in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001- £50,000	1	25,977	0	0	0	25,977	0	0
£50,001- £100,000	0	0	0	0	0	0	0	0
£100,001- £150,000	0	0	0	0	0	0	0	0
£150,001- £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non contractual payments requiring Department of Health approval	0	0
Total	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are accounted for in the full year of departure. Where Croydon Health Services NHS Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill health retirement costs are met by the NHS pension scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Annual Accounts



Annual Accounts 2015/16 for Croydon Health Services

About Croydon Health Services NHS Trust

Croydon Health Services NHS Trust (the "Trust") was established in 1993 (Statutory Instrument 1993 No. 27) and provides a range of healthcare services to a population of around 377,570 centred in the London Borough of Croydon.

The Trust's land and buildings were valued independently by the Valuation Office Agency (an executive agency of HM Revenue and Customs) as at 31 March 2016 on a Modern Equivalent Asset (MEA) basis. The valuation report was signed by Peter Ashby, MRICS an external RICS Registered Valuer who has the appropriate knowledge, skills and understanding to undertake the valuation completely, as required by the RICS Valuation - Professional Standards, 8th edition. As a full valuation was carried out at Croydon University Hospital and Simpson Close properties in 2014/15 and Purley Hospital and the health centres had a full valuation in 2013/14 a desk top valuation of the estate was conducted.

In 2015/16, the Trust provided services from the following sites:

- Croydon University Hospital, a 643 bed acute hospital in Thornton Heath;
- Purley Hospital, providing outpatient, urgent care and diagnostic services
- The Sickle Cell and Thalassaemia Centre located in Thornton Heath;
- Various Community Services sites.

The Trust is one of the largest employers in Croydon, employing 3,283 permanent whole time equivalent staff at 31 March 2016, with a turnover of circa £255 million in 2015/16.

The Trust's main source of income is from services commissioned by Croydon Clinical Commissioning Group (CCG), NHS England and London Borough of Croydon. The Trust has smaller contracts with other neighbouring CCGs.

Summary of 2015/16 Financial Performance

Key Financial Targets

The table below sets out the Trust's Financial Targets, and its performance against these, in the 2015/16 Financial Year:

Target	Performance	Target met?
Breakeven on revenue and operating costs	The Trust achieved a deficit of £32.4m (£34.5m deficit after technical adjustments)	<input checked="" type="checkbox"/>
Keep within the capital resource limit (CRL) of £12.819m	The Trust remained within the CRL, and generated an underspend of £0.075m	<input type="checkbox"/>
Remain within the external financing limit (EFL) of £34.862m	The Trust remained within its EFL, and over achieved on this by £0.465m	<input type="checkbox"/>
Keep within a Capital Cost Absorption Rate (CCAR) of 3.5%	The Trust kept within the 3.5% CCAR. This has resulted in dividend payments of £5.486m to the Department of Health.	<input type="checkbox"/>

Further copies of these accounts can be obtained from:

**PA to the Director of Finance
Croydon Health Services NHS Trust
2nd Floor, Nightingale House
530 London Road
Croydon
CR7 7YE
Tel: 020 8401 3563**

Statement of Comprehensive Income for year ended 31 March 2016

		2015/16	2014/15
	NOTE	£000s	£000s
Gross employee benefits	9.1	(184,187)	(172,899)
Other operating costs	7	(97,658)	(94,859)
Revenue from patient care activities	4	237,856	231,653
Other operating revenue	5	17,498	14,626
Operating surplus/(deficit)		(26,491)	(21,479)
Investment revenue	11	27	21
Finance costs	12	(430)	(13)
Surplus/(deficit) for the financial year		(26,894)	(21,471)
Public dividend capital dividends payable		(5,486)	(5,815)
Retained surplus/(deficit) for the year		(32,380)	(27,286)
Other Comprehensive Income		2015/16	2014/15
		£000s	£000s
Impairments and reversals taken to the revaluation		10,716	1,784
Net gain/(loss) on revaluation of property, plant &		9,456	2,887
Total Other Comprehensive Income		20,172	4,671
Total comprehensive income for the year		(12,208)	(22,615)
Financial performance for the year			
Retained surplus/(deficit) for the year		(32,380)	(27,286)
Prior period adjustment to correct errors and other		3	0
Impairments (excluding IFRIC 12 impairments)		(1,686)	(463)
Adjustments in respect of donated gov't grant asset		(430)	217
Adjusted retained surplus/(deficit)		(34,493)	(27,532)

The notes on pages 107 to 166 form part of this account.

Statement of Financial Position as at 31 March 2016

		31 March 2016	31 March 2015
	NOTE	£000s	£000s
Non-current assets:			
Property, plant and equipment	13	219,880	192,702
Intangible assets	14	1,530	784
Trade and other receivables	19.1	906	908
Total non-current assets		222,316	194,394
Current assets:			
Inventories	18	2,580	3,033
Trade and other receivables	19.1	22,362	16,161
Cash and cash equivalents	20	1,959	1,003
Sub-total current assets		26,901	20,197
Non-current assets held for sale		0	0
Total current assets		26,901	20,197
Total assets		249,217	214,591

Current liabilities			
Trade and other payables	21	(42,900)	(32,522)
Provisions	25	(4,089)	(2,894)
Borrowings	22	(17)	0
Total current liabilities		(47,006)	(35,416)
Net current assets/(liabilities)		(20,105)	(15,219)
Total assets less current liabilities		202,211	179,175
Non-current liabilities			
Provisions	25	(760)	(855)
Borrowings	22	(77)	0
DH revenue support loan	22	(29,629)	0
DH capital loan	22	(5,600)	0
Total non-current liabilities		(36,066)	(855)
Total assets employed:		166,145	178,320
FINANCED BY:			
Public Dividend Capital		114,228	114,198
Retained earnings		(40,491)	(9,201)
Revaluation reserve		92,408	73,323
Total Taxpayers' Equity:		166,145	178,320

The notes on pages 107 to 166 form part of this account.

The financial statements on pages 99 to 166 were approved by the Board on 2016 and signed on its behalf by

John Goulston

Chief Executive:

Date: 31 May 2016

Statement of Changes in Taxpayers' Equity for the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	114,198	(9,201)	73,323	0	178,320
Changes in taxpayers' equity for 2015/16					
Retained surplus/(deficit) for the year	0	(32,380)	0	0	(32,380)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	9,456	0	9,456
Impairments and reversals	0	0	10,716	0	10,716
Transfers between reserves	0	1,087	(1,087)	0	0
Reclassification Adjustments					
New temporary and permanent PDC received - cash	30	0	0	0	30
New temporary and permanent PDC repaid in year	0	3	0	0	3
Net recognised revenue/(expense) for the year	30	(31,290)	19,085	0	(12,175)
Balance at 31 March 2016	114,228	(40,491)	92,408	0	166,145

Balance at 1 April 2014	89,652	17,117	69,620	0	176,389
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year	0	(27,286)	0	0	(27,286)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	2,887	0	2,887
Impairments and reversals	0	0	1,784	0	1,784
Reclassification Adjustments					
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		968	(968)	0	0
New temporary and permanent PDC received - cash	45,882	0	0	0	45,882
New temporary and permanent PDC repaid in year	(21,336)	0	0	0	(21,336)
Net recognised revenue/(expense) for the year	24,546	(26,318)	3,703	0	1,931
Balance at 31 March 2015	114,198	(9,201)	73,323	0	178,320

Statement of Cash Flows for the Year ended 31 March 2016

	Note	2015/16	2014/15
		£000s	£000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		(26,491)	(21,479)
Depreciation and amortisation	7	7,345	6,894
Impairments and reversals	15	(1,686)	(463)
Donated Assets received credited to revenue but non-cash	5	0	0
Government Granted Assets received credited to revenue but non-cash		0	0
Interest paid	12	(418)	0
PDC Dividend (paid)/refunded		(5,818)	(6,371)
(Increase)/Decrease in Inventories		453	(609)
(Increase)/Decrease in Trade and Other Receivables		(5,864)	(1,355)
(Increase)/Decrease in Other Current Assets		0	0

Increase/(Decrease) in Trade and Other Payables		9,813	5,313
Provisions utilised		(342)	(825)
Increase/(Decrease) in movement in non cash provisions		1,430	1,306
Net Cash Inflow/(Outflow) from Operating Activities		(21,578)	(17,589)
Cash Flows from Investing Activities			
Interest Received	11	27	21
(Payments) for Property, Plant and Equipment		(11,576)	(6,528)
(Payments) for Intangible Assets		(1,176)	(7)
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(12,725)	(6,514)
Net Cash Inflow / (outflow) before Financing		(34,303)	(24,103)

Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		30	45,882
Gross Temporary (2014/15 only) and Permanent PDC Repaid		0	(21,336)
Loans received from DH - New Capital Investment Loans		5,600	0
Loans received from DH - New Revenue Support Loans		50,929	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		(21,300)	0
Net Cash Inflow/(Outflow) from Financing Activities		35,259	24,546
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		956	443
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		1003	560
Effect of exchange rate changes in the balance of cash held in foreign		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	20	1,959	1,003

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

1.2 Critical accounting judgements and key sources of estimation uncertainty

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

1.2.1 Critical judgements in applying accounting policies

There have been no critical judgements, apart from those involving estimation (see below), non consolidation of charity accounts and the ability of the Trust to operate on a going concern basis (see note 28 Events after the reporting period).

1.2.2 Key sources of estimation uncertainty

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

Revenue - Note 1.3 and Note 4 and 5

The basis of calculation for partially completed spells is detailed in note 1.3.

Asset Lives – Note 13.3

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and physical asset verification exercises.

The minimum and maximum estimated economic lives of each class of asset are disclosed in note 13.3, and the carrying values of property, plant and equipment and intangible assets in notes 13.1 and 14.1 respectively.

Land and Buildings Valuations – Notes 1.6, 13.1 and 13.3

All land and buildings are restated at fair value by way of annual professional valuations carried out by an independent external valuer.

Provision for Impairment of Receivables – Note 19.3

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The Trust follows the guidance issued in the NHS Trusts' Manual for Accounts in relation to the recommended rate for Injury Cost Recovery receivables.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of *length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS 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 e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a

compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.4 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.5 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly

simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

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

Measurement

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software

is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

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

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

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

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

1.9 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.10 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.11 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met

when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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

1.12 Leases

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

The trust as lessee

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

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

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

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

The NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

1.13 Inventories

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

1.14 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 NHS trust's cash management.

1.15 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of -1.55% (for short term provisions of between 0 and 5 years inclusive); -1.00% (for medium term provisions of between 6 to 10 years inclusive); and -0.8% (for long term provisions of over 10 years) in real terms (1.37% for employee early departure obligations).

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

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

1.16 Clinical negligence costs

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

1.17 Non-clinical risk pooling

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

1.18 Contingencies

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

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

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

1.19 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and

impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.20 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.21 Value Added Tax

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

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. There were no third party assets held by the Trust at 31st March 2016.

1.24 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (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.

1.25 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).

1.26 Subsidiaries

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

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

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

However, the Charitable Funds have not been consolidated as it does not meet the criteria for consolidation into these accounts. This is in accordance with the requirements of IAS 27 which requires entities to be consolidated if they are material. The transactions of Croydon Health Services Charitable Funds are deemed not material in the context of the group and therefore are not consolidated.

1.27 Joint arrangements

Material entities over which the NHS trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the NHS body is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. Croydon Health Services has entered into a joint operation with St George's University Hospitals NHS Foundation Trust and Kingston Hospital NHS Foundation Trust for the provision of its Pathology Services. The joint operation is known as "South West London Pathology". The Trust shares control of the joint operation equally with its partners in the operation.

1.28 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.29 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

The Trust operates as a single operating segment.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. None of these activities individually exceed £1m, nor are they otherwise material.

4. Revenue from patient care activities	2015/16	2014/15
	£000s	£000s
NHS Trusts	554	742
NHS England	22,390	26,981
Clinical Commissioning Groups	201,296	193,396
Foundation Trusts	2,588	3,884
Department of Health	8	0
NHS Other (including Public Health England and Prop Co)	402	422
Non-NHS:		
Local Authorities	9,380	4,955
Private patients	211	209
Overseas patients (non-reciprocal)	153	298
Injury costs recovery	842	696
Other	32	70
Total Revenue from patient care activities	237,856	231,653

5. Other operating revenue	2015/16	2014/15
	£000s	£000s
Recoveries in respect of employee benefits	123	56
Patient transport services	1	0
Education, training and research	9,645	9,687

Charitable and other contributions to revenue expenditure - NHS	155	181
Receipt of donations for capital acquisitions - Charity	667	18
Non-patient care services to other bodies	2,858	1,648
Income generation (Other fees and charges)	1,584	1,522
Rental revenue from operating leases	2,465	1,514
Total Other Operating Revenue	17,498	14,626
Total operating revenue	255,354	246,279

6. Overseas Visitors Disclosure	2015/16	2014/15
	£000	£000s
Income recognised during 2015-16 (invoiced amounts and accruals)	153	298
Cash payments received in-year (re receivables at 31 March 2015)	23	37
Cash payments received in-year (re invoices issued 2015-16)	51	65
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	1	82
Amounts added to provision for impairment of receivables (re invoices issued 2015-16)	2	101
Amounts written off in-year (irrespective of year of recognition)	25	83

7. Operating expenses	2015/16	2014/15
	£000s	£000s
Trust Chair and Non-executive Directors	85	88
Supplies and services - clinical	46,142	45,677
Supplies and services - general	9,583	10,384
Consultancy services	1,213	2,412
Establishment	6,522	6,995
Transport	1,849	1,512
Premises	13,194	10,582
Hospitality	95	3
Insurance	9	11
Legal Fees	177	617
Impairments and Reversals of Receivables	97	381
Depreciation	6,915	6,495
Amortisation	430	399
Impairments and reversals of property, plant and equipment	(1,686)	(463)
Audit fees	99	92
Clinical negligence	12,242	8,468
Education and Training	692	1,206
Total Operating expenses (excluding employee benefits)	97,658	94,859
Employee Benefits		
Employee benefits excluding Board members	182,943	171,694
Board members	1,244	1,205
Total Employee Benefits	184,187	172,899
Total Operating Expenses	281,845	267,758

8. Operating Leases

8.1 Croydon Health Services NHS Trust as lessee				2015/16	2014/15
	Land	Buildings	Other	Total	Total
	£000s	£000s	£000s	£000s	£000s
Payments recognised as an expense					
Minimum lease payments				1,800	631
Total				1,800	631
Payable:					
No later than one year	1	563	773	1,337	609
Between one and five years	1	191	2,145	2,337	656
After five years	107	280	0	387	291
Total	109	1,034	2,918	4,061	1,556

Land lease payments relate to peppercorn rent paid on Purley Hospital site.

8.2 Croydon Health Services NHS Trust as lessor

The Trust is the lessor of parts of its premises to external organisation, and for staff accommodation, for which it charges rental revenue.

	2015/16	2014/15
	£000	£000s
Recognised as revenue		
Rental revenue	2,465	1,514
Total	2,465	1,514
Receivable:		
No later than one year	641	918
Between one and five years	2,398	2,590
After five years	4,157	2,875
Total	7,196	6,383

9. Employee benefits and staff numbers

9.1 Employee Benefits - Gross Expenditure	2015/16		
	Total	Permanently employed	Other
	£000s	£000s	£000s
Salaries and wages	158,634	123,113	35,521
Social security costs	10,928	10,791	137
Employer Contributions to NHS BSA - Pensions Division	15,145	15,032	113
Total employee benefits	184,707	148,936	35,771
Employee costs capitalised	520	20	500
Gross Employee Benefits excluding capitalised costs	184,187	148,916	35,271
Employee Benefits - Gross Expenditure 2014/15	2014/15		
	Total	Permanently employed	Other
	£000s	£000s	£000s
Salaries and wages	148,039	119,904	28,135
Social security costs	10,776	10,617	159
Employer Contributions to NHS BSA - Pensions Division	14,548	14,431	117
TOTAL - including capitalised costs	173,363	144,952	28,411
Employee costs capitalised	464	70	394
Gross Employee Benefits excluding capitalised costs	172,899	144,882	28,017
In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.			

9.2 Staff Numbers

	2015/16			2014/15
	Total	Permanently employed	Other	Total
	Number	Number	Number	Number
Average Staff Numbers				
Medical and dental	483	448		35 506
Administration and estates	1,046	925		121 999
Healthcare assistants and other support staff	604	440		164 501
Nursing, midwifery and health visiting staff	1,357	1,071		286 1,220
Scientific, therapeutic and technical staff	454	399		55 443
TOTAL	3,944	3,283		661 3,669
Of the above - staff engaged on capital projects	10	2		8 7

9.3 Staff Sickness absence and ill health retirements

	2015/16	2014/15
	Number	Number
Total Days Lost	24,049	23,398
Total Staff Years	3,266	3,217
Average working Days Lost	7.36	7.27
	2015/16	2014/15
	Number	Number
Number of persons retired early on ill health grounds	3	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	106	45

9.4 Exit Packages agreed in 2015-16

Exit package cost band (including any special payment element)	2015/16							
	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
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	1	25,977	0	0	1	25,977	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	1	25,977	0	0	1	25,977	0	0

	2014/15							
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
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	1	1,401	0	0	1	1,401	0	0
£10,000-£25,000	1	11,339	0	0	1	11,339	0	0
£25,001-£50,000	1	35,824	0	0	1	35,824	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	1	140,002	0	0	1	140,002	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	1	242,825	1	242,825	0	0
Total	4	188,566	1	242,825	5	431,391	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

**The NHS Pension Scheme is used for compulsory redundancies

9.5 Exit packages - Other Departures analysis	2015/16		2014/15	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	1	243
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	0	0	1	243
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

9.6 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

10. Better Payment Practice Code

10.1 Measure of compliance	2015/16	2015/16	2014/15	2014/15
	Number	£000s	Number	£000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	56,922	117,742	55,719	101,329
Total Non-NHS Trade Invoices Paid Within Target	25,106	40,057	35,399	48,932
Percentage of NHS Trade Invoices Paid Within Target	44.11%	34.02%	63.53%	48.29%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,606	29,272	1,835	25,260
Total NHS Trade Invoices Paid Within Target	401	17,056	665	15,169
Percentage of NHS Trade Invoices Paid Within Target	24.97%	58.27%	36.24%	60.05%
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 a valid invoice, whichever is later.				

11. Investment Revenue	2015/16	2014/15
	£000s	£000s
Interest revenue		
Bank interest	27	21
Subtotal	27	21
Total investment revenue	27	21

12. Finance Costs	2015/16	2014/15
	£000s	£000s
Interest		
Interest on loans and overdrafts	418	0
Total interest expense	418	0
Other finance costs	0	0
Provisions - unwinding of discount	12	13
Total	430	13

13.1 Property, plant and equipment

2015/16	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction & payments on account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2015	49,360	115,396	3,549	5,158	23,228	6	11,874	1,119	209,690
Additions of Assets Under Construction	0	0	0	5,865	0	0	0	0	5,865
Additions Purchased	0	2,304	0	0	1,709	0	1,590	6	5,609
Additions - Purchases from Cash Donations & Government Grants	0	398	0	0	269	0	0	0	667
Reclassifications	0	(433)	0	(2,998)	385	0	2,944	102	0
Disposals other than for sale	0	0	0	0	(11)	0	0	0	(11)
Upward revaluation/positive indexation	846	6,432	214	0	0	0	0	0	7,492
Impairments/reversals charged to reserves	(865)	11,367	214	0	0	0	0	0	10,716
At 31 March 2016	49,341	135,464	3,977	8,025	25,674	6	16,408	1,227	240,122
Depreciation									
At 1 April 2015	0	19	0	0	10,688	6	5,551	724	16,988

Disposals other than for sale	0	0	0	0	(11)	0	0	0	0	(11)
Upward revaluation/positive indexation	0	(1,902)	(62)	0	0	0	0	0	0	(1,964)
Impairments/Reversals charged to operating expenses	0	(1,686)	0	0	0	0	0	0	0	(1,686)
Charged During the Year	0	3,606	62	0	1,831	0	1,337	79	6,915	
At 31 March 2016	0	37	0	0	12,508	6	6,888	803	20,242	
Net Book Value at 31 March 2016	49,341	135,427	3,977	8,025	13,166	0	9,520	424	219,880	
Asset financing:										
Owned - Purchased	49,341	133,423	3,977	8,025	12,094	0	9,520	362	216,742	
Owned - Donated	0	2,004	0	0	836	0	0	62	2,902	
Owned - Government Granted	0	0	0	0	142	0	0	0	142	
Held on finance lease	0	0	0	0	94	0	0	0	94	
Total at 31 March 2016	49,341	135,427	3,977	8,025	13,166	0	9,520	424	219,880	

Revaluation Reserve Balance for Property, plant & equipment

	Land	Buildings	Dwellings	Assets Under Construction & payments on account	Plant & Machinery	Transport Equipment	Information technology	Furniture & Fittings	Total
	£000s	£000's	£000's	£000's	£000's	£000's	£000s	£000's	£000s
At 1 April 2015	38,844	32,772	1,707	0	0	0	0	0	73,323
Movements (specify)	(18)	18,641	462	0	0	0	0	0	19,085
At 31 March 2016	38,826	51,413	2,169	0	0	0	0	0	92,408

Additions to Assets Under Construction in 2015-16

	Assets Under Construction & payments on account	
	£000's	
Buildings excl Dwellings		5,419
Plant & Machinery		446
Balance as at YTD		5,865

13.2 Property, plant and equipment prior-year

2014/15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2014	47,169	113,926	3,172	2,596	21,010	6	11,046	1,104	200,029
Additions of Assets Under Construction	0	0	0	6,616	0	0	0	0	6,616
Additions Purchased	0	431	0	0	896	0	54	0	1,381
Additions – Purchases from Cash Donations & Government Grants	0	6	0	0	12	0	0	0	18
Reclassifications	0	1,955	0	(4,054)	1,310	0	774	15	0
Revaluation	2,174	(2,475)	163	0	0	0	0	0	(138)
Impairments/negativ e indexation charged to reserves	0	(1,876)	0	0	0	0	0	0	(1,876)
Reversal of Impairments charged to reserves	17	3,429	214	0	0	0	0	0	3,660

At 31 March 2015	49,360	115,396	3,549	5,158	23,228	6	11,874	1,119	209,690
Depreciation									
At 1 April 2014	0	13	0	0	8,952	6	4,390	620	13,981
Revaluation	0	(2,969)	(56)	0	0	0	0	0	(3,025)
Impairments/negative indexation charged to operating expenses	0	11	0	0	0	0	0	0	11
Reversal of Impairments charged to operating expenses	0	(474)	0	0	0	0	0	0	(474)
Charged During the Year	0	3,438	56	0	1,736	0	1,161	104	6,495
At 31 March 2015	0	19	0	0	10,688	6	5,551	724	16,988
Net Book Value at 31 March 2015	49,360	115,377	3,549	5,158	12,540	0	6,323	395	192,702
Asset financing:									
Owned - Purchased	49,360	113,738	3,549	5,158	11,688	0	6,322	381	190,196
Owned - Donated	0	1,639	0	0	687	0	1	14	2,341
Owned - Government Granted	0	0	0	0	165	0	0	0	165
Total at 31 March 2015	49,360	115,377	3,549	5,158	12,540	0	6,323	395	192,702

13.3 (cont). Property, plant and equipment

Donated assets were received from the Croydon Health Services Charitable Funds and The League of Friends.

The Trust's land and buildings were valued independently by the Valuation Office Agency (an executive agency of HM Revenue and Customs) as at 31 March 2016 on a Modern Equivalent Asset (MEA) basis. The valuation report was signed by Peter Ashby, MRICS an external RICS Registered Valuer who has the appropriate knowledge, skills and understanding to undertake the valuation completely, as required by the RICS Valuation - Professional Standards, 8th edition. As a full valuation was carried out at Croydon University Hospital and Simpson Close properties in 2014/15 and Purley Hospital and the health centres had a full valuation in 2013/14 a desk top valuation of the estate was conducted.

The MEA basis requires the valuer to review the building in use and value them on the basis of what it would cost to build a new structure capable of providing identical services.

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

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

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

Remaining Economic Lives of Non Current Assets

	Min Life	Max Life
Intangible Assets	Years	Years
Software Licences	5	7
IT-in house & 3 rd Party Software	3	8
Property, Plant and Equipment		
Buildings exc Dwellings	5	87
Dwellings	15	71
Plant & Machinery	5	15
Transport & Equipment	5	5
Information Technology	5	9
Furniture and Fittings	5	15

14.1 Intangible non-current assets

2015/16	IT - in-house & 3rd party software	Computer Licenses	Total
	£000's	£000's	£000's
At 1 April 2015	14	3,966	3,980
Additions Purchased	0	1,176	1,176
At 31 March 2016	14	5,142	5,156
Amortisation			
At 1 April 2015	5	3,191	3,196
Charged during the year	9	421	430
At 31 March 2016	14	3,612	3,626
Net Book Value at 31 March 2016	0	1,530	1,530
Asset Financing: Net book value at 31 March 2016 comprises:			
Purchased	0	1,515	1,515
Donated	0	15	15
Government Granted	0	0	0
Total at 31 March 2016	0	1,530	1,530

14.2 Intangible non-current assets prior year

2014/15	IT - in-house & 3rd party software	Computer Licenses	Total
	£000s	£000s	£000s
Cost or valuation:			
At 1 April 2014	14	3,959	3,973
Additions - purchased	0	7	7
At 31 March 2015	14	3,966	3,980
Amortisation			
At 1 April 2014	0	2,797	2,797
Charged during the year	5	394	399
At 31 March 2015	5	3,191	3,196
Net book value at 31 March 2015	9	775	784
Net book value at 31 March 2015 comprises:			
Purchased	9	755	764
Donated	0	20	20
Government Granted	0	0	0

Total at 31 March 2015	9	775	784
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14.3 Intangible non-current assets

As software assets are not revalued, there is no corresponding revaluation reserve for intangible assets.

The Trust does not carry any internally generated intangible assets. All intangible assets are held at cost and depreciated at rates calculated to write them down to nil net book value over the estimated useful life of the asset.

15. Analysis of impairments and reversals recognised in 2015/16

	Total
	£000s
Property, Plant and Equipment Impairments and reversals taken to SoCI	
Changes in market price	(1,686)
Total charged to Annually Managed Expenditure	(1,686)
Total Impairments of Property, Plant and Equipment changed to SoCI	(1,686)
Total Impairments charged to SoCI - AME	(1,686)
Overall Total Impairments	(1,686)

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI	0	0	0	0	0
Changes in market price	(1,686)	0	0	0	(1,686)
Total charged to Annually Managed Expenditure	(1,686)	0	0	0	(1,686)
Total Impairments of Property, Plant and Equipment changed to SoCI	(1,686)	0	0	0	(1,686)

16. Commitments

16.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment*	16,480	952
Intangible assets	-	0
Total	16,480	952

*The Trust has contracted with Galliford Try to build the Emergency Department refurbishment at a GMP of £19.3m (including VAT) of which £13.4m remains to be spent over the course of financial years 2016/17 and 2017/18.

The Trust has also elected to purchase modular units which are being used in the decant area of the ED refurbishment and will incur an additional commitment of £0.7m.

The Trust has contracted with Gray Dungate Poole Ltd to refurbish the Dental Suite at a cost of £0.7m.

The Trust has contracted with Peak Contractors Ltd to refurbish the Tollgate School at a cost of £1.6m to house the Child Development Centre.

16.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for a wide range of services including computer maintenance and licensing; hotel and other domestic services; facilities, building, ground and fire alarm maintenance. The payments to which the trust is committed are as follows:

	31 March 2016	31 March 2015
	£000s	£000s
Not later than one year	18,139	17,950
Later than one year and not later than five year	17,327	18,372
Later than five years	12,959	14,643
Total	48,425	50,965

17. Intra-Government and other balances	Current receivables	Non- current receivables	Current payables	Non- current payables
	£000s	£000s	£000s	£000s
Balances with Other Central Government Bodies	49	0	5,349	0
Balances with Local Authorities	2,994	0	0	0
Balances with NHS bodies inside the Departmental Group*	13,898	0	6,178	35,229
Balances with Bodies External to Government	5,421	906	31,390	77
At 31 March 2016	22,362	906	42,917	35,306
Prior period:				
Balances with Other Central Government Bodies *	920	0	5,225	0
Balances with Local Authorities	803	0	0	0
Balances with NHS bodies inside the Departmental Group	11,714	0	2,255	0
Balances with Bodies External to Government	2,724	908	25,042	0
At 31 March 2015	16,161	908	32,522	0

18. Inventories	Drugs	Consumables	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	896	2,072	65	3,033	0
Additions	15,161	9,917	4	25,082	0
Inventories recognised as an expense in the period	(15,150)	(10,368)	(17)	(25,535)	0
Balance at 31 March 2016	907	1,621	52	2,580	0

19.1 Trade and other receivables	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS receivables - revenue	12,778	11,652	0	0
NHs prepayments and accrued income	752	0	0	0
Non-NHS receivables - revenue	4,315	1,941	906	0
Non-NHS prepayments and accrued income	3,417	1,348	0	0
PDC Dividend prepaid to DH	417	85		
Provision for the impairment of receivables	(1,482)	(1,491)	0	0
VAT	537	898	0	0
Operating lease receivables	349	570	0	0
Other receivables	1,279	1,158	0	908
Total	22,362	16,161	906	908
Total current and non-current	23,268	17,069		
Included in NHS receivables are prepaid pension contributions:	0			
The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.				

19.2 Receivables past their due date but not impaired	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	4,344	2,693
By three to six months	757	531
By more than six months	2,373	791
Total	7,474	4,015

19.3 Provision for impairment of receivables	2015/16	2014/15
	£000s	£000s
Balance at 1 April 2015	(1,491)	(1,304)
Amount written off during the year	106	194
Amount recovered during the year	0	1
(Increase)/decrease in receivables impaired	(97)	(382)
Balance at 31 March 2016	(1,482)	(1,491)

20. Cash and Cash Equivalents	31 March 2016	31 March 2015
	£000s	£000s
Opening balance	1,003	560
Net change in year	956	443
Closing balance	1,959	1,003
Made up of		
Cash with Government Banking Service	1,930	974
Cash in hand	29	29
Cash and cash equivalents as in statement of financial position	1,959	1,003
Cash and cash equivalents as in statement of cash flows	1,959	1,003

21. Trade and other payables	Current		Non-Current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS payables - revenue	4,260	1,779	0	0
NHS accruals and deferred income	1,918	476	0	0
Non-NHS payables - revenue	12,245	3,642	0	0
Non-NHS payables - capital	3,720	3,155	0	0
Non-NHS accruals and deferred income	15,349	17,930	0	0
Social security costs	1,567	1,510	0	0
Accrued Interest on DH Loans	60		0	0
Tax	1,640	1,641	0	0
Other	2,141	2,389	0	0
Total	42,900	32,522	0	0
Total payables (current and non-current)	42,900	32,522	0	0
Included above:				
To Buy Out the Liability for Early Retirements Over 5 Years	0	0		
Number of Cases Involved (number)	0	0		
Outstanding Pension Contributions at the year end	2,142	2,074		

22. Borrowings	Current		Non-Current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
Department of Health- revenue support loan	0	0	29,629	0
Department of Health- capital loan	0	0	5,600	0
PFI liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
LIFT liabilities:				0
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	17	0	77	0
Total	17	0	35,306	0
Total other liabilities (current and non-current)	35,323	0		

22.1 Borrowings / Loans – repayment of principal falling due in:	31 March 2016		
	DH	Other	Total
	£000s	£000s	£000s
0-1 Years	0	17	17
1-2 Years	275	17	292
2-5 Years	27,222	60	27,282
Over 5 Years	7,732	0	7,732
Total	35,229	94	35,323

23. Deferred income	Current		Non-Current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
Opening balance at 1 April 2014	107	173	0	0
Deferred revenue addition	75	0	0	0
Transfer of deferred revenue	0	(66)	0	0
Current deferred Income at 31 March 2016	182	107	0	0
Total deferred income (current and non-current)	182	107		

24. Finance lease obligations as a lessee Amounts payable under finance leases (other)	Minimum Lease Payments		Present Value Of Minimum Lease Payments	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
Within one year	17	0	17	0
Between one and five years	77	0	77	0
After five years	0	0	0	0
Less future finance charges	0	0	0	0
Minimum Lease Payments / Present value of minimum lease payments	94	0	94	0
Included in:				
Current borrowings			17	0
Non-current borrowings			77	0
Total			94	0

25. Provisions	Total	Early Departure Costs	Legal Claims	Other
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	3,749	831	178	2,740
Arising during the year	3,944	5	36	3,903
Utilised during the year	(342)	(93)	(20)	(229)
Reversed unused	(2,514)	(16)	(110)	(2,388)
Unwinding of discount	12	12	0	0
Balance at 31 March 2015	4,849	739	84	4,026
Expected Timing of Cash Flows:				
No Later than One Year	4,089	99	84	3,906
Later than One Year and not later than Five Years	444	402	0	42
Later than Five Years	316	238	0	78
Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:				
As at 31 March 2016	152,685			
As at 31 March 2015	87,512			
Early Departure Costs relate to pre-1995 early retirement. The Trust pays NHS Pensions an amount each quarter for these former employees, and the provision balance represents the estimated costs of the continuing liabilities. Legal claims are liabilities relating to Third Parties Scheme (LTPS) cases which are dealt with by the NHS Litigation Authority on behalf of the Trust.				
Included in "other" liabilities are amounts relating to injury benefits; pay provisions for outstanding bank holidays, overtime, on call and night duty; the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme; and contract termination and compensation provisions.				

26. Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	(67)	(76)
Employment Tribunal and other employee related litigation	(120)	(25)
Other*	0	(39)
Net value of contingent liabilities	(187)	(140)

27. Financial Instruments

27.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups (CCG) and the way those CCGs are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHS Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care CCGs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27.2 Financial Assets	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0	0	0	0
Receivables - NHS	0	12,778	0	12,778
Receivables - non-NHS	0	4,315	0	4,315
Cash at bank and in hand	0	1,959	0	1,959
Total at 31 March 2016	0	19,052	0	19,052
Embedded derivatives	0	0	0	0
Receivables - NHS	0	11,652	0	11,652
Receivables - non-NHS	0	1,941	0	1,941
Cash at bank and in hand	0	1,003	0	1,003
Total at 31 March 2015	0	14,596	0	14,596

27.3 Financial Liabilities	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0	0	0
NHS payables	0	4,260	4,260
Non-NHS payables	0	12,245	12,245
PFI & finance lease obligations	0	94	94
Other financial liabilities	0	35,229	35,229
Total at 31 March 2016	0	51,828	51,828
Embedded derivatives	0	0	0
NHS payables	0	2,255	2,255
Non-NHS payables *(restated)	0	3,642	3,642
Total at 31 March 2015	0	5,897	5,897

28. Events after the end of the reporting period

In 2015/16 the Trust reported an adjusted retained deficit of £34.5m. The Trust is forecasting a deficit of £39.8m in 2016/17 which is, in the Trust's view, a realistic forecast based on increased costs associated with service developments, current levels of vacancies and increased levels of resilience.

The Service Developments will require additional staff that will potentially come at a premium if posts are unable to be filled under the new national capped rates. Due to the levels of vacancies that the Trust is already suffering, additional resourcing will put a greater strain on an already limited pool of staff.

An ACAS statement setting out the terms of the junior doctor's contracts agreement has been presented to the government and NHS employers and BMA on the 18 May 2016. This has now been agreed by all parties as resolving the current dispute subject to securing the support of BMA junior doctor members in a referendum. Some elements of the new contract, if approved in the referendum, will be implemented in August this year and all junior doctors will move on to the agreed new terms between October 2016 and August 2017. A full contract agreed between the parties will be published at the end of May 2016. There may be a cost implication when the contract is fully rolls out in October 2016.

The Trust will also incur additional employer costs as result of changes to National Insurance (NI) costs and pay uplifts resulting from the national pay award. The gross increase to the Tariff offsets the additional costs for inflation, NHS Litigation Authority Medical Insurance and NI adjustment however incremental drift is a cost pressure as it is not met by this increase.

Profitability alone does not ensure the Going Concern status of an organisation. The critical factor that management use to determine the Going Concern status of Croydon Health Services Trust is whether we can maintain sufficient working balances, to ensure our creditors are paid. The Trust's Better Payment Practice figures showed a weakening in the Trust's ability to pay suppliers within 30 days in 2015/16. The Trust mandated the use of Purchase Orders in 2015/16 which for a short while slowed the authorisation process at the Trust. However, the real cause of the weakening position was the fact that the Trust suffered cash shortages throughout the year. The Trust was reliant on its working capital facility of £21.3m which attracts interest of 3.5% until February when its application for a revenue support loan of £26.4m at an interest rate of 1.5% was approved. The Trust effectively was loaned £26.4m to pay back its working capital support facility and given an additional £5.1m to pay a backlog of creditors, some of which related to prior financial years. Having replenished its working capital facility the Trust drew down an additional £3.2m of support to pay creditors in March 2016. This took the total revenue support received in 2015/16 to £29.6m.

In 2016/17 the Trust will continue to rely on its working capital facility to pay creditors. Our planned deficit of £39.8m would suggest that we will need to submit our application for revenue support earlier in the financial year. The Trust has contacted NHS Improvement with regard to the issuing of a similar letter of support re cash as that which was received at the end of the last financial year. NHS Improvement has provided the Trust with an assurance that the Department of Health will make sufficient cash financing available to the Trust, either through an Interim Revolving Working Capital

Support Facility or an Interim Revenue Support Loan, over the next 12 months period such that the Trust is able to fund all essential operational liabilities.

The Trust continues to receive cash support from the DH in the form of a capital investment loan which will be drawn down over the course of the next two financial years to fund the on-going refurbishment of the Emergency Department at a total cost of £21m. The support of the DH in this regard gives us additional support to the Trust's going concern status.

The Trust therefore has a reasonable expectation that adequate resources will be available to continue in operational existence for the foreseeable future.

29. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with Croydon Health Services NHS Trust.

Body	£000s	Nature of Transactions/Relationship
Croydon CCG	184,436	Revenue/expenditure for the provision of healthcare and other services
Bromley CCG	3,595	Revenue for the provision of healthcare and other services
East Surrey CCG	2,261	Revenue for the provision of healthcare and other services
Lambeth CCG	3,582	Revenue for the provision of healthcare and other services
Merton CCG	1,979	Revenue for the provision of healthcare and other services
Sutton CCG	1,560	Revenue for the provision of healthcare and other services
Health Education England	9,145	Revenue for education and training
NHS Litigation Authority	12,242	Payments for Clinical Negligence Scheme for Trust's contributions
NHS England	22,828	Revenue for the provision of healthcare and other services
St Georges Healthcare NHS Foundation Trust	11,704	Payments as host of South West London Pathology Joint Operation and other healthcare services
Moorfields Eye Hospital NHS Foundation Trust	1,749	Revenue/expenditure for the provision of healthcare and other services
Epsom and St Helier NHS Trust	809	Revenue/expenditure for the provision of healthcare and other services

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. These are listed below:

Body	£000s	Nature of Transactions/Relationship
HM Revenue & Customs	10,928	PAYE, National Insurance contributions and VAT refunds
National Health Service Pension Scheme	15,145	Employers' and employees' pension contributions
Croydon London Borough Council	9,075	Revenue/expenditure for the provision of healthcare and other services

The Trust Board is the Corporate Trustee of the Croydon Health Services Charitable Fund (Registered Charity No. 1054824), and some of the members of the Trust Board are also members of the Charitable Funds Committee. The total value of the charitable contributions to the Trust was £154k in 2015/16 (£187k in 2014/15).

30. Losses and special payments

The total number of losses cases in 2015/16 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
	£s	
Losses	108,191	31
Special payments	28,561	18
Total losses and special payments	136,752	49

The total number of losses cases in 2014/15 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
	£s	
Losses	106,733	58
Special payments	80,386	21
Total losses and special payments	187,119	79

31. Financial performance targets

31.1 Breakeven performance	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
	£000s									
Turnover	166,030	177,771	184,653	198,499	241,804	236,941	243,551	244,595	246,279	255,354
Retained surplus/(deficit) for the year	122	5,044	2,149	1,098	4,913	4,059	9	(25,136)	(27,286)	(32,380)
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	8	0	0	0	5,428	(463)	(1,686)
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	(92)	190	25	217	(430)

Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	0	0	0	0	0	0	0
Absorption accounting adjustment	0	0	0	0	0	0	0	0	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	3
Break-even in-year position	122	5,044	2,149	1,106	4,913	3,967	199	(19,683)	(27,532)	(34,493)	
Break-even cumulative position	(5,790)	(746)	1,403	2,509	7,422	11,389	11,588	(8,095)	(35,627)	(70,120)	

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'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.

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
	%	%	%	%	%	%	%	%	%	%
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.07	2.84	1.16	0.56	2.03	1.67	0.08	(8.05)	(11.18)	-13.51

Break-even cumulative position as a percentage of turnover	-3.49	(0.42)	0.76	1.26	3.07	4.81	4.76	(3.31)	(14.47)	-27.46
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The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

31.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

31.3 External financing

The Trust is given an External Financing Limit which it is permitted to undershoot.

	2015/16	2014/15
	£000s	£000s
External Financing Limit (EFL)	34,862	24,141
Cash flow financing	34,303	24,103
Finance leases taken out in the year	94	0
Other capital receipts	0	0
External financing requirement	34,397	24,103
Under/(over) spend against EFL	465	38

31.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015/16	2014/15
	£000s	£000s
Gross capital expenditure	13,411	8,020
Less: book value of assets disposed of	0	0
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(667)	(18)
Charge against the capital resource limit	12,744	8,002
Capital resource limit	12,819	8,350
(Over)/underspend against the capital resource limit	75	348

Appendix A - Croydon Health Services NHS Trust Year End Performance Summary – 2015/16

Croydon Health Services continues to review its overall performance standards through its high level dashboard. Reporting is aligned with the Care Quality Commission's (CQC) five domains and is based on indicators set out in the TDA Accountability Framework and Oversight model.

Performance against key quality, operational and finance measures is reviewed at the Trust Board, Board Committees, within Clinical Directorates and at Directorate Performance Review Meetings. The Trusts end of year performance dashboard sets out high level performance against a range of measures which is detailed below:

Responsiveness Standards	2015/16	Annual Target
A&E 4 Hour Total Time in Department (All Types)	92.33%	95.00%
A&E 4 Hour Total Time in Department (Type 1)	88.70%	95.00%
A&E : 12 Hour Trolley Waits	0	0
RTT waiting times for admitted pathways: percentage within 18 weeks	80.10%	90.00%
RTT waiting times for non-admitted pathways: percentage within 18 weeks	92.80%	95.00%
RTT waiting times for incomplete pathways	94.53%	92.00%
RTT Incomplete 52+ Week Waiters	12	0
Diagnostic > 6 Week Waits	0.22%	1.00%
Cancer Waits - Referral to First Appt for Urgent Suspected Cancer (14 Days)	95.28%	93.00%
Cancer Waits - Referral to First Appt for Breast Symptoms (14 Days)	94.75%	93.00%
Cancer Waits - Subsequent Treatment: Surgery (31 Days)	100.00%	94.00%
Cancer Waits - Subsequent Treatment: Drugs (31 Days)	100.00%	98.00%
Cancer Waits - Diagnosis to First Treatment (31 Days)	98.61%	96.00%
Cancer Waits - Referral to Treatment for Urgent Suspected Cancer (62 Days)	85.61%	85.00%
Cancer Waits - Referral to Treatment for NSP Referrals (62 Days)	91.30%	90.00%
Cancer Waits - Referral to Treatment for Consultant Upgrade Referrals (62 Days)	96.12%	85.00%
Urgent Operations being Cancelled for the Second Time	0	0
Cancelled Operations not readmitted within 28 Days	3	0
Cancelled Operations not readmitted within 28 Days - % of all Last Minute Cancellations	1.88%	5.00%
Certification against compliance/ access to health care for people with learning disabilities	C	C
Delayed Transfers of Care	2.12%	3.50%

Caring Standards	2015/16	Annual Target
Friends and Family Test - % Likely to Recommend A&E	92.60%	90.00%
Friends and Family Test - % Likely to Recommend DC	96.63%	90.00%
Friends and Family Test - % Likely to Recommend Inpatients	92.68%	90.00%
Friends and Family Test - % Likely to Recommend Maternity	94.39%	90.00%
Friends & Family Test - % Likely to Recommend Outpatients (Inc Purley)	93.81%	90.00%
Friends & Family Test - % Likely to Recommend Community	96.95%	90.00%
Timely Response to Complaints	81.00%	80.00%
Mixed Sex Accommodation Breaches	0	0

Safe Standards	2015/16	Annual Target
Infection Control: Clostridium Difficile Incidences (Hospital Acquired)	20	<16
Infection Control: MRSA Bacteraemias (Hospital Acquired)	1	0
Incidents: Never Events	1	0
Patient Safety Thermometer - % of Patients Harm Free	96.00%	95.00%
Maternal Deaths	1	0
VTE Risk assessment on admission as Inpatient	95.28%	95.00%
Incidents: Serious Incidents	91	Trend
Admissions to adult facilities of patients under 16 years of age	0	0

Effectiveness Standards	2015/16	Annual Target
Emergency Re-Admission Rate: Post Elective Spell	2.27%	Trend
Emergency Re-Admission Rate: Post Emergency Spell	11.44%	Trend
SHMI - Rolling 12 months	110.40	100.00
Hospital Standardised Mortality Ratio (HSMR)	86.89	100.00
Midwife/Birth Ratio	1:26	<=1:28 Green, >1:40 Red
New Birth Visits within 10-14 Days	84.20%	90.00%

Well Led Standards	2015/16	Annual Target
Workforce Turnover	14.86%	10.50%
Sickness Absence	3.31%	3.50%
Vacancy Rate (Census Point)	14.79%	11.50%
Temporary costs as % of Total Paybill	20.80%	10.00%
PDR Compliance (Census Point)	68.00%	85.00%
Friends and Family Test - Response Rate A&E	13.07%	20.00%
Friends and Family Test - Response Rate DC	20.30%	30.00%
Friends and Family Test - Response Rate IP	35.57%	30.00%
Friends and Family Test - Response Rate Maternity	25.32%	20.00%
Friends & Family Test - Response Rate Outpatients	8.43%	25.00%

Appendix B - Croydon Health Services NHS Trust Sustainability Report 2015/16

As an NHS organisation and as a spender of public funds, we have an obligation to reduce our environmental impact. This approach reduces the Trust's impact on the environment and saves money as less resources are consumed. Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge our responsibility to becoming more sustainable to the environment by working hard to minimise our carbon footprint.

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

1.1. Data Normalisation

It is important to consider the hospitals environmental impact in proportion to the number of people it employs and the floor space of the trusts buildings. Therefore in order to provide some organisational context,

Table 1 explains how the organisation has changed over time.

Context info	2013/14	2014/15	2015/16
Floor Space (m ²)	93,140	97,776	97,776
Number of Staff	3,677	3,612	3,673

Table 1: Staff, floor space & occupied beds

To understand the Trust performance on sustainability, the organisational carbon footprint can be normalised in terms of gross internal area (GIA) or number of employees. Carbon footprint by GIA and number of employees remains flat due to increases in procurement footprint which outweigh reductions in energy footprint.

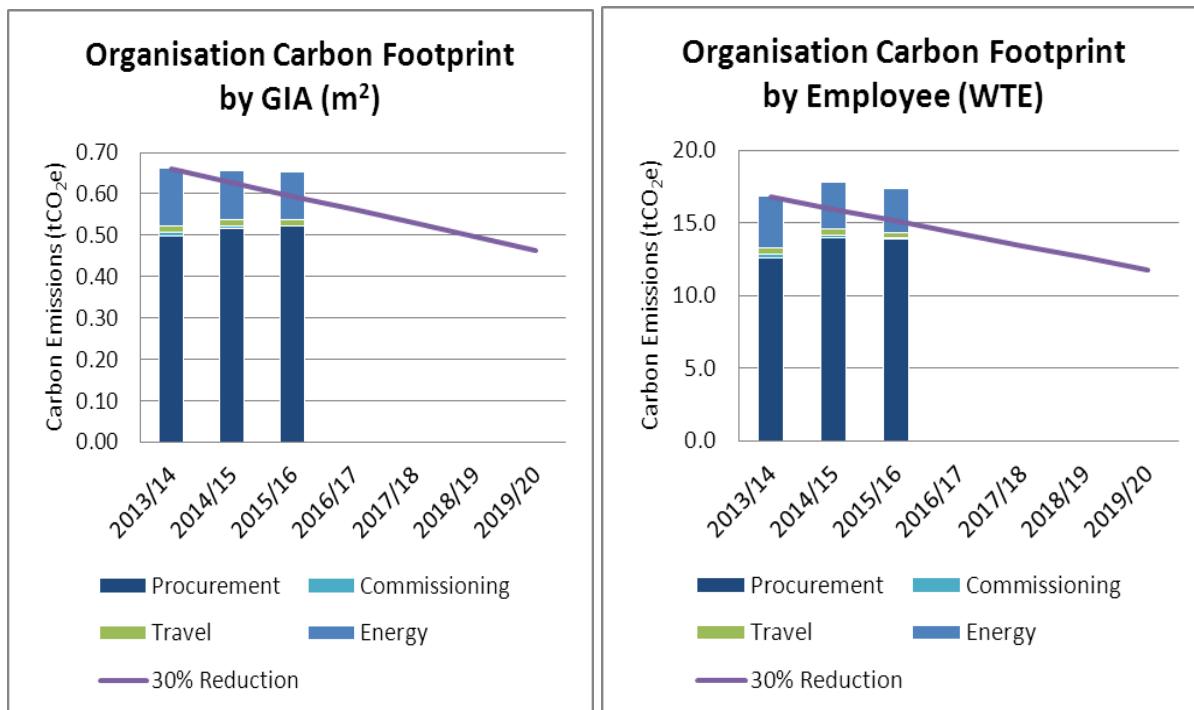


Figure 1: Carbon Footprint normalised by GIA and number of employees

Benchmarking by Gross Internal Area (tCO_2e/m^2)				Benchmarking by Number of Staff (tCO_2e/WTE)		
Area	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16
Energy	0.14	0.12	0.12	3.54	3.23	3.07
Travel	0.01	0.02	0.02	0.39	0.41	0.39
Procurement	0.50	0.52	0.52	12.58	14.00	13.92
Commissioning	0.01	0.01	0.00	0.30	0.14	0.01
Total	0.66	0.66	0.65	16.80	17.77	17.40

Table 2: Trust Emissions Breakdown by GIA & WTE

The remainder of this report uses figures that have been compared directly to the previous years with no normalisation for floor area or staff numbers so the year on year changes can be more clearly seen.

1.2. Overall strategy for sustainability

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Table 3 shows this below.

Area	Is sustainability considered?
Travel	No
Procurement (environmental)	Yes

Procurement (social impact)	Yes
Suppliers' impact	Yes

Table 3: Areas where sustainability is considered

We are currently developing a sustainability strategy and a Sustainable Development Management Plan (SDMP). The purpose of this strategy is to embed the trusts commitment to sustainable development in long term business objectives, and ensure long term consistency in the approach to achieve them. The scope of this strategy is focused on improving environmental sustainability including:

- Carbon emissions reduction
- Minimising usage of natural resources
- Preparing the Trust for extreme weather events

This strategy includes several future initiatives to allow us to achieve our goal of 30% reduction in carbon emissions, these include:

- Combined heat and power unit optimisation
- Optimisation of heat use
- Lighting upgrade
- Green travel initiatives
- Staff behaviour change
- Renewable energy implementation

1.3. Carbon Footprint

The Trust believes it is important to understand the carbon impact of all aspects of its work and are working to map out how and where its carbon footprint sits.

Table 4 & Figure 2 below shows the proportions of the carbon footprint by major usage areas. It can be seen that 76.4% of the Trust's carbon footprint is due to procurement and 17.0% is due to energy. Capital spend in Figure 2 is modelled using the NHS Sustainable Development Unit (SDU) carbon factors for capital spend, the calculation and breakdown of other areas are discussed further below.

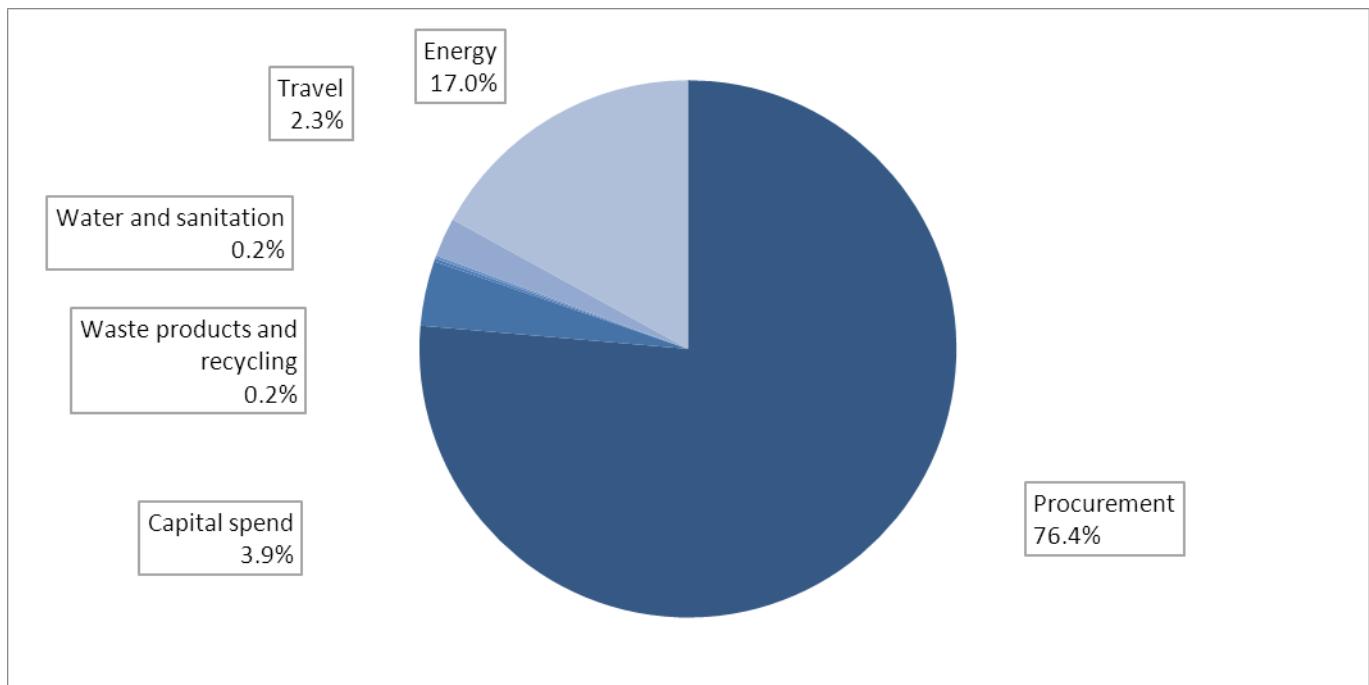


Figure 2: Proportions of Carbon Footprint

Area	Emissions (tCO2e)
Procurement	48,404
Energy	10,777
Capital spend	2,472
Travel	1,484
Water and sanitation	120
Waste products and recycling	115
Total	63,426

Table 4: Trust Emissions Breakdown

1.4. Procurement

This section looks at the Trust's carbon emissions from procurement. Procurement makes up the largest proportion of the Trust's carbon footprint and accounts for emissions estimated at 48,800 tCO₂e per annum. These emissions were calculated using the NHS SDU carbon factors based on spend for each purchase category. These figures do not account for inflation in cost of goods and services and as such procurement emissions increase in line with year on year increases in cost. Any underlying improvements in procurement sources are therefore not shown in these figures. Figure 2 below shows the breakdown of emissions by different spend category. Over the next year the Trust aims to improve the tracking of its procurement and commissioning carbon footprint.

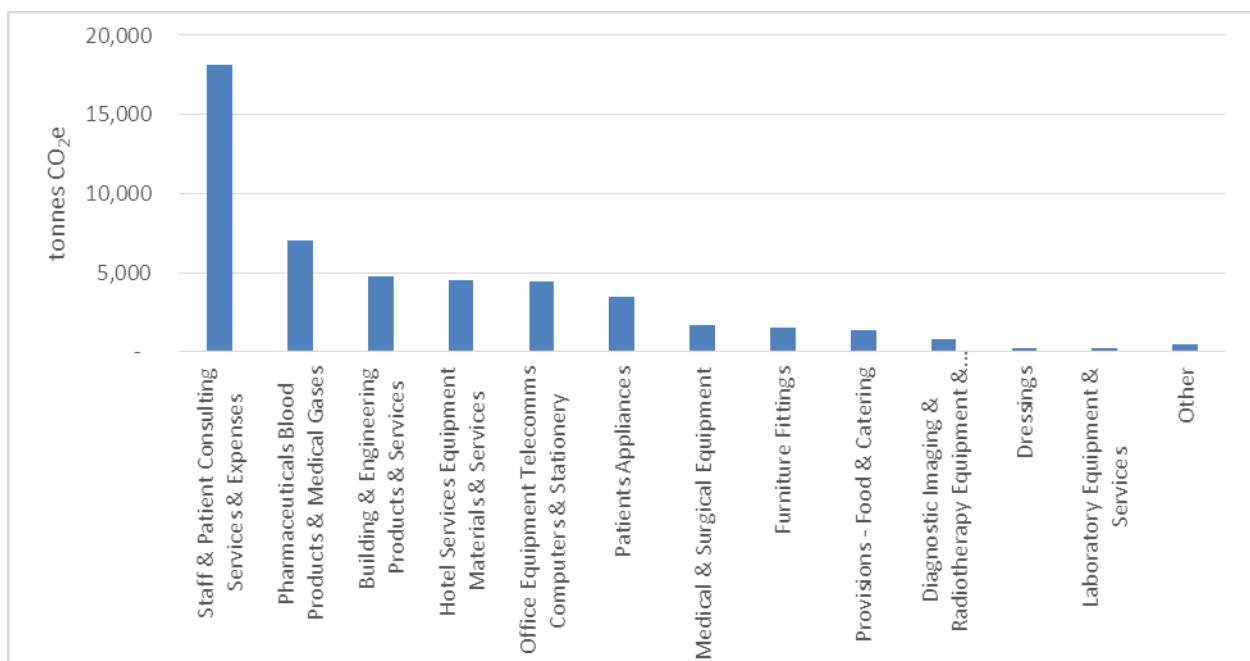


Figure 3: Procurement & Commissioning Carbon Footprint by Category

1.5. Energy

This section looks at the Trust's carbon emissions from energy and total energy spend. This provides a top line view of the types of energy the Trust is using, the biggest change to energy use being the installation of two Combined Heat and Power (CHP) engines half way through 2014/15. This significantly changed the proportions of gas and electricity used by the Trust as the CHP engines generated 71.7% of the electricity requirements in 2015/16 using natural gas, vastly reducing imported electricity. The installation of the engines also explains the cost reductions in energy spend seen over the last two years. It is however important to remember that this cost reduction does not factor in the operating costs of the CHP engines.

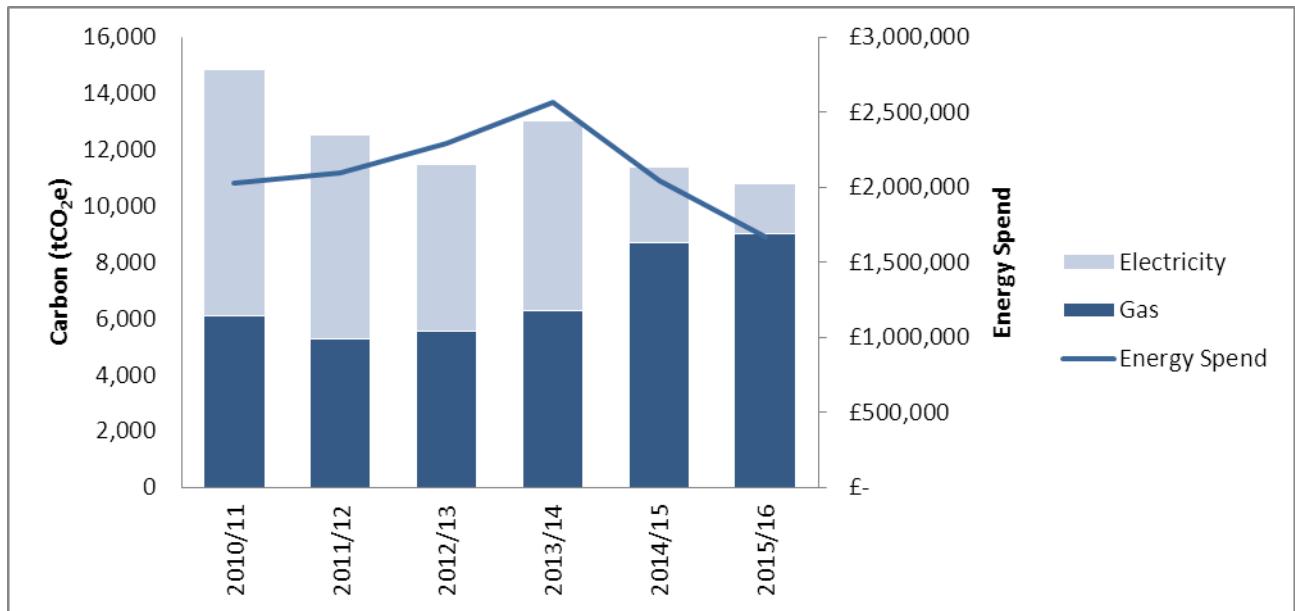


Figure 4: Carbon Emissions by year

Figure 4 shows that the overall carbon emissions from energy use decreased by 5.3% from the previous year and 17.1% from pre CHP levels. The amount of gas used increased by 1,500 MWh (3.8%) as the CHP engines ran for a full year, this meant that more electricity was produced on site and less had to be imported dropping electricity carbon emissions by 34.4%.

2015/16 was the first year that the CHP engines will have run for the full year. There have been a number of issues with CHP performance that are in the process of being resolved or have been fixed. This should improve the efficiency of the CHP engines, reducing gas use over the coming year.

Table 5 below show more detail on how much of each energy type was used and the amount that was spent by energy type.

Resource		2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Gas	Use (kWh)	29,778,122	25,831,662	27,052,170	29,545,625	41,365,855	42,929,557 ¹
	tCO ₂ e	6,085	5,279	5,528	6,268	8,679	9,007 ¹
Electricity	Use (kWh)	14,738,224	12,912,997	10,387,845	14,570,526	11,550,782	14,005,282 ¹
	tCO ₂ e	8,762	7,236	5,929	6,736	2,698	1,770 ¹
Total Energy tCO ₂ e		14,848	12,515	11,458	13,004	11,377	10,777 ¹
Energy Spend		£ 2,024,955	£ 2,091,451	£ 2,296,089	£ 2,562,898	£ 2,045,020	£ 1,664,692 ¹

Table 5: Carbon emissions and energy spend (¹ data used extrapolated from 11 months usage data [April 15 – Feb 16])

From

Table 5 it can be seen that the Trust spent £1.66m on energy last financial year. This is a decrease of 18.6% from the previous year and 35% from pre CHP levels. Last year 10,926 MWh of electricity were generated from the two CHP engines. Of this generated electricity, 885 MWh, was sold back to National Grid, the profits from this sale are not included in the energy spend. The majority of generated electricity was consumed by the site reducing the carbon emissions associated with the use of grid electric. The gas used to generate the exported electricity is included in the chart above as the generated heat was used on-site.

1.6. Travel

We can improve local air quality and improve the health of our community by promoting active / non-carbon intense travel – for our staff, patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We also support a culture for active travel to improve staff wellbeing and reduce sickness.

Minor decreases in patient transport mileage and business travel are due to year on year fluctuations in travel requirements. The average claim for business travel in 2015/16 was 193 miles per person per month down from 201 miles per person per month in 2014/15. The Trust is bringing in a new mileage claims system in Q1 2016/17 which aims to simplify mileage tracking and prevent erroneous claims. It is anticipated that there will be a reduction in business mileage in 2016/17.

Staff commuting impact is estimated from total number of staff on site and average distances travelled from National Travel Survey figures. More staff are employed by the Trust than last year so the impact of this has increased. The Trust is aiming to improve its knowledge of lengths and type of staff commuting in the next year. This will enable the Trust to better model emissions due to staff commuting and implement programs to reduce the environmental impact of staff commuting.

The site has recently installed electric vehicle charge points to facilitate the uptake of low carbon vehicles.

Category	Mode	2013/14	2014/15	2015/16
Patient Transport Mileage	km	155,686	242,094	230,961 ¹
	tCO ₂ e	36	55	52 ¹
Business Travel	km	1,081,569	1,110,074	1,005,275
	tCO ₂ e	248	253	226
Staff commute	km	4,494,807	5,672,142	5,837,560
	tCO ₂ e	1,032	1,295	1,312

Table 6: Travel Impact (¹ data used extrapolated from 11 months usage data [April 15 – Feb 16])

1.7. Waste minimisation and management

The Trust recognises the importance of reducing waste and in particular waste sent to landfill. Last year 1,739 tonnes of waste was created. Figure 5 below shows the waste destinations. It can be seen that 39% was recycled and 39% was burnt for energy recovery. The amount of waste sent to landfill decreased significantly from 2014/15 with a 23.5% reduction or 81.3 tonnes being sent to other treatments. Recycling increased 54% from 2014/15 levels. The Trust is currently investigating alternative waste disposal methods to further reduce the environmental and carbon impact of its waste.

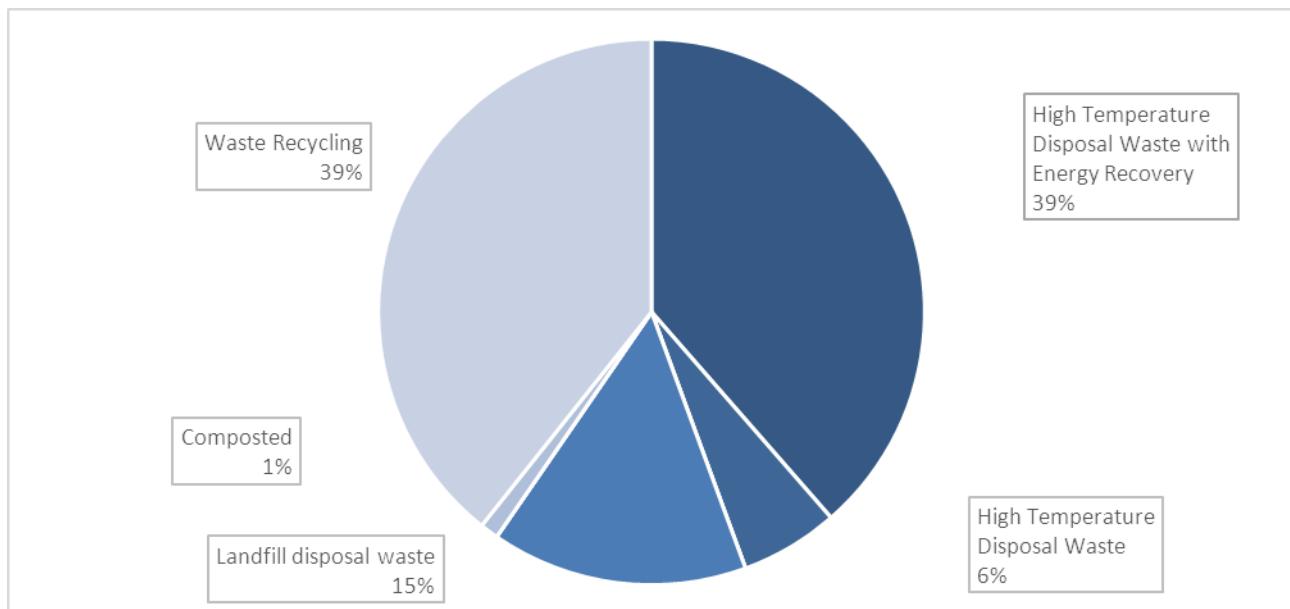


Figure 5: Waste Destinations (data used extrapolated from 10 months usage data [April 15 – Jan 16])

1.8. Water Consumption

The Trust recognises clean water is a finite resource and its use must be reduced and optimised.

Figure 6 below show how much water the Trust used compared to previous years. It can be seen that the trust used 16.5% less water in 2015/16 than in 2014/15 reducing its carbon impact by 24 tCO₂e. This has been achieved through reduction in leakages.

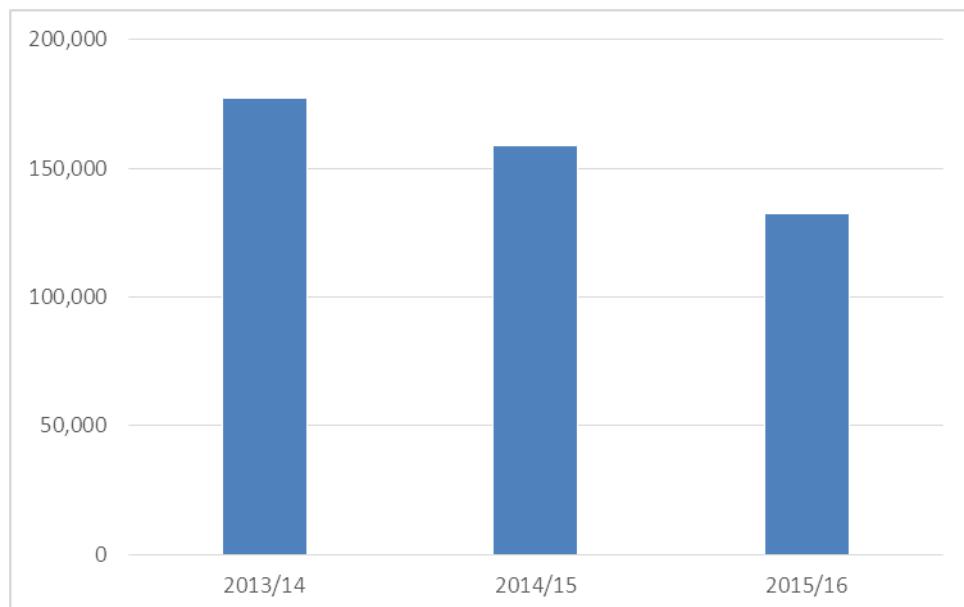


Figure 6: Mains Water use by year (m³)

To find out more about our services, call us
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