ANNUAL REPORT

2015-2016

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

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

www.epsom-sthelier.nhs.uk

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1 OVERVIEW

Our team hard at work in one of our operating theatres

Welcome – a message from our Chairman and Chief Executive

Welcome to our annual report for 2015-16 – a look back at our busiest ever year, including the key achievements, improvements and challenges we experienced over the past 12 months.

We are delighted to say that, over the course of the year, our staff worked tirelessly to provide treatment and care in a staggering 899,250 patient contacts – that's an increase of more than 10,000 people compared to the previous year. We would like to take this opportunity to publicly thank all of our staff and volunteers for their continued hard work and commitment to caring for our patients, no matter what the circumstance or the scale of the challenge.

Despite the unprecedented demand on our services, we are pleased to tell you that we were able to make significant strides in planning for the future of our hospitals last year, and have put the wheels in motion on a number of different and exciting long-term plans.

For the first time in recent history, we published a five year strategy for Epsom and St Helier hospitals, cementing our commitment to providing consultant-led, 24/7 A&E, maternity and inpatient paediatric services. Developing and publishing our five year strategy has provided certainty to our patients, public and staff on our future, and we couldn't be more proud of that.

As a result of the five year strategy, we have been able to increase the number of clinical staff by almost 350, which has in turn resulted in our agency rate being halved and our agency nurse spend reducing by 70%.

We believe that the biggest challenge we now face is the state of our buildings. In June 2015, we launched an in-depth review into the fabric of our buildings. Since then, we have met with and had feedback from hundreds and hundreds of people about what they want from our hospital buildings and how we can make sure our buildings match their health needs for years to come.

That work is still continuing, and we hope to make further strides forward in the coming year.

But of course, all of this strategic planning had to be delivered in addition to our day job of providing our patients with a high level of compassionate care and keeping our hospitals running smoothly.

During the year, we marked a number of important achievements that showcase our commitment to great patient care, including achieving key waiting time standards for our cancer patients, keeping mortality consistently lower than expected in hospitals of our size, and seeing a further decrease in the number of hospital-associated infections.

But 2015-16 was also a year of challenges – we did not perform as well as we had planned to financially, and have put a number of stringent measures in place to make sure that we can save money and perform in line with our forecasts throughout the year. You can read more about our finances in The Accounts from page 56.

For more information about the performance of our hospitals, including our regularly updated waiting times and infection prevention and control figures, please visit **www.epsom-sthelier.nhs.uk/performance**.

We are incredibly proud of our hospitals and staff, and we hope that this report reflects all of the hard work that goes into making our organisation the success that it is. We hope you find this report interesting and informative.

Laurence Newman
Chairman
laurence.newman@esth.nhs.uk

Daniel Elkeles
Chief Executive
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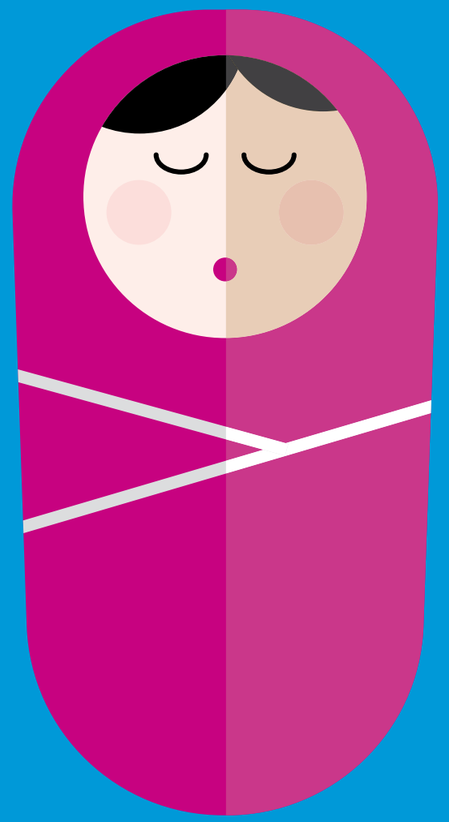
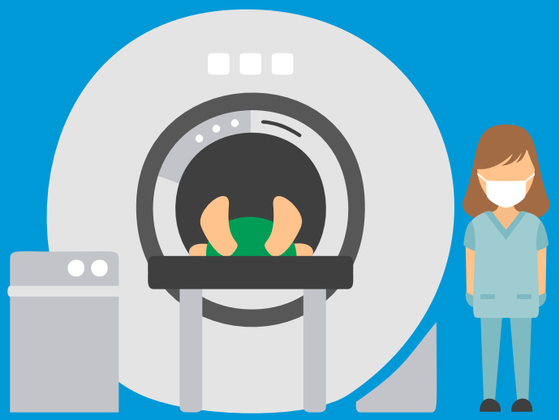
We have treated a record number of patients – more than 899,250 people came to us for care

5,004 babies were born in our hospitals, with an additional 108 babies arriving by home birth



We reduced waiting times for those patients needing urgent cancer care

We invested £15.5 million in improving our facilities and purchasing new equipment



About us

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

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

With more than 899,000 people coming to our hospitals for care and treatment every year, our team of almost 5,000 staff and 500 volunteers work around the clock to keep our busy hospitals running smoothly.

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

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

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

DID YOU KNOW?

The most common reason for people being admitted to our hospitals was to have cataract surgery.

Medics in training in our state-of-the-art simulation centre

Our five year strategy

At the start of the year, we published a five year strategy that laid out how both Epsom and St Helier hospitals will continue to provide consultant-led, 24/7 A&E, maternity and inpatient paediatric services.

In addition, St Helier will provide specialist and emergency care, such as acute surgery, for our most sick patients and Epsom will expand its range of planned care. We will work with GPs to provide significantly more care in community settings so that people only come to hospital when it is absolutely necessary.

But without a dedicated team of staff and volunteers who feel valued and supported in their work, we simply would not be able to achieve that. So, along with greatly improving substantive staffing levels, we seek to engage, empower, develop and equip our teams to perform to their full potential, with clear responsibility and accountability. We have committed to help and reward all staff who actively wish to come on this change journey with us, supporting them in their education and continuing professional development.

We aspire to be a high quality organisation where we are both an 'employer of choice' and a 'provider of choice'.

The principal challenges that we face in order to deliver our vision are:

- The need to strengthen staffing in key service areas – we will tackle this through a proactive and creative recruitment strategy, by valuing our staff and improving their working lives, and through role and service redesign.
- Variability in the delivery of clinical care, which increases risk and potential harm for our patients. We will work together to instil the culture of 'one team, one trust' and work to consistent, evidence-based operating practices across all our services and sites.
- Poor estates – the quality of the St Helier estate, in particular, is unacceptable. We will tackle this by agreeing a five year investment plan for our estate at both sites and developing a long term plan to deliver first-class facilities for our patients as part of the ongoing work across south west London.
- Finance – in order to develop new models of care, invest in quality and innovation, and tackle our poor estate, we will need to create a recurrent surplus each year. This requires us to become more efficient, remove unnecessary duplication and reduce our overhead costs.

Triple trouble - parents Finlay and Emanuela get ready to take their new arrivals home

Alistair, Frederick and Finlay Campbell were the first set of triplets born at St Helier in 2016

Our values and objectives

Our values

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

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

Some of our inpatients told us that they often think of things to ask their doctors and nursing teams after they've been seen, and that it would be helpful to have a place to jot down questions and thoughts so that they can remember at a later time.

As part of the Patient First programme, we launched specially designed post-it notes so that patients can take notes of their burning questions, and our staff know to check the post-it pad at regular intervals and provide answers

The team in our Assisted Conception Unit meet to consider a patient's care

Our values are:

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

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

Respect each other – working for the NHS can be challenging at times, with limited resources and more people than ever needing our help. With a mutual respect for our colleagues, we can appreciate and recognise everyone's contribution through their hard work and commitment.

Protect the environment – by doing all we can to cut our carbon footprint, we can help protect the environment and, importantly, save money in what are challenging financial times across the health service. It is not just about turning off lights when you leave the room – although that does make a huge difference. It is much bigger than that: from the way we deal with our waste and recycling to the way that we order our equipment and supplies, we can all make a difference to our hospitals' carbon footprint.

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

Our objectives

Each year, we set corporate objectives for the organisation. For 2015-16, our corporate objectives laid out our aspirations as follows:

- Delivering safe and effective care with respect and dignity
- Creating a positive experience that meets the expectations of our patients, their families and carers
- Providing responsive care that delivers the right treatment, in the right place at the right time
- Being financially sustainable
- Working in partnership.

PATIENT FIRST

2 PERFORMANCE ANALYSIS

Deliver safe and effective care with dignity and respect

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

We measure our performance in a number of ways, from how we achieve key standards, to commissioning detailed surveys that tell us what our patients really think of our services. In November 2015, the Care Quality Commission undertook a thorough inspection of all our services – you can read more about our performance on page 21.

We also ask our patients to take part in the Friends and Family Test (which asks if patients rate our services highly enough to recommend us to a loved one should they need hospital care). **During this year, 70,142 patients had their say and a whopping 93.9% of people surveyed would recommend us to their friends and family.**

Keeping our patients safe

The hospital standardised mortality ratio (HSMR) is an indicator of whether the death rate at a hospital is higher or lower than you would expect. It looks at the majority of activity in a hospital where risk of death is significant, and compares how many people would be expected to die with the actual rate of death. Our HSMR was consistently lower than expected, meaning that we performed within the top quartile for all acute trusts throughout 2015-16.

We made a clear commitment to recruiting permanent staff during this year, and as a result, we have increased the number of clinical staff by almost 350, which has in turn resulted in our agency rate being halved and our agency nurse spend reducing by 70%. That's great news for patients, who are benefiting from a greater continuity in their care, as well as our teams across the hospitals.

We also invested an additional £2.5 million in bolstering the number of consultants we have on our wards and in our departments, and have seen a significant increase in the range of services available overnight and at weekends.

As part of this work, we also enhanced leadership within the trust by progressing board development, appointing associate medical directors to lead on education, research and development, and innovation and quality, and developing clinical leaders in the directorates.

Chief Nurse Charlotte Hall and C6 Ward Manager Celestina inspect the newly refurbished ward

Investing in the care we provide

We continue to invest millions of pounds each year into improving our services and building on our achievements so far. This year was no different.

We invested more than £15 million in improving our hospital buildings and facilities, including £2.3 million on the brand new, state-of-the-art Eye Unit at St Helier and £757,000 on refurbishing the dedicated cardiology and respiratory ward (C6) at St Helier Hospital.

The project saw the Coronary Care Unit (CCU) and the main ward area of C6 transformed into a bright and welcoming environment that boasts top class facilities and a range of new equipment.

In December, The Rt Hon Chris Grayling, MP for Epsom and Ewell, officially opened the Eye Unit and brand new Cardiology Day Unit at Epsom Hospital.

Before unveiling the special commemorative plaque in the Eye Unit, which opened its doors for the first time earlier in the year following a £1.2 million investment, Mr Grayling met with staff and was given a tour of the state-of-the-art facility, including the cutting edge equipment and modern fixtures and fittings throughout.

It was then time to cut the ribbon to the Cardiology Day Unit, which sits adjacent to the Eye Unit in block G (Woodcote Wing). The new service has allowed the trust to expand the range of care offered to cardiac patients, providing a waiting and recovery area for people undergoing investigative procedures in the mobile Cardiac Catheterisation Unit (often referred to as a cath lab).

This year also saw the official opening of our £100,000 simulation training centre at Epsom (pictured right). The centre includes a collection of six simulation manikins which represent different ages and genders (including a pregnant woman, three adults, a young child and a baby), allowing staff to undergo realistic training in a number of different scenarios. And in order to be as lifelike as possible, the manikins have a pulse, can mimic talking, crying, sweating, and even urinating. We were honoured to welcome broadcaster Jeremy Vine to declare the unit officially open.

The Rt Hon Chris Grayling, MP for Epsom and Ewell, officially opened the Eye Unit and brand new Cardiology Day Unit at Epsom Hospital

Broadcaster Jeremy Vine checks for a pulse on one of the state-of-the-art manikins

Protecting our patients' information

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

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

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

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

Every member of staff is required to undertake mandatory and refresher training on information governance, and ensure all portable IT equipment – such as laptops and data sticks – are encrypted.

The Department of Health's 'Information Governance Toolkit', which the trust is required to complete yearly, provides guidance and assurance that the risks to data security, including data protection and confidentiality, are minimised. It also requires us to have robust processes in place to monitor and report any threats or incidents.

The trust achieved 72% in the Health and Social Care Information Centre's (HSCIC) information Governance Toolkit for 2015-16.

Throughout 2015-16, we experienced a total of 879 information governance incidents. Of those 21 were reported as a 'loss' and three were reported to the Information Commissioner's Office.

Principles of remedy

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

The six principles are:

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

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

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

STANDARD	RESULT
Infection prevention and control – have no more than **39** cases of Clostridium difficile.	**ACHIEVED –** we recorded **30** cases of Clostridium difficile.
Infection prevention and control – have **zero** cases of MRSA (bacteraemia).	**DID NOT ACHIEVE –** we recorded **five** cases of MRSA.
Emergency access – 95% of our 151,418 patients attending A&E should be treated, admitted or discharged within a maximum of four hours.	**DID NOT ACHIEVE –** we were just shy of this standard, with **94.5%** of our patients seen within the time limit.
18 week wait – 92% of patients waiting to start their consultant-led elective treatment should be seen within 18 weeks of referral.	**ACHIEVED – 92.5%** of our patients requiring admission were treated within 18 weeks.
Stroke care – at least **80%** of patients should spend at least **90%** of their hospital stay in a stroke unit.	**ACHIEVED – 84.1%** of patients spent 90% of their time in a stroke unit.
Cancer related standards	
Two week rule (the maximum wait for an urgent referral).	**ACHIEVED – 94.6%** of these patients were seen within this time.
31 days to treatment from confirmed diagnosis.	**ACHIEVED – 98.6%** of these patients were seen within this time.
Maximum waiting time of **62 days** from referral to treatment.	**DID NOT ACHIEVE – 80.5%** of our patients received treatment in this period. Although we were below where we aimed to be for the year, our performance against this standard improved greatly within the year.

Two biomedical scientists from St Helier were awarded medals for their efforts and bravery in helping to tackle the devastating Ebola outbreak that swept across parts of Africa this year. Pictured with their medals above are Patrick O'Brien, our Chief Executive Daniel and Anthony Fairbairn

Care Quality Commission registration

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

In November, our hospitals welcomed a team of inspectors from the CQC, as they began a detailed four-day inspection of our staff and services. The CQC are the independent regulator of health and social care in England, and it's their job to make sure patients are being given safe, effective, compassionate care. To get a full and thorough understanding of exactly how well our hospitals operate, inspectors interviewed staff about their work, talked to patients about the care they receive, and monitored the care being given to make sure the right systems and processes are in place.

Once the inspectors looked at every detail of our hospitals, they used their evidence to create a report and rating (which could either be outstanding, good, requires improvement or inadequate), which details what we do well and what we need to improve.

Our hospitals were rated as 'Requires Improvement', with SWLEOC being awarded the acclaimed rating of 'Outstanding'.

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

But, as well as things for us to be proud of as an organisation, there are areas that we need to improve. As a whole team, across the organisation, we have displayed a very tangible team spirit in order to address some tricky issues.

Great progress has been made on the areas that the CQC identified as concerns at the time of their visit – thank you everyone for all of your hard work in making improvements.

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

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

Since we launched our Patient First programme last year – an interactive programme that helps to ensure each and every patient is at the absolute centre of how the hospitals work – 42% of our entire workforce have undergone a full day's workshop.

Our Patient First programme is a credit to our hospitals, as it empowers all of our staff to recognise where improvements can be made and challenge any behaviour or standards that undermine great care for our patients. The programme helps our staff to drive forward meaningful change themselves and gives them a route to escalate issues where necessary.

Here are just a few examples of the changes that have been made as a result of our Patient First work:

- A full review into how easy it is to navigate our hospitals was launched, with improvements already implemented
- Photoboards on all of our wards show the names and roles of staff working in the department, so visitors know who's who
- Staff wear different coloured lanyards with roles printed on them so that patients can easily identify people who don't always wear uniforms, including doctors, pharmacists and porters
- Our nurses have introduced a 'dementia suitcase' and memory boxes for patients with dementia. These familiar items and distractions help to calm patients in the unfamiliar surroundings of a hospital.

You can sign up to our Patient First newsletter by emailing **patientfirst@esth.nhs.uk** – a great way to keep up with all of the latest goings on at our hospitals.

Christine Garrod, Senior Sister in children's A&E at Epsom

Engaging with our patients

We are committed to engaging with our patients and other local people through the use of social media, and at the time of writing, have more than 7,100 'followers' on Twitter and 2,700 'likes' on Facebook. Throughout the year, we also hosted a number of public events for our patients so that they could let us know what they think of our services.

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

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

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

Our top tweet of the year, which was seen by more than 6,600 people, featured our Chief Nurse Charlotte and Senior Communications Officer Adam

We have two onsite nurseries, dedicated to looking after children of staff while they are hard at work. Pictured here is Nursery Manager for Willows, Caroline Thomas

Senior nursing staff at Epsom and St Helier hospitals are sporting bright new uniforms that help make them more recognisable to patients and visitors

An engaged workforce

Feedback from the 2015 National Staff Survey has put us in the top 20% nationally for staff feeling engaged, which is determined by how many of our staff would recommend our hospitals as a place to work or receive treatment, motivation at work and the ability of staff to contribute to improvement at work. That is a fantastic result, but there's more!

We were also in the top 20% for the following:

- Staff satisfaction with the quality of work and patient care they are able to offer
- Staff motivation at work
- The low number of staff experiencing physical violence from patients, relatives or the public
- Effective use of patient/service user feedback from the annual staff survey.

DID YOU KNOW?

The pages of our website were viewed more than 1.8 million times – the most searched for term was 'blood test', and we had visitors from as far away as India, Saudi Arabia and New Zealand.

A medical photographer at Epsom and St Helier hospitals is raising money and awareness for refugees in Europe, by pledging to walk a staggering 4,350 kilometres (2,702 miles) – the distance between Damascus and London

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

Chief Executive Daniel Elkeles (centre) was joined by the Rt Hon Tom Brake, MP for Carshalton and Wallington, and Paul Scully, MP for Sutton and Cheam, as well as special guests from the NPC and Sutton Seniors' Forum. Mr Scully and Mr Brake also signed the Dignity Code

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

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

We are absolutely delighted that we met key standards for patients waiting for cancer treatment, from the first appointment with us because a GP suspects a possible cancer, to the 62 day maximum waiting period from referral to treatment, we strived to be responsive to these patients.

Staff working in our A&E departments went above and beyond to ensure that our patients were seen, treated or discharged within a maximum of four hours. Despite sterling efforts from staff, we were just below the national standard of 95%, caring for 94.5% of patients in our departments within four hours.

Considering that 151,418 people came to our A&E departments during the year, that was not an easy thing to achieve and we performed strongly when compared to other acute trusts in the local area.

In addition, nurses caring for patients living with dementia at Epsom and St Helier hospitals have developed a series of initiatives to help connect with those patients, keep them comfortable and support their families.

The new, innovative resources include tools such as a dementia care chart on patients' beds that indicates key information about the patient's likes and dislikes, specially made knitted hand muffs known as 'Twiddlemuffs', and a 'reminiscence suitcase' to help evoke the patient's happy memories.

We also specially adapted one of our wards to care solely for people living with dementia. Ward C2 at St Helier has been specifically redesigned to include features known to help people with dementia feel less disorientated or confused, including brightly coloured walls around the beds to help patients recognise their own bed space.

Epsom and St Helier hospitals have signed up to the National Pensioners' Convention (NPC) Dignity Code, reaffirming the trust's ongoing commitment to providing elderly people with the care they deserve (pictured above right).

To mark the occasion, Chief Executive Daniel Elkeles was joined by the Rt Hon Tom Brake, MP for Carshalton and Wallington, and Paul Scully, MP for Sutton and Cheam, as well as special guests from the NPC and Sutton Seniors' Forum. Mr Scully and Mr Brake also signed the Dignity Code.

DID YOU KNOW?

The busiest week for A&E was the penultimate week of the year (week ending 20 March) when we saw 3,361 patients. This was almost 100 more than the next busiest week (which was the following week!) and over 450 more than the average weekly volume for the year.

Ready for anything – our resilience plans

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

As part of these plans, this year we put in place a £1.1 million programme to deal with the challenges of winter, including recruiting more nurses and doctors to work in our busy A&E departments, preparing additional beds for patients who are admitted in emergencies, and opening some of our key departments for longer.

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

- Business continuity
- Flu pandemic
- Mass casualty.

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

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

Staff from Epsom Hospital threw a surprise 'thank you' party for a woman who, despite being diagnosed with a terminal illness, has knitted 3,000 blankets for premature babies cared for in the Neonatal Unit

Maintain financial sustainability

We always knew that our plan to breakeven in 2015-16 was ambitious, and as the year began, we realised that the financial risks in the original plan were too great. We revised our forecast position and working with our healthcare partners and regulators, agreed to end the year at a deficit position of £28.4 million.

We actually ended the year with a deficit of £25.8 million. We would like to thank our staff for tightening their belts while making sure our patients are still receiving the care that they need.

We did not perform as well as we had planned to financially, and have put a number of stringent measures in place to make sure that we can save money and perform in line with our forecasts throughout the year.

Our hospitals operate with an underlying deficit of more than £19 million – that means that every year, we have a gap of £19 million before April has even begun. That's a huge challenge for us, and means that in challenging years like the last one (where we have to spend more money on caring for patients and investing in quality) our deficit becomes even greater.

And sadly, this isn't an unusual position – many acute trusts are in a very difficult position, but we would like to assure local people and our patients that we are doing all we can to keep control of our finances.

There are a number of reasons why our financial forecast had to be revised, including a very busy winter during which we needed extra staff and extra resources to care for huge patient numbers. On top of our planned £2.3 million winter resilience funding, we needed to invest an additional £4.5 million to keep up our good work throughout this incredibly busy period.

We also needed to invest in quality. We spent millions of pounds recruiting hundreds of substantive nurses and doctors, and we know that this will pay great dividends this year as we reduce the amount of money we have had to spend on expensive agency staff.

We would like to thank our staff for tightening their belts while making sure our patients are still receiving the care that they need.

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

Key to achieving our mission 'to put the patient first by delivering great care to every patient, every day' is partnership working. Over the year we have been working closely with our patients, commissioners, other health and care providers, local authorities, the voluntary sector, NHS England, the NHS Trust Development Authority and Monitor (the latter two merged into one organisation on 1 April 2016, and are known as NHS Improvement) in the interests of our patients and a sustainable local health and social care economy.

Highlights of our partnership working included opening the Community Assessment and Diagnostics Unit (CADU) at the Epsom Hospital site in November 2015, following an intensive period of planning over just three months.

The concept behind CADU is simple: too many elderly people have to come to Epsom A&E because that is the only way clinicians working in the community can get access to the immediate diagnostics, specialist advice, multi-agency assessment and enhanced care package they need to care for their patients.

CADU provides this care in a community-facing way on an acute hospital site. Patients who need immediate assessment are referred by their GP or community matron – they may attend the same day or be booked in for the next day; other patients are brought directly to the unit by the ambulance service responding to an emergency call and some are referred following triage in A&E.

However patients come to CADU, their needs are the same. Over a maximum 12 hour period, each person attending receives a full multi-agency health and care assessment, immediate diagnostics and specialist opinion (if required). Each person leaves CADU having agreed a revised care plan which always includes agreement with their own GP and community team and follow-up by the Red Cross. It may include provision of an enhanced care package for up to 72 hours including up to four visits a day and a night service to bridge with ongoing community services.

Nurse Joanne Burton completes vital paper work

CADU is a pioneering service in a number of ways:

- It was genuinely co-designed with patients and carers. Their involvement changed and continues to change the way the service is provided and the outcomes that are measured
- It is run by a single multi-disciplinary and multi-agency team, led by GPs and includes acute clinicians, community clinicians, social care practitioners and voluntary services
- With consent, the CADU team has full visibility of the patient's GP record
- Service redesign within the hospital has enabled rapid access to diagnostic testing and reporting and to specialist opinion
- Service redesign by social care has enabled rapid assessment and immediate provision of enhanced reablement packages co-ordinated by the CADU team
- It has been established using the principles of continuous learning and adaption
- It was genuinely co-designed by the Epsom Health and Care Provider Alliance, including the establishment of a Memorandum of Understanding and agreement of shared person-centric outcomes.

The Red Bag: improving life for care home residents

Working with Sutton Homes of Care, we helped to launch the Red Bag in November 2015 – an innovative initiative to improve care for people living in residential and care homes across the London Borough of Sutton.

The Red Bag is a simple but effective idea that means people living in care homes take a Red Bag with them if they need to be rushed into Epsom and St Helier hospitals. The Red Bag contains a set of forms, the resident's medication and some personal belongings, such as a change of clothes. The Red Bag stays with the person until they are discharged from hospital, and contains their discharge summary when they are ready to leave hospital and return home.

The forms in the Red Bag make sure that both ambulance and hospital staff have an agreed set of information about a resident's medical history and their recent health, enabling them to quickly establish the facts and what treatment the person may need. Previously, hospital staff might need to make several telephone calls just to obtain vital information about the person they are treating.

The Red Bag will also clearly identify someone as being a care home resident and this will sometimes mean that the person can be discharged quicker than someone returning to their own home, due to the level of care and support available to them in their care home.

Epsom and St Helier were involved in the Red Bag initiative from conception, and welcome the positive impact it will have on patient safety. The Red Bag helps us to provide effective care and means staff have the relevant information to help patients settle better in hospital. We can be confident that patients will come to hospital with the relevant paperwork and personal effects such as clothing, glasses and hearing aids, which are less likely to get misplaced along the patient's journey.

Communication between residential care and the trust has improved greatly and we have a better understanding of each other's role in the care of elderly patients.

SWLEOC

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

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

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

SWLEOC provides high quality, cost efficient, elective orthopaedic services ranked amongst the best in the world.

Left: South West London Elective Orthopaedic Centre (SWLEOC) has taken delivery of eight new models that will be used for research into osteoporosis (a condition which makes bones brittle and fragile) and to help explain different conditions and surgical procedures to patients

Maternity services at Epsom and St Helier hospitals will be investing over £46,000 in additional services and support for pregnant women with a BMI (Body Mass Index) of 30 and above, who may be at higher risk of experiencing complications

Caring for patients who need our help

The number of people admitted to St Helier Hospital with alcohol-related illnesses and injuries has jumped by 50% in the past two years – prompting the launch of a new specialist service to support patients with problem drinking and those suffering from alcohol-related conditions.

Figures show that in 2013, 247 people needed to stay overnight at St Helier Hospital because of alcohol consumption, rising to 332 in 2014 and hitting a high of 370 patients in 2015.

Additional support for patients with alcohol misuse issues is now available, thanks to the hospital's new Alcohol Liaison Service – an initiative that has been commissioned by the London Borough of Sutton, developed in partnership with South West London and St George's Mental Health NHS Trust, and led by specialist nurse Sarah Moloi.

The new service, which will provide support to those drinking above recommended weekly limits, those with alcohol dependency and patients with alcohol-related physical illnesses, has got off to a busy start. As staff have got to know Sarah, the number of referrals of patients with problem drinking has increased, with up to 10 new cases each week.

A nurse in our Renal Unit prepares a patient for dialysis

Our play specialists help to distract and calm our younger patients as they prepare for and undergo procedures

Key to achieving our mission 'to put the patient first by delivering great care to every patient, every day' is partnership working.

3

CORPORATE GOVERNANCE REPORT 2015-16

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

1 As Accountable Officer, and Chief Executive of the trust, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding quality standards and ensuring the best use of public funds and acknowledge my responsibilities for demonstrating an understanding of propriety and accountability as set out in the Accountable Officer Memorandum for Chief Executives of NHS Trusts[1].

2 Since my appointment as Chief Executive on 1 January 2015 I have worked closely with the NHS Trust Development Authority (now NHS Improvement) through regular dialogue and meetings to review strategic and operational issues and to ensure that the trust is contributing positively to the overall health of the local population in the geographical areas where services are provided.

Corporate governance

3 Governance arrangements were in place to monitor the board's effectiveness. In 2015 the board asked external advisors to review board effectiveness through a piece of diagnostic work on board development. This diagnostic was completed in September 2015 and presented to the board at its seminar on 5 October 2015. A number of recommendations were made in the areas of strategy and risk, capability and culture, processes and structure, and measurement. An action plan was developed and progress against the plan has been reviewed regularly. Most of the recommendations have now been accepted and incorporated into practice, and any outstanding actions will be picked up as part of the corporate governance review following feedback received from the November CQC inspection.

4 Following the work with external advisors, board reporting has been refined with the development of an integrated performance report based around the CQC domains with each domain having an identified executive director and non-executive director lead. The board also approved the adoption of a new trust-wide governance framework, which is the overarching governance document for the trust, bringing together the terms of reference of all board committees, standing orders, standing financial instructions and internal and external control mechanisms. The board reviews, on a quarterly basis, the Board Assurance Framework, prior to which it will have been considered by the relevant board committee.

5 During December 2015 and January 2016 the board undertook a review of its governance arrangements following feedback received by the Care Quality Commission (CQC) after their inspection visit in November 2015. Informal feedback given following the CQC inspection identified areas for improvement that included the Board Assurance Framework and the over-riding governance arrangements.

6 The review comprised a review of the trust's governance arrangements against best practice amongst NHS providers, including:

- A review of governance arrangements at Frimley Health NHS Foundation Trust and Salford Royal NHS Foundation Trust, the only two acute trusts judged as 'Outstanding' by the CQC
- A review of the improvements that Croydon Health Services NHS Trust were implementing to strengthen their governance arrangements following their CQC inspections
- Working with the NHS Trust Development Authority to identify a trust judged to have made improvements to governance, and the external support they used to feed in to this work and action plans
- An examination of best practice guidance from NHS Providers through their governance network and drawing on their expertise.

7 The review concluded that the board required:

- A monthly trust-wide Integrated Performance Report that identifies specific specialty or areas that are outliers
- Divisions to have their own 'local' version of an Integrated Performance Report, including key national standards/guidance
- Effective risk registers for divisions and corporate areas, and the means to aggregate these upwards into a trust-wide risk register
- A means of gathering 'soft intelligence' to inform the board of what is happening at ward level.

8 Throughout January to March 2016, the trust developed an Integrated Performance Report (IPR) which reports key performance metrics across each of the five domains of the trust's corporate objectives: safe and effective care, creating a positive patient experience, responsive care, financial sustainability and working in partnership. The final version of the IPR became operational from April 2016. Throughout 2016-17, a 'local' version of the same report will be established at divisional reporting level.

9 In February 2016 the board approved the establishment of a new board committee called the Performance Assurance and Risk Committee. The committee met in April and May 2016. The board formally approved the committee's terms of reference on 13 May 2016. It is chaired jointly by the Chief Executive and a newly-appointed Associate Non-Executive Director, and will review all extreme/high level divisional risks on a monthly basis and each divisional risk register on a rotating basis at least twice each year. It will also identify and review similar risks which occur across divisions and aggregate these to a higher level if appropriate. The committee will inform the board, via the IPR, of all extreme/high risks to achievement of the corporate objectives. The priority for 2016-17 is to embed this new governance and risk process.

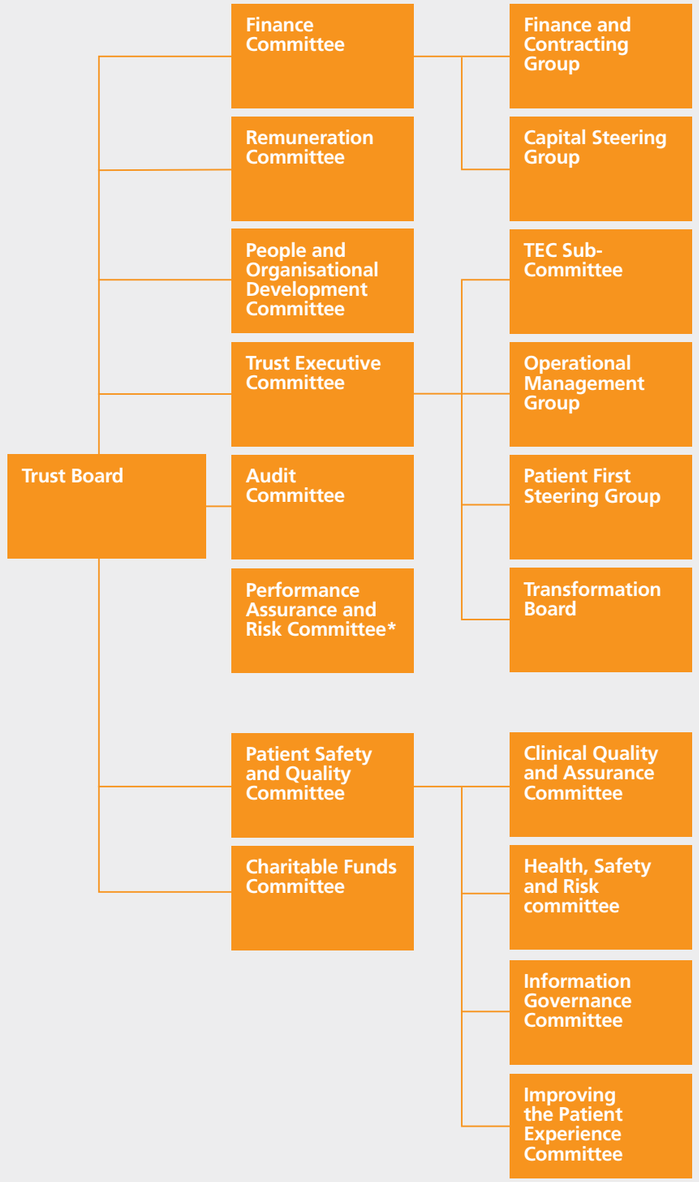
10 The board has also recognised that it needs to strengthen the means of gathering 'soft' intelligence about what is happening at ward level and has agreed to introduce the following measures to address this:

- Informal and formal visits to wards and patient areas
- Utilising Healthwatch feedback from patients
- Developing engagement metrics which will be included in the 2016-17 IPR
- Implementing a 'guardian service' and publishing whistleblowing headline actions and learning.

11 Table 1 (right) shows the eight board committees which provide assurance to the trust board. These are supported by sub-committees which enable the board committees to challenge and scrutinise the work of the clinical, operational and financial management of the trust. Each board committee is chaired by a non-executive director, with the exception of the Trust Executive Committee and the Performance Assurance and Risk Committee, which will be co-chaired by the Chief Executive and the Associate Non-Executive Director. Each board committee has an executive director lead.

12 The Remuneration Committee consists of non-executive directors only. The Audit Committee has three non-executive director members supported by the trust's external auditors, internal audit, counter fraud and trust management as required.

13 Board members are required to attend at least 75% of board and committee meetings in person. Executive directors are expected to send a suitably briefed deputy able to make decisions on their behalf if they are unable to attend in person. A record of board members' attendance at trust board meetings is shown on pages 48 and 49, which also indicates where and when changes in executive and non-executive director posts occurred.



* Committee first met in April 2016

1 **http://www.info.doh.gov.uk/doh/finman.nsf/072561aa006322660725618c006b09a0/3bf24de22efb45cd802568f70038d723?OpenDocument**

14 Each board committee reviews terms of reference annually, including its purpose, membership, quorum and frequency of meetings. Attendance records of board members are recorded in the minutes of each meeting and published on the trust's website.

The trust board

15 The role of the trust board is to:

- Exercise all the powers of the trust on its behalf, as set out in its establishment order to provide goods and services - hospital accommodation and services and community health services - for the purposes of the health service
- Govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the trust is providing safe, high quality, patient-centred care
- Set the strategic direction of the trust and associated plans, agreeing the corporate objectives as part of the business planning cycle at the start of each financial year, and reviewing the Assurance Framework regularly throughout the year
- Ensure 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.
- Ensure high standards of clinical and corporate governance
- Review all dimensions of quality (safety, experience and outcomes) and performance against the NHS Constitution and other contractual standards
- Oversee financial stewardship
- Establish the values of the trust and promote these in the way that the board does business and interacts with the rest of the organisation and external stakeholders
- Ensure effective dialogue with the local community.

Highlights of board committee reports

16 The Finance Committee meets monthly and has reviewed the financial performance of the organisation and forward plans for 2016-17.

17 The Patient Safety and Quality Committee played a significant role in planning in the lead up to the November 2015 CQC inspection, and was also involved in reviewing and responding to the immediate issues identified as a result of the inspection, particularly in relation to critical care.

18 The Audit Committee reviewed the new governance arrangements introduced within the year, and also internal and external audit reports and technical accounting arrangements for the treatment of balance sheet adjustments.

19 The People and Organisational Development Committee meets quarterly and during 2015-16 reviewed the range of recruitment initiatives and also the 2014 staff survey results and associated action plans.

20 The Trust Executive Committee (TEC) meets on a monthly basis and comprises all clinical leads, heads of nursing, divisional and directorate general managers. TEC reviews the integrated performance report on a monthly basis, and also receives regular updates on the transformation programme of work and associated risks.

21 The Remuneration Committee has discharged its functions in 2015-16 in relation to the process for executive appointments and the remuneration for every new executive appointment as well as any in-year executive portfolios that merited remuneration consideration.

Quality governance

22 The trust board approved a Quality Strategy for 2016-2017 in March 2014 which comprises an annual review and report to patients and the public about the quality of trust services and a forward commitment to continuous evidence based quality improvement. The Quality Account demonstrates to patients and the public how the trust is doing against agreed quality priorities and where it will focus priorities for quality improvement in 2016-17. Prior to publication, the trust is required to formally engage with, and seek assurance from, specific groups including Healthwatch, commissioners and the Overview and Scrutiny Committee, on the content of the Quality Account.

23 Indicators of quality are evidenced through:

- Quality dashboards at division and trust level
- Divisional reports to the quality governance committees
- Reports on Never Events and Serious Incidents to the trust board and committees
- Reports and reviews including incidents, complaints and clinical audits
- The trust's Quality Account Report.

24 Performance against the national priorities set out in the NHS Trust Development Authority Accountability Framework 2015-16 for quality-caring, effective, responsive, safe and well-led - is monitored monthly at directorate, trust and board level.

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

26 The Quality Account is reviewed through our internal assurance processes; by the Trust Executive Committee and the Patient Safety and Quality Committee and is noted at our Audit Committee. The 2015-16 Quality Account will be presented at the trust's Annual Public Meeting at the end of June 2016 and will be published on NHS Choices website and the trust website.

27 Independent external assurance of the statements made in the Quality Account is undertaken by the trust's external auditors Grant Thornton UK LLP. The Quality Account for 2015-16 is at the time of writing, still subject to external audit.

Clinical Audit

28 During 2015-16 the trust participated in 29 (100%) of the national clinical audits and four (100%) national confidential enquiries of those which it was eligible to participate in. Details of these are contained in the Quality Account. The trust also reviewed the reports of just over 200 local clinical audits at clinical audit half day meetings and the appropriate directorate management team meeting. Learning from audits is also shared at joint specialty audit half day meetings, educational meetings and by presentation and posters at the clinical audit open afternoon, held annually.

Never Events

29 The reporting of Never Events is through the Patient Safety and Quality Committee, a board committee, and then upwards to the trust board within the public part of the meeting. There were a total of four Never Events at the trust during 2015-16.

30 The board has previously decided that all Never Events should be reported publicly and considered in more detail privately as part of its review of all Serious Incidents.

Serious Incident Reporting

31 The board receives regular reports on all Serious Incidents following scrutiny at the Serious Incident Panel and the Patient Safety and Quality Committee. Serious Incidents are escalated to Executive level as they occur, and are reported weekly at the Chief Executive team meeting and through the Patient Safety and Quality Committee and Board.

Risk assessment and management

32 The trust offers risk management training at various levels as below:

- Level 1 – for staff who have no management responsibilities, held on a monthly basis
- Level 2 – for clinical and non-clinical ward and department managers and their deputies, held every two months
- Level 3 – for executive directors, service directors, general managers and senior nurse managers (staff with strategic responsibility for determining and implementing effective health and safety management), held four times a year.

The trust also offers risk assessor training, Level 1 COSHH (Control of Substances Hazardous to Health) training, and health and safety training for staff throughout the year. Staff have access to the schedule of training for health and safety and risk management, and are given guidance on how they can book their place.

33 The following measures are in place to ensure the trust identifies, evaluates and controls risk:

- The trust's Risk Management Strategy outlines the strategic framework in relation to risk management. It describes the trust's processes in managing risk that supports the principles of integrated governance and improving patient safety, and outlines the responsibilities which staff must undertake and the procedures to follow in order to minimise risk and reduce harm
- The Board Assurance Framework identifies the risks to the achievement of the trust's annual corporate objectives. The Board Assurance Framework is reviewed by the board quarterly to ensure the board is sighted on progress. Detailed scrutiny of progress against each of the 25 objectives for 2015-16 has also been undertaken quarterly through the board committee structure, with appropriate committees reviewing each risk, eg the Finance Committee reviews the risks within the domain of financial sustainability
- The trust has attached a risk appetite to the achievement of each of the 25 corporate objectives for 2015-16 and the criteria used in defining risk appetite against the 5x5 scoring matrix is:
  - No appetite for failing to achieve this objective. This appetite has been applied to all patient safety and quality objectives and objectives wholly within our control. These objectives have an appetite score of zero
  - A little appetite for failing to achieve this objective. This has been applied to some objectives and has an appetite score of five
  - Some appetite for failing to achieve this objective. This is where the achievement is mainly outside of the trust's control. This has an appetite score of ten.

34 As part of the process of reviewing our overall risk management processes, we are also looking at how risks are articulated. For example, a review of the wording of the risk relating to IT highlighted that the risk was larger than previously articulated. This risk, along with all other risks, will be monitored closely, including via review at the newly established Performance Assurance and Risk Committee, which is a sub-committee of the trust board.

35 At the start of 2015-16 the trust identified four key challenges for the year. These were:

- The need to strengthen staffing in key service areas – we will tackle this through a proactive and creative recruitment strategy, by valuing our staff and improving their working lives, and through role and service redesign
- Variability in the delivery of clinical care, which increases risk and potential harm for our patients. We will work together to instil a culture of 'one team, one trust' and work to consistent, evidence-based operating practices across all our services and sites
- Poor estates – the quality of the St Helier estate, in particular, is unacceptable. We will tackle this by agreeing a five year investment plan for our estate at both sites and developing a long term plan to deliver first class facilities for our patients as part of the ongoing work across south west London
- Finance – in order to develop new models of care, invest in quality and innovation, and tackle our poor estate, we will need to create a recurrent surplus each year. This requires us to become more efficient, remove unnecessary duplication and reduce our overhead costs.

36 At the end of the year, while progress is being made in some areas, the board has identified that these remain our four key challenges, particularly in relation to finance.

37 The trust has a structural deficit of circa £15 million resulting from providing services over two sites and operating from sub-optimal buildings. The trust entered 2015-16 with an underlying recurrent deficit of £19.2 million that deteriorated to a reported position of £25.8 million by the end of the year. The main contributing factors towards this increased deficit were:

- Investment needed to ensure that the trust met the access targets/referral to treatment cancer targets
- Additional capacity and staffing required to cope with winter pressures
- Investments in staffing made following feedback from the CQC inspection in November 2015
- Investment in clinical posts to achieve London Quality Standards.

38 In order to improve the underlying position for 2016-17, the trust has appointed external consultants to:

- Put in place systems and processes to reduce expenditure in the short term through greater scrutiny and review of non-pay and temporary staffing
- Develop a transformation programme that empowers staff to develop new ways of working that will result in greater efficiency, help move towards financial sustainability and improve clinical quality.

It is envisaged that this transformation programme will run over two years.

Risk and control framework

39 The Risk Management Strategy and the policies and procedures which underpin it extend across both clinical and non-clinical areas of risk. These include incident reporting, root cause analysis and risk assessment systems supported by clear procedures. Evaluation of risk takes place so that action plans are implemented to eliminate or minimise risks. Existence of evidence-based practice is incorporated into all aspects of patient care and treatment by appropriately trained healthcare professionals. The trust encourages an open and honest culture which empowers staff to report incidents and to assess risks in a just and fair environment.

40 The trust uses the web-based Datix risk management system across all modules. This integrated system covers incident reporting, complaints, claims, Coroner's inquests and the risk register. The system enables feedback to staff on actions taken as a result of their report.

Effectiveness of risk management and internal controls

41 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways:

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the Internal Audit Annual Plan. The Head of Internal Audit affirmed that 'reasonable assurance' could 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, there were some weakness in the design and/or inconsistent application of controls that put the achievement of particular objectives at risk. Internal Audit issued reports with overall 'limited assurance' in respect of e-rostering payroll incidents, discharge planning, cancelled operations and infection control.
- My review is also informed by the various reports presented to board committees and the trust board throughout the year including performance against the national priorities for quality and governance as set out in the NHS Trust Development Authority Accountability Framework.
- It has also been informed by other reports, including the trust's registration status with the Care Quality Commission (without conditions). I have also been informed by external inspections from:
  - Register of external inspections report – this report identifies all external agency inspections
  - Chemical, Biological, Radiological and Nuclear (CBRN) Assurance - the trust is compliant with the statutory requirements
  - Staff Survey results for 2015 – these were reported to the board in April 2016
  - Patient Led Assessments of the Care Environment (PLACE) – which reported favourably on the trust's standards for privacy and dignity, quality of food, cleanliness but less favourably on the condition of the trust's buildings and environment
  - Local Counter Fraud reports.
- The trust has a robust performance management framework in place. During 2015-16 directorate performance has been reviewed through monthly directorate performance meetings. A directorate specific scorecard is considered at each meeting and directorates are held accountable for their standards of quality, performance and finance. The Performance Assurance and Risk Committee reviews risks at directorate as well as trust wide level, and identifies common themes that may be aggregated at trust-wide level.
- The trust is aware of its obligations under Section 92 of the Care Act 2014 which came into effect on 1 April 2015 relating to false or misleading information.

Information governance

42 The trust takes any data security risk extremely seriously. A programme of work via the Information Governance Committee has monitored compliance with the national Information Governance Toolkit. The trust met compliance with its submission for 2015-16 with a Level 2 score (green rated) of 72%.

43 The total number of trust information governance incidents reported in 2015-16 was 879. Three incidents were self-reported to the Information Commissioner's Office by the trust in 2015-16:

- May 2015 – a camera system used in ophthalmology was stolen, with windows removed and internal doors forced open in order to remove the equipment which was bolted to the table. The ophthalmology service has now moved to another building and the Information Commissioner has confirmed that no further action will be taken
- December 2015 – health records securely destroyed in error. The case is still open and an investigation is underway
- February 2016 – a handover document was found off site by a member of the public and returned to the trust. The staff member concerned met with the medical director to discuss the correct handling of confidential information. The Information Commissioner has confirmed that no further action is to be taken.

Fraud and Counter Fraud

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

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

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

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

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

Significant issues

49 I am reporting the following significant issues in 2015-16:

- The immediate concerns raised by the Care Quality Commission about the leadership of the Critical Care service at the trust and the effective management of deteriorating patients identified during the Chief Inspector of Hospitals inspection in November 2015. A range of measures were put in place immediately to address these concerns:
  - The Critical Care leadership team from St George's were brought in to provide leadership for our Critical Care service and have completed a diagnostic to assess the extent to which the unit was meeting the relevant clinical and nursing standards
  - A 24/7 Acute Response Service was established on both sites
  - An audit was undertaken into whether the current processes in place may have compromised patient care.

  The Chief Inspector of Hospitals stated he was satisfied that the immediate actions taken met his expectations.

  The board have received regular progress reports on improvements to the Critical Care service and I am satisfied that the measures taken have addressed the CQC concerns and are now making a noticeable improvement.
- Concerns raised by the Care Quality Commission during the inspection in November 2015 that the Board Assurance Framework and wider governance arrangements were not sufficiently robust to ensure that the board and executive had oversight of the risks which were likely to impact on the organisation's ability to provide safe and effective care. An internal governance review has been undertaken and the board has implemented improvements as outlined in four to eight above.
- The Trust entered 2015-16 with an underlying recurrent deficit of £19.2 million that deteriorated to a reported position of £25.8 million by the end of the year. Measures taken to improve the underlying position for 2016-17 are outlined in 38 above.

Discharge of Statutory Functions

50 Epsom and St Helier University Hospitals NHS Trust is a statutory body established on 1 April 1999 under Statutory Instrument 1999 No. 848 (the Establishment Order) under the National Health Service and Community Care Act 1990. Under section 5(1)(a) of the National Health Service and Community Care Act 1990 the trust was established for the purpose of assuming responsibility for the ownership and management of hospitals or other establishments or facilities previously managed by the Regional, District or Special Health Authorities and the trust's functions shall be to own and manage Epsom Hospital, St Helier Hospital, associated establishments and facilities, hospital accommodation and community health services.

51 The trust has maintained compliance with this statutory responsibility throughout 2015-16.

Accountable Officer:
Daniel Elkeles, Chief Executive

Organisation:
Epsom and St Helier University Hospitals NHS Trust

Date: 31 May 2016

Directors' Report

Board of Directors 2015-16 In Year Appointments

	Name	Position	2015-16 start date	End of tenure of directorship (if applicable)
Non-Executive Directors	Laurence Newman	Chairman	n/a	n/a
	Patricia Baskerville	Non-Executive Director and Vice Chair	n/a	n/a
	Steve Poulton	Non-Executive Director	n/a	n/a
	Dr Iain MacPhee	Non-Executive Director	n/a	n/a
	Richard Noble	Non-Executive Director	n/a	n/a
	Elizabeth Bishop	Non-Executive Director	n/a	n/a
Executive Directors	Daniel Elkeles	Chief Executive	n/a	n/a
	Dr Ruth Charlton	Joint Medical Director and Deputy Chief Executive	n/a	n/a
	Dr James Marsh	Joint Medical Director	n/a	n/a
	Charlotte Hall	Chief Nurse	26 May 2015	n/a
	Carole Webster	Interim Chief Nurse	1 April 2015	22 May 2015
	Rakesh Patel	Chief Financial Officer	1 May 2015	n/a
	Paresh Patel	Interim Chief Financial Officer	1 April 2015	1 May 2015
	Kevin Croft	Director of People and Organisational Development	n/a	n/a
	Sue Jones	Chief Operating Officer (interim)	29 February 2016	n/a
	Jackie Sullivan	Chief Operating Officer	1 April 2015	26 February 2016
	Peter Davies	Director of Strategy, Corporate Affairs and ICT	n/a	n/a
	Tim Hamilton	Director of Communications	1 April 2015	1 May 2015
		Director of Communications	26 October	n/a
	Lisa Thomson	Director of Communications	5 May 2015	23 October 2015
	Trevor Fitzgerald	Director of Estates, Facilities and Capital Projects	1 December 2015	n/a

The register of members' interests can be found at www.epsom-sthelier.nhs.uk/board-disclosures

Attendance at board meetings

	08 May 2015	01 Jun 2015	26 Jun 2015	30 Jul 2015	04 Sep 2015	09 Oct 2015	27 Nov 2015	12 Feb 2016	11 Mar 2016
PRESENT:									
Laurence Newman, Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Daniel Elkeles, Chief Executive	✓	✓	✓	X	✓	✓	✓	✓	✓
Pat Baskerville, Vice Chair and Non-Executive Director	✓	✓	✓	X	✓	✓	✓	✓	✓
Elizabeth Bishop, Non-Executive Director	✓	✓	✓	✓	X	✓	✓	✓	✓
Dr Ruth Charlton, Joint Medical Director and Deputy Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Charlotte Hall, Chief Nurse (from 26 May 2015)		✓	✓	✓	✓	✓	✓	✓	✓
Carole Webster, Interim Chief Nurse (from 1 April to 22 May 2015)	✓								
Dr James Marsh, Joint Medical Director	✓	✓	✓	X	✓	✓	✓	✓	✓
Dr Iain MacPhee, Non-Executive Director	✓	✓	X	X	✓	✓	✓	✓	✓
Richard Noble, Non-Executive Director	✓	✓	X	✓	X	✓	✓	✓	✓
Rakesh Patel, Chief Financial Officer (joined 1 May 2015)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Poulton, Non-Executive Director	X	Telephone	X	✓	X	✓	✓	✓	X
Jackie Sullivan, Chief Operating Officer (from 1 April 2015 to 26 February 2016)	✓	✓	✓	✓	X	✓	✓	✓	
Sue Jones, Interim Chief Operating Officer (from 29 February 2016)									✓
IN ATTENDANCE:									
Kevin Croft, Director of People and Organisational Development	✓	X	✓	X	✓	✓	✓	✓	✓
Peter Davies, Director of Strategy, Corporate Affairs and ICT	✓	✓	✓	✓	✓	✓	X	✓	✓
Trevor Fitzgerald, Director of Estates, Facilities and Capital Projects							X	✓	✓
Lisa Thomson, Director of Communications (from 5 May to 23 October 2015)	✓	✓	✓	X	✓	✓	X	X	✓
Tim Hamilton, Director of Communications (from 1 April to 1 May 2015 and from 26 October to date)							✓	X	X
Phil Ireland, Trust Secretary	X	✓	✓	✓	X	✓	✓	✓	✓

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority (now NHS Improvement) 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.

Daniel Elkeles
Chief Executive

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.

Daniel Elkeles
Chief Executive

31 May 2016

Rakesh Patel
Chief Financial Officer

31 May 2016

Remuneration and staff report

Single total figure remuneration table:
Directors' and senior managers' salaries and allowances – audited

	2015-16						2014-15					
Name and title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) bands of £5,000) £000	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits(bands of £2,500) £000	(f) TOTAL (a to e) bands of £5,000) £000
Mr Laurence Newman Chairman	20-25					20-25	20-25	0	0	0	0	20-25
Patricia Baskerville Non-Executive Director	5-10					5-10	5-10	0	0	0	0	5-10
Elizabeth Bishop Non-Executive Director	5-10					5-10	5-10	0	0	0	0	5-10
Dr Iain MacPhee, Non-Executive Director	5-10					5-10	5-10	0	0	0	0	5-10
Steve Poulton Non-Executive	5-10					5-10	5-10	0	0	0	0	5-10
Richard Noble Non-Executive Director	5-10					5-10	0-5	0	0	0	0	0-5
Daniel Elkeles Chief Executive	175-180				105-107.5	285-290	40-45	0	0	0	87.5-90	130-135
Rakesh Patel Chief Financial Officer	115-120					115-120						
Paresh Patel Interim Chief Financial Officer	5-10				5-7.5	15-20						
Dr James Marsh Joint Medical Director	190-195				35-37.5	230-235	180-185				25-27.5	205-210
Dr Ruth Charlton Deputy Chief Executive and Joint Medical Director	200-205				70-72.5	275-280	210-215				47.5-50	255-260
Jackie Sullivan Chief Operating Officer	110-115				15-17.5	125-130	120-125				42.5-45	162.5-165
Sue Jones Interim Chief Operating Officer	5-10				0-2.5	10-15						
Charlotte Hall Chief Nurse	95-100				142.5-145	240-245						
Carole Webster Interim Chief Nurse	15-20				5-7.5	20-25						
Kevin Croft Director of People and Organisational Development	110-115				27.5-30	140-145	110-115				72.5-75	185-190
Peter Davies Director of Strategy and Business Development	105-110				25-27.5	130-135	110-115				25-27.5	135-140
Trevor Fitzgerald Director of Estates, Facilities and Capital Projects	30-35				5-7.5	35-40						
Tim Hamilton Director of Communications	40-45				2.5-5	45-50						
Lisa Thomsom Director of Communications	45-50					45-50						

* The amounts disclosed above for Dr James Marsh and Dr Ruth Charlton, joint medical directors of the Trust, includes remuneration paid for work performed both as a clinical member of staff and as senior managers. The salary Dr Ruth Charlton receives for her clinical role is in the banding £125,000 and £130,000.

The salary for Dr James Marsh that relates to his clinical role is in the banding £115,000 and £120,000.

Salary and other remuneration – this covers both pensionable and non-pensionable amounts.

The amounts paid or payable by the NHS body in respect of only the period the senior manager held office are shown.

All pension-related benefits are those from participating in the pension scheme for that year, where a whole year has not been served these are on a pro-rata basis.

2015-16 Senior managers' remuneration report (pensions) audited

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension at 31 March 2016 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2015 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2016 £000	(h) Employer's contribution to stakeholder pension £000
Daniel Elkeles Chief Executive	5-7.5	5-7.5	35-40	95-100	420	54	479	0
Paresh Patel Interim Chief Financial Officer	0-2.5	0-2.5	25-30	80-85	330	4	388	0
Dr James Marsh Joint Medical Director	0-2.5	0	40-45	125-130	738	21	768	0
Dr Ruth Charlton Deputy Chief Executive and Joint Medical Director	2.5-5	0-2.5	50-55	150-155	868	47	926	0
Jackie Sullivan Chief Operating Officer	0-2.5	0-2.5	50-55	155-160	1054	26	1095	0
Sue Jones Interim Chief Operating Officer	0-2.5	0-2.5	20-25	65-70	490	2	514	0
Charlotte Hall Chief Nurse	5-7.5	17.5-20	35-40	105-110	559	129	718	0
Carole Webster Interim Chief Nurse	0-2.5	0-2.5	30-35	95-100	527	8	587	0
Kevin Croft Director of People and Organisational Development	0-2.5	0	30-35	90-95	504	15	524	0
Peter Davies Director of Strategy and Business Development	0-2.5	0-2.5	45-50	0	505	21	533	0
Trevor Fitzgerald Director of Estates, Facilities and Capital Projects	0-2.5	0-2.5	20-25	65-70	341	4	358	0
Tim Hamilton Director of Communications	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Lisa Thomsom Director of Communications	0	0	15-20	55-60	340	0	333	0

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS pension scheme are based on the previous discount rate and have not been recalculated.

Real increase in CETV

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

The following executives did not serve the entire financial year

	From	To
Rakesh Patel Chief Financial Officer	01/05/2015	31/03/2016
Paresh Patel Interim Chief Financial Officer	01/04/2015	01/05/2015
Jackie Sullivan Chief Operating Officer	01/04/2015	29/02/2016
Sue Jones Interim Chief Operating Officer	29/02/2016	31/03/2016
Charlotte Hall Chief Nurse	26/05/2015	31/03/2016
Carole Webster Interim Chief Nurse	01/04/2015	26/05/2015
Trevor Fitzgerald Director of Estates, Facilities and Capital Projects	01/12/2015	31/03/2016
Tim Hamilton Director of Communications	19/10/2015	31/03/2016
Lisa Thomsom Director of Communications	05/05/2015	23/10/2015

Fair pay ratios

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

The banded remuneration of the highest paid director in the Trust in the financial year 2015-16 was £205,000-210,000 (2014-15, £210,000 to £215,000). This was six times (2014-15, six) the median remuneration of the workforce, which was £32,852 (2014-15, £33,038).

In 2015-16, no (2014-15, none) employees received remuneration in excess of the highest-paid director. Board remuneration ranged from a band of £5,000-£10,000 to a band of £200,000-£205,000 (2014-15 £0-£5000 to £210,000-215,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions.

The highest paid employee of the trust remains the Joint Medical Director and Deputy Chief Executive.

Remuneration Report	2015-16				2014-15			
	No.	Salary (exc non-consol perf. pay) £000s	Non-consolidated performance pay £000s	Benefits in kind £000s	No.	Salary (exc non-consol perf. pay) £000s	Non-consolidated performance pay £000s	Benefits in kind £000s
Highest paid directors by band		205-210	N/A	N/A	1	205-210	N/A	N/A
Highest paid employees by band	3	170-175	N/A	N/A	2	170-175	N/A	N/A
	4	175-180	N/A	N/A	2	175-180	N/A	N/A
	0	180-185	N/A	N/A	1	180-185	N/A	N/A
	3	185-190	N/A	N/A	3	185-190	N/A	N/A
	1	190-195	N/A	N/A	1	190-195	N/A	N/A
	1	195-200	N/A	N/A	1	195-200	N/A	N/A
		200-205	N/A	N/A	1	200-205	N/A	N/A
Highest paid directors total renumeration		205-210				210-215		
Median total		32,852				33,038		
Ratio		6.21				6.40		

In compiling this table the trust has only included permanent substantive employees. Last year it included bank staff who are a pool of weekly paid staff who fill vacant shifts and posts on a temporary basis.

Staff numbers

		Audited		2014-15
	Total	Permanently employed	Other	Total
	number	number	number	number
Average staff numbers				
Medical and dental	762	663	99	734
Ambulance staff	0	0	0	0
Administration and estates	1,140	976	164	1,099
Healthcare assistants and other support staff	988	740	248	944
Nursing, midwifery and health visiting staff	1,779	1,455	324	1,694
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	253	186	67	362
Social care staff	0	0	0	0
Healthcare science staff	171	169	2	
Other	0	0	0	0
TOTAL	5,093	4,189	904	4,833
Of the above - staff engaged on capital projects	21	9	12	21

Exit packages agreed in 2015-16

		2015-16		2014-15		
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	0	0	0	0	0	0
£10,001-£25,000	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	0	0	0	0	0	0
Total resource cost (£000s)	0	0	0	0	0	0
No redundancy or other exit packages were agreed or paid during 2015-16 or 2014-15.						

Off payroll engagements table 1

Table 1: 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	35
Of which, the number that have existed:	
for less than one year at the time of reporting	15
for between one and two years at the time of reporting	12
for between two and three years at the time of reporting	6
for between three and four years at the time of reporting	1
for four or more years at the time of reporting	1

Off payroll engagements table 2

Table 2: For new off payroll engagements between 1 April 2015 and 31 March 2016, for more than £200 per day and last longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	13
Number of new engagements which include contractual clauses giving the Epsom and St Helier University Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Off payroll engagements table 3

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April and 31 March 2016

	Number
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.	16

Staff sickness absence and ill-health retirements

	2015-16 Number	2014-15 Number
Total days lost	36,994	40,199
Total staff years	4,062	3,955
Average working days lost	9	10

	2015-16 Number	2014-15 Number
Number of persons retired early on ill-health grounds	4	7
Total additional pensions liabilities accrued in the year	£000s 265	£000s 315

The trust spent £1,784k (2014-15 £1,215k) on consultancy services to support the following activities, the improving private patient income, supporting the Estates Strategy, theatre efficiency and trust transformation projects.

No new staff policies during the year, but existing policy and process is in place and details available upon request.

We also have the 'two ticks, positive about disabled people' symbol in place on all our recruiting adverts, showing we operate a fair and transparent recruitment process.

On our TRAC recruitment system candidates can, if they wish to, declare a disability and claim a guaranteed interview, if their application meets the minimum criteria.

This is hidden from recruiting managers so that they shortlist in accordance with the person specification. The system alerts the recruitment team to any application where a candidate has declared disability and not been shortlisted. We can then cross check to make sure the candidate has been treated fairly.

Financial review

NHS finances came under increasing pressure during 2015-16 with trusts experiencing greater demand on services, shortages of permanent staff in key areas and working with social and primary care partners facing similar challenges. Within this environment, the trust posted a deficit of £25.8 million for 2015-16 compared to breakeven for 2014-15.

During 2015-16, analysis undertaken by the trust demonstrated that providing our acute services on multiple sites means we duplicate costs, and the sub-standard buildings add an additional £15 million to our cost base every year. In addition, the trust benefitted from one-off gains in 2014-15, like the sale of land at Sutton Hospital, to deliver breakeven. Both of these factors meant that the trust entered the beginning of 2015-16 with a run rate equivalent to a deficit of £19.2 million and ended with a £25.8m deficit. The main reason for the increased deficit was our investment in clinical staff and the need to rely on temporary staff to fill vacancies in the earlier part of the year.

The trust made significant investments in staffing during the year:

- Increased staffing during the winter period in A&E, and additional bed capacity to cope with increased demand whilst performing well against standards
- The trust also invested in staffing to ensure we performed well on both the 18 week and the cancer standards
- The trust also recruited to clinical posts in Ophthalmology, Palliative Care, Paediatrics and Maternity.

In common with other trusts, we experienced high levels of agency staffing costs, particularly in the earlier part of the financial year. However, through successful recruitment campaigns, our nursing agency costs had reduced from 12% of total nursing costs at the beginning of the year to 7.3% in March. This downward trend has continued in April 2016.

Increasing our staffing numbers and costs has undoubtedly contributed to the trust performing well in delivering the Constitutional standards and improved quality during 2015-16.

Key financial targets

The table below sets out the financial targets for Epsom and St Helier University Hospitals NHS Trust, and the performance against these, for the 2015-16 financial year:

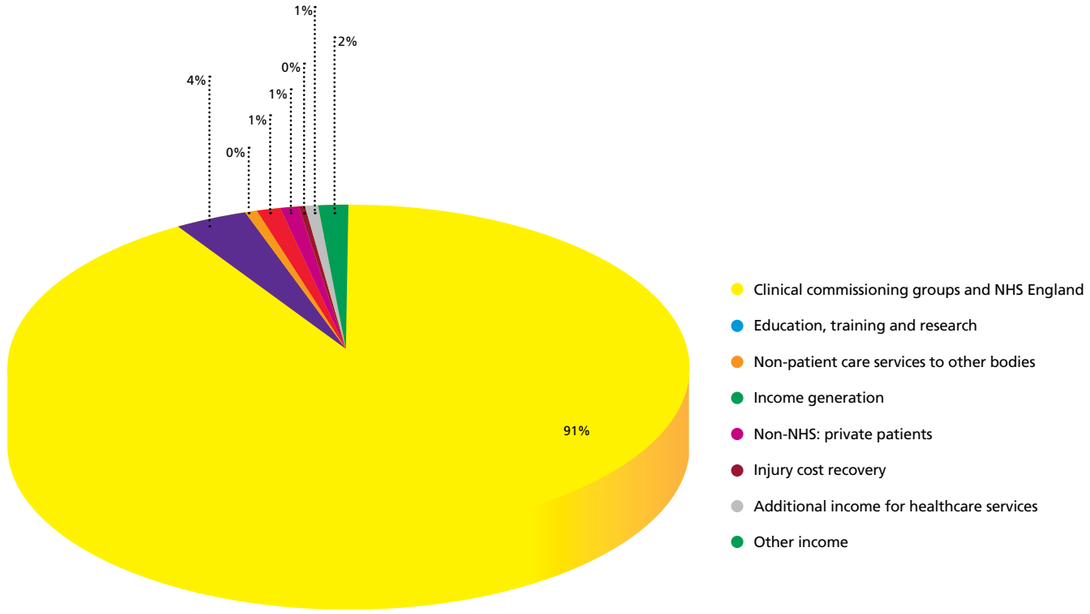
Target	2015-16 performance	Target met?	2014-15 performance	Target met?
Achieve a 2% surplus on income and expenditure	The trust posted a reported deficit of £25.8 million	No	The trust posted a reported surplus of £0.1 million	No
Keep within capital resource limit (CRL)	Underspend of £0.2 million	Yes	Underspend of £2.3 million	Yes
Remain within the external financing limit (EFL) of (+) £0.1 million	Undershot by £0.7 million	Yes	Undershot by £0.9 million	Yes
Keep within a capital cost absorption rate (CCAR) of 3.5%	The trust kept within the 3.5% CCAR, resulting in dividend payments of £4.5 million	Yes	The trust kept within the 3.5% CCAR, resulting in dividend payments of £5.1 million	Yes
Meet the requirement of the Public Sector Payment Policy to settle creditors within 30 days	The trust achieved a settlement rate of 46% for non-NHS and 47% for NHS invoices, by volume, and 60% for non-NHS and 49% for NHS invoices, by value	No	The trust achieved a settlement rate of 68% for non-NHS and 90% for NHS invoices, by volume, and 72% for non-NHS and 89% for NHS invoices, by value	No

Where our money comes from

Trust income increased by £6.8 million between 2014-15 and 2015-16. The total income received by the trust during 2015-16 was £372.6 million, of which £348.3 million was for clinical services and £24.2 million related to income for non-patient care services, such as research and development, training and education, and facilities income.

The following charts show the breakdown of different types of income received by the trust during the year and compares income received during 2015-16 to 2014-15:

	2015-16 Amount £000s	2014-15 Amount £000s	Year on year change £000s	Year on year change %
Clinical commissioning groups and NHS England	337,979	332,972	5,007	2%
Education, training and research	14,323	15,574	-1,251	-8%
Non-patient care services to other bodies	1,889	1,994	-105	-5%
Income generation	4,623	4,785	-162	-3%
Non-NHS: private patients	3,744	3,635	109	3%
Injury cost recovery	824	1,031	-207	-20%
Additional income for delivery of healthcare services	2,600	0	2,600	-
Other income	6,609	5,778	831	14%
Total	**372,591**	**365,769**	**6,822**	**2%**



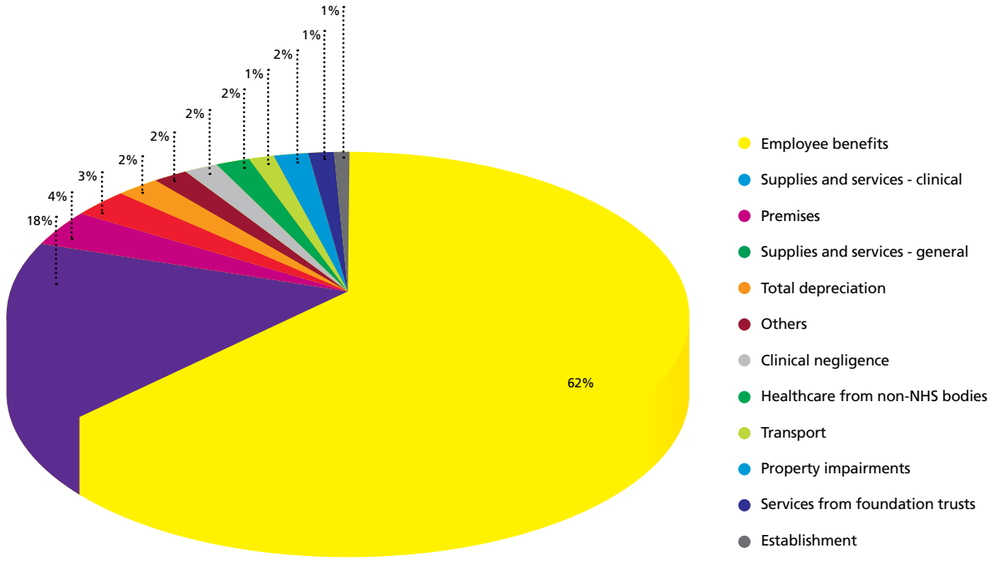
What we spend our money on

The trust spent £402.1 million in operating costs during 2015-16, an increase of £31.5 million from 2014-15 (this includes impairments of £8.5 million in 2015-16 and £4.6 million in 2014-15). The largest expenditure was staffing at £250 million.

Other areas of expenditure include £72.1 million on supplies and services for direct patient care, £11.8 million on non-clinical supplies, £23.6 million on transport, premises and establishment costs, and £9.7 million on the depreciation and amortisation of our capital assets.

The following table shows the breakdown of different types of expenditure incurred by the trust during the year and compares spend incurred during 2015-16 to 2014-15:

	2015-16	2014-15		
	Amount	Amount	Year on year change	Year on year change
	£000s	£000s	£000s	%
Employee benefits	249,970	231,523	18,447	8%
Supplies and services - clinical	72,106	65,501	6,605	10%
Premises	14,598	14,230	368	3%
Supplies and services - general	11,809	10,954	855	8%
Total depreciation	9,132	8,660	472	5%
Others	6,903	7,795	-892	-11%
Clinical negligence	7,200	7,382	-182	-2%
Healthcare from non-NHS bodies	8,042	6,231	1,811	29%
Transport	5,643	5,474	169	3%
Property impairments	8,542	4,631	3,911	84%
Services from foundation trusts	4,843	5,261	-418	-8%
Establishment	3,371	3,006	365	12%
Total	**402,159**	**370,648**	**31,511**	**9%**



Impairment of our St Helier asset under construction

The trust's Outline Business Case, approved by the Department of Health in 2010, was predicated on a £219 million redevelopment of St Helier Hospital. This project was to be delivered in four phases; decant outpatients and administrative offices to Sutton and the demolition of Ferguson House during the new hospital build at St Helier, a new hospital building on the site of Ferguson House and refurbishment, backlog maintenance of existing buildings at St Helier plus a multi-storey car park.

The trust incurred expenditure of £9.9 million between 2009-10 and 2012-13 relating to this programme on the following:

- An in-house project team plus management consultancy support, cost consultants, architects, engineers and other necessary professional fees (totalling 8.5 million)
- Backlog maintenance totalling £1.4 million. This was spent on improving the Trust's physical assets and would have been taken into account in the five year revaluation exercise conducted in 2014-15.

This programme was halted in 2014 due to the uncertainty of service re-configuration in south west London. These costs were classified as assets under construction on the balance sheet.

During 2015-16, The trust's board concluded that there was no likelihood that the schemes in the original programme would obtain Full Business Case approval from the Department of Health and therefore the expenditure incurred to date on the proposed redevelopment of St Helier was no longer likely to generate economic benefits. Consequently, the £9.9 million of expenditure held as an asset under construction were written off (impaired) in full.

The costs were written off in 2015-16, with £8.5 million charged to the income and expenditure account and £1.4 million written off to the revaluation reserve.

This impairment is not taken into account when measuring the trust's 2015-16 financial performance against its Income and Expenditure plan and there was no cash outflow as a result.

Capital investment

During 2015-16 the trust invested £15.5 million in capital expenditure. Our largest project was a new Eye Unit at the St Helier site, which cost £2.3 million. A further £10.3 million was invested in improving our clinical spaces and patient environment and over £1.4 million modernising our information communications technology infrastructure.

Improving value for money

The trust made £13.1 million of efficiency savings during the financial year, which equates to 3.5% of total income.

The trust has plans to deliver a £15.5 million quality and cost improvement programme during 2016-17.

Counter fraud

Counter fraud services are provided through the trust's internal audit contract with the London Audit Consortium. The trust also has a counter fraud and whistleblowing policy.

Counter fraud services provide advice and support to the trust and advise on appropriate proactive initiatives whilst carrying out reactive investigations where required.

External auditors

The trust's external auditor is Grant Thornton. The total cost of their statutory work in 2015-16 was £97,000 (£104,000 in 2014-15). This included the auditing of the annual accounts and this annual report.

Audit Committee 2015-16

The Audit Committee provides an objective view of the trust's internal control and is responsible for:

- Monitoring governance, risk management and internal control
- Ensuring there is an effective internal audit function
- Reviewing the work and findings of the external auditor
- Considering governance implications and reviewing the financial reporting arrangements of the trust.

Charitable funds

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

Looking forward to 2016-17

The financial environment in 2016-17 will be equally as challenging as that experienced over the past few years. The trust is an active participant in the development of the south west London and Surrey Heartlands sustainability and transformation plans which will form the strategic backdrop for Epsom and St Helier over the next five years.

For 2016-17 the trust is budgeting for a deficit of £15 million and to deliver a cost reduction and transformation programme of £15.5 million.

A three-year transformation programme begins in 2016-17, with the trust committed to delivering services that improve both the patient experience, quality, and deliver financial benefits.

The trust will work with Department of Health and NHS Improvement to secure a loan to ensure there is sufficient cash during 2016-17.

Preparation of the accounts on a going concern

The trust recorded an adjusted retained deficit of £25.8 million for the year ended 31 March 2016, in line with the £25.8 million control total agreed with the NHS Trust Development Authority after a capital to revenue transfer of £2.6 million.

For the financial year commencing 1 April 2016, the trust has budgeted for a deficit of £31.9 million which requires us to make incremental savings of £15.5 million. This plan is has been submitted to NHS Improvement and requires additional cash support to meet liabilities in the next 12 months. The trust continues to discuss the formal agreement of this funding with NHS Improvement. However, in the interim, the trust has received written confirmation from the Trust Development Authority that it is reasonable to expect that cash financing will be made available such that the trust is able to meet its liabilities in the next 12 months.

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

4 THE ACCOUNTS

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

We have audited the financial statements of Epsom and St Helier University Hospitals NHS 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).

This report is made solely to the Directors of Epsom and St Helier University Hospitals 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 criteria 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 these criteria as those 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 Epsom and St Helier University Hospitals NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended
- 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
- The other information published together with the audited financial statements in the annual report 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 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.

On 27 May 2016, we referred a matter to the Secretary of State under section 30 of the Act in relation to Epsom and St Helier University Hospitals NHS trust's breach of the break-even duty for the three year period ended 31 March 2016.

We 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 qualified value for money conclusion

The trust's outturn position for 2015-16 was a £25.8 million deficit, which was a significant deterioration compared to the original breakeven budget, and was achieved through the use of non-recurrent measures, the most significant being a £2.6 million capital to revenue transfer. The trust's operational plan for 2016-17 shows a further deterioration, to a forecast deficit of £31.9 million for 2016-17.

The deterioration in the trust's financial outturn was due to underachievement against its cost improvement plan, higher than expected staff and non-pay costs and lower than expected income from private patients.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Epsom and St Helier University Hospitals 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 to you by exception if:

- In our opinion the governance statement does not comply with guidance issued by the NHS trust Development Authority 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 Epsom and St Helier University Hospitals NHS Trust in accordance with the requirements of the Act and the Code of Audit Practice.

Emily Hill
for and on behalf of Grant Thornton UK LLP, Appointed Auditor
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

31 May 2016

Statement of comprehensive income for year ended 31 March 2016

	Note	2015-16 £000s	2014-15 £000s
Gross employee benefits	10.1	**(249,970)**	(231,523)
Other operating costs	8	**(152,189)**	(139,125)
Revenue from patient care activities	5	**348,343**	339,987
Other operating revenue	6	**24,248**	25,782
Operating surplus/(deficit)		**(29,568)**	(4,879)
Investment revenue	12	**33**	24
Other gains and (losses)	13	**(172)**	5,087
Finance costs	14	**(348)**	(106)
Deficit for the financial year		**(30,055)**	126
Public dividend capital dividends payable		**(4,480)**	(5,084)
Retained surplus/(deficit) for the year		**(34,535)**	(4,958)

The trust is assessed on its performance before impairments and donated and granted assets: financial performance as reported above is therefore different to total comprehensive income for the year.

The notes starting on page 64 form part of this account.

Other Comprehensive Income

Impairments and reversals taken to the revaluation reserve	**(1,345)**	(5,026)
Net gain/(loss) on revaluation of property, plant and equipment	**2,552**	19,402
Total other comprehensive income for the year	**1,207**	14,376
Total comprehensive income for the year	**(33,328)**	9,418

Financial performance for the year

Retained deficit for the year	**(34,535)**	(4,958)
Impairments (excluding IFRIC 12 impairments)	**8,542**	8,225
Adjustments in respect of donated gov't grant asset reserve elimination	**205**	405
Adjusted retained surplus/(deficit)	**(25,788)**	78

Statement of financial position as at 31 March 2016

	Note	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	**176,015**	177,298
Intangible assets	16	**1,334**	1,852
Trade and other receivables	20.1	**241**	202
Total non-current assets		**177,590**	179,352
Current assets:			
Inventories	19	**4,250**	3,960
Trade and other receivables	20.1	**19,815**	20,423
Cash and cash equivalents	21	**2,669**	2,724
Sub-total current assets		**26,734**	27,107
Non-current assets held for sale	22	**0**	0
Total current assets		**26,734**	27,107
Total assets		**204,324**	206,459
Current liabilities:			
Trade and other payables	23	**(47,153)**	(37,020)
Provisions	28	**(511)**	(1,071)
Borrowings	24	**0**	(39)
Total current liabilities		**(47,664)**	(38,130)
Net-current assets/(liabilities)		**(20,930)**	(11,023)
Total assets less current liabilities		**156,660**	168,329
Non-current liabilities:			
Provisions	28	**(2,288)**	(2,667)
DH revenue support loan	24	**(24,600)**	0
Total non-current liabilities		**(26,888)**	(2,667)
Total assets employed		**129,772**	165,662
Financed by:			
Public Dividend Capital		**177,561**	180,123
Retained earnings		**(85,539)**	(51,009)
Revaluation reserve		**37,750**	36,548
Total taxpayers' equity		**129,772**	165,662

The notes starting on page 64 form part of this account.

The financial statements on pages 60-63 were approved by the board on 31 May 2016 and signed on its behalf by the Chief Executive.

Daniel Elkeles
Chief Executive

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	**180,123**	**(51,009)**	**36,548**	**0**	**165,662**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(34,535)			(34,535)
Net gain/(loss) on revaluation of property, plant, equipment			2,552		2,552
Impairments and reversals			(1,345)		(1,345)
Transfers between reserves		5	(5)	0	0
Reclassification adjustments					
Permanent PDC received - cash	38				38
Permanent PDC repaid in year	(2,600)				(2,600)
Net recognised revenue/(expense) for the year	**(2,562)**	**(34,530)**	**1,202**	**0**	**(35,890)**
Balance at 31 March 2016	**177,561**	**(85,539)**	**37,750**	**0**	**129,772**
Balance at 1 April 2014	**179,643**	**(46,777)**	**22,898**	**0**	**155,764**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		(4,958)			(4,958)
Net gain/(loss) on revaluation of property, plant, equipment			19,402		19,402
Impairments and reversals			(5,026)		(5,026)
Transfers between reserves		726	(726)	0	0
Reclassification Adjustments					
New temporary and permanent PDC received - cash	480				480
Net recognised revenue/(expense) for the year	**480**	**(4,232)**	**13,650**	**0**	**9,898**
Balance at 31 March 2015	**180,123**	**(51,009)**	**36,548**	**0**	**165,662**

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)		**(29,568)**	(4,879)
Depreciation and amortisation	8	**9,650**	9,206
Impairments and reversals	17	**8,542**	4,631
Donated assets received credited to revenue but non-cash	6	**(208)**	(103)
Government granted assets received credited to revenue but non-cash		**(83)**	0
Interest paid		**(244)**	(54)
PDC dividend (paid)/refunded		**(4,084)**	(5,174)
(Increase)/decrease in inventories		**(290)**	(370)
(Increase)/decrease in trade and other receivables		**576**	4,754
Increase/(decrease) in trade and other payables		**9,759**	(1,992)
Provisions utilised		**(993)**	(429)
Increase/(decrease) in movement in non cash provisions		**20**	(450)
Net Cash Inflow/(outflow) from operating activities		**(6,923)**	5,140
Cash flows from investing activities			
Interest received		**33**	24
(Payments) for property, plant and equipment		**(15,296)**	(11,655)
(Payments) for intangible assets		**0**	(361)
Proceeds of disposal of assets held for sale (PPE)		**131**	7,763
Net cash inflow/(outflow) from investing activities		**(15,132)**	(4,229)
Net cash inflow/(outflow) before financing		**(22,055)**	911
Cash flows from financing activities			
Gross temporary (2014-15 only) and permanent PDC received		**38**	480
Gross temporary (2014-15 only) and permanent PDC repaid		**(2,600)**	0
Loans received from DH - new revenue support loans		**24,600**	0
Other loans received		**0**	188
Other loans repaid		**(38)**	(150)
Capital element of payments in respect of finance leases and on-SoFP PFI and LIFT		**0**	(3)
Net cash inflow/(outflow) from financing activities		**22,000**	515
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(55)**	1,426
Cash and cash equivalents (and bank overdraft) at beginning of the period		**2,724**	1,298
Cash and cash equivalents (and bank overdraft) at year end	**26**	**2,669**	2,724

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 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Charitable Funds

The trust did not consolidate the NHS charitable funds for which it is a corporate trustee as the Epsom and St Helier NHS Trust Charitable Fund's income, resources, assets and liabilities are not material for the year ended 31 March 2016. The directors have assessed the impact of not consolidating the accounts of its related charity and deemed it to be immaterial and not adversely affect the interpretation of the accounts by its stakeholders. This is consistent with Note 1.29 (page 70).

1.4 Pooled budgets

The NHS trust has no pooled budgets.

1.5 Critical accounting judgements and key sources of estimation uncertainty

These have been included with the appropriate notes to the accounts.

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.

1.5.1 Critical judgements in applying accounting policies

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

- Ascertaining if an arrangement contains a lease to assess whether it is an operating or finance lease
- During the year the trust's board has concluded that expenditure incurred to date on the proposed development of St Helier is no longer likely to generate economic benefits for the trust. It was therefore impaired in full. Details of this impairment are disclosed in Note 17.

1.5.2 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:

- Property, plant and equipment have lives and values based on estimates carried out by professional valuers. This is described fully in the relevant note
- Accruals and deferred income are based on best estimates of the expenditure still to be incurred for this financial year and the income received which in fact relates to next financial year
- Provisions are all based on the best estimates of future payments that will need to be made to meet current obligations. The basis of these estimates and the timing of the cash flows are described in the relevant note
- Pension fund valuations and settlements are estimated using guidelines set out by NHS Business Authority. The basis is set out in the relevant note
- Inventories were also estimated and this has been disclosed accordingly under the relevant note.

1.6 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.

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, eg 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.

1.7 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.

1.8 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.

1.9 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 current 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.

1.10 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 £5,000.

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.

1.11 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.

1.12 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.

1.13 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.

1.14 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.

1.15 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.

1.16 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.

1.17 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 three 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.

1.18 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 -0.8% in real terms for long term liabilities, 1.55% for short term liabilities, and -1% for medium term liabilities.

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.

1.19 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA 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 NHSLA on behalf of the trust is disclosed at Note 28.

1.20 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.

1.21 Carbon Reduction Commitment (CRC) Scheme
CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within 12 months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 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.

1.23 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 de-recognised 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.

Financial assets at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/ deficit on de-recognition. The trust did not hold any available for sale financial assets at 31 March 2016 (31 March 2015 £nil)

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.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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 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.

1.24 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.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The trust did not hold any financial liabilities at fair value through profit and loss at 31 March 2016. (31 March 2015 £nil)

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. The trust did not hold any financial liabilities at fair value through profit and loss at 31 March 2016 (31 March 2015 £nil)

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method. The trust did not hold any other financial liabilities at 31 March 2016 (31 March 2015 £nil)

1.25 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 property, plant, or equipment. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.26 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. Details of third party assets are given in Note 38 to the accounts.

1.27 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.

1.28 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).

1.29 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 Trust does not have any subsidiaries.

The trust did not consolidate the NHS charitable funds for which it is a corporate Trustee as the Epsom and St Helier NHS trust Charitable Fund's income, resources, assets and liabilities are not material for the year ended 31 March 2016. The directors have assessed the impact of not consolidating the accounts of its related charity and deemed it to be immaterial and not adversely affect the interpretation of the accounts by its stakeholders.

1.30 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.

1.31 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.

1.32 Going concern
IAS 1 requires management to assess, as part of the accounts preparation process, the trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the trust without the transfer of its services to another entity.

The trust has reported a cumulative breakeven position of (£52,268k) in 2015-16 and has failed to meet its statutory breakeven duty over three and five years. Grant Thornton has written to the Secretary of State for Health as required by statute to this effect. The trust is in discussions with the NHS Trust Development Authority (NTDA) with regards to its Integrated Business Plan.

Whilst the trust faces some medium term uncertainty regarding the configuration of its services and must meet challenging efficiency targets, there is no decision to liquidate the entity or cease trading. The trust has submitted an operating plan for 2016-17 predicting improved underlying financial performance. The trust has also received a letter of support from the NTDA confirming that it will make available necessary financing to meet our liabilities in the next 12 months.

For this reason the going concern basis has been adopted for preparing the accounts.

2 Pooled budgets

The trust has not been a party to pooled budgets either in the financial year to 31 March 2016 or financial year to 31 March 2015.

3 Operating segments

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

Healthcare activities	**2015-16 £000s**	2014-15 £000s
Income received from clinical commissioning groups and NHS England	**337,979**	332,972

No other single customer accounted for more than 10% of the trusts income. Note 5 provides a detailed breakdown of the amount disclosed above. All clinical commissioning groups and NHS England are considered as one customer as they are under common control.

4 Income generation activities

The trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary table - aggregate of all schemes	**2015-16 £000s**	**2014-15 £000s**
Income	**2,912**	3,018
Less full cost	**2,054**	2,375
Surplus/(deficit)	**858**	643

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

5 Revenue from patient care activities

	2015-16 £000s	**2014-15 £000s**
NHS trusts	**57**	337
NHS England	**47,712**	53,639
Clinical commissioning groups	**290,267**	279,333
Foundation trusts	**2,045**	761
NHS other (including Public Health England and Prop Co)	**296**	273
Additional income for delivery of healthcare services	**2,600**	0
Non-NHS:		
Local authorities	**519**	477
Private patients	**3,744**	3,635
Overseas patients (non-reciprocal)	**255**	388
Injury costs recovery	**824**	1,031
Other	**24**	113
Total revenue from patient care activities	**348,343**	339,987

The £2,600k NHS other income is a centrally mandated capital to revenue transfer as agreed by the Department of Health.

6 Other operating revenue

	2015-16 £000s	2014-15 £000s
Education, training and research	**14,323**	15,574
Charitable and other contributions to revenue expenditure - NHS	**215**	180
Receipt of donations for capital acquisitions - charity	**208**	103
Receipt of government grants for capital acquisitions	**83**	0
Non-patient care services to other bodies	**1,889**	1,994
Income generation (other fees and charges)	**4,623**	4,785
Other revenue	**2,907**	3,146
Total other operating revenue	**24,248**	25,782
Total operating revenue	**372,591**	365,769

7 Overseas visitors disclosure

	2015-16 £000s	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**255**	388
Cash payments received in-year (re receivables at 31 March 2015)	**52**	0
Cash payments received in-year (iro invoices issued 2014-15)	**203**	388
Amounts written off in-year (irrespective of year of recognition)	**24**	0

8 Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS trusts	**1,513**	2,784
Services from CCGs/NHS England	**18**	3
Services from other NHS bodies	**59**	0
Services from NHS foundation trusts	**4,843**	5,261
Total services from NHS bodies*	**6,433**	8,048
Purchase of healthcare from non-NHS bodies	**8,042**	6,231
Trust chair and non-executive directors	**58**	63
Supplies and services - clinical	**71,908**	65,501
Supplies and services - general	**11,809**	10,954
Consultancy services	**1,784**	1,215
Establishment	**3,371**	3,006
Transport	**5,643**	5,474
Business rates paid to local authorities	**1,008**	1,057
Premises	**14,598**	13,173
Hospitality	**4**	8
Insurance	**38**	38
Legal fees	**539**	600
Impairments and reversals of receivables	**40**	0
Inventories write down	**198**	0
Depreciation	**9,132**	8,660
Amortisation	**518**	546
Impairments and reversals of property, plant and equipment	**8,542**	4,631
Internal audit fees	**198**	198
Audit fees	**89**	104
Other auditor's remuneration	**10**	10
Clinical negligence	**7,200**	7,382
Research and development (excluding staff costs)	**5**	16
Education and training	**924**	1,057
Other	**98**	1,153
Total operating expenses (excluding employee benefits)	**152,189**	139,125
Employee benefits	**248,697**	230,412
Employee benefits excluding board members	1,273	1,111
Board members		
Total employee benefits	**249,970**	231,523
Total operating expenses	**402,159**	370,648

Other auditor's remuneration relates to the Audit of the Trust's Quality Accounts
Services from NHS bodies does not include expenditure which falls into a category below.

9 Operating leases

During 2015-16 and 2014-15 the trust leased buildings and other assets to provide healthcare to its patients. The most significant of these leases were the lease of Woodcote Lodge, for staff accommodation in Epsom, and Manorgate House in Kingston which was used for the provision of renal services.

9.1 Epsom and St Helier University Hospitals NHS Trust as lessee

	2015-16 Land £000s	Buildings £000s	Other £000s	Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**468**	463
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**468**	463
Payable:					
No later than one year	16	436	4	**456**	468
Between one and five years	64	0	0	**64**	74
After five years	592	0	0	**592**	608
Total	**672**	**436**	**4**	**1,112**	1,150
Total future sublease payments expected to be received:				0	0

9.2 Epsom and St Helier University Hospitals NHS Trust as lessor

The trust was not a lessor of assets in the current or prior year.

10 Employee benefits and staff numbers

10.1 Employee benefits

Employee benefits - gross expenditure	2015-16 Total £000s	Permanently Employed £000s	Other £000s
Salaries and wages	**214,114**	171,215	42,899
Social security costs	**15,720**	14,128	1,592
Employer contributions to NHS BSA - Pensions Division	**21,729**	20,536	1,193
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**251,563**	**205,879**	**45,684**
Employee costs capitalised	**1,593**	720	873
Gross employee benefits excluding capitalised costs	**249,970**	**205,159**	**44,811**

Employee benefits - gross expenditure	2014-15 Total £000s	Permanently Employed £000s	Other £000s
Salaries and wages	196,848	158,845	38,003
Social security costs	15,847	14,236	1,611
Employer Contributions to NHS BSA - Pensions Division	20,282	19,167	1,115
Other pension costs	0	0	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	232,977	192,248	40,729
Employee costs capitalised	1,454	1,454	0
Gross employee benefits excluding capitalised costs	231,523	190,794	40,729

10.2 Pension costs

Past and present employees are covered by the provisions. 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 of the two NHS Pension Schemes 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.

11 Better Payment Practice Code

	2015-16 Number	**2015-16 £000s**	2014-15 Number	2014-15 £000s
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**109,745**	**172,291**	85,961	133,307
Total non-NHS trade invoices paid within target	**50,712**	**102,595**	59,183	95,545
Percentage of NHS trade invoices paid within target	**46.2%**	**59.5%**	68.8%	71.7%
NHS payables				
Total NHS trade invoices paid in the year	**3,568**	**11,008**	3,649	**18,171**
Total NHS trade Invoices paid within target	**1,682**	**5,352**	3,313	**16,170**
Percentage of NHS trade invoices paid within target	**47.1%**	**48.6%**	90.8%	89.0%

The Better Payment Practice Code requires the trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

12 Investment revenue

	2015-16 £000s	2014-15 £000s
Rental revenue		
Other finance lease revenue	0	0
Subtotal	**0**	0
Interest revenue		
Bank interest	33	24
Subtotal	**33**	**24**
Total investment revenue	**33**	**24**

13 Other gains and losses

	2015-16 £000s	2014-15 £000s
Gain/(loss) on disposal of assets other than by sale (PPE)	(172)	(146)
Gain (loss) on disposal of assets held for sale	0	5,233
Total	**(172)**	**5,087**

14 Finance costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**314**	54
Interest on obligations under finance leases	**0**	0
Interest on late payment of commercial debt	**0**	0
Total interest expense	**314**	54
Other finance costs	**0**	0
Provisions - unwinding of discount	**34**	52
Total	**348**	106

15.1 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	39,352	166,216	857	13,415	34,150	0	9,543	1,352	**264,885**
Additions of Assets Under Construction				2,842					**2,842**
Additions purchased	0	10,108	0	0	1,052	0	1,201	0	**12,361**
Additions - non cash donations (ie physical assets)	0	0	0	0	208	0	0	0	**208**
Reclassifications	0	2,781	4	(2,785)	9	0	(9)	0	**0**
Disposals other than for sale	0	(155)	0	(131)	(66)	0	0	0	**(352)**
Upward revaluation/positive indexation	0	2,539	13	0	0	0	0	0	**2,552**
Impairment/reversals charged to operating expenses	0	0	0	(8,542)	0	0	0	0	**(8,542)**
Impairments/reversals charged to reserves	0	0	0	(1,345)	0	0	0	0	**(1,345)**
At 31 March 2016	**39,352**	**181,489**	**874**	**3,454**	**35,436**	**0**	**10,735**	**1,352**	**272,692**
Depreciation									
At 1 April 2015	7,393	52,190	261	0	19,131	0	7,285	1,327	**87,587**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	(14)	0	0	(28)	0	0	0	**(42)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged during the year	0	5,928	50	0	2,546	0	602	6	**9,132**
At 31 March 2016	**7,393**	**58,104**	**311**	**0**	**21,649**	**0**	**7,887**	**1,333**	**96,677**
Net Book Value at 31 March 2016	**31,959**	**123,385**	**563**	**3,454**	**13,787**	**0**	**2,848**	**19**	**176,015**
Asset financing:									
Owned - purchased	31,959	119,663	0	3,454	12,149	0	2,845	19	170,089
Owned - donated	0	3,722	563	0	1,638	0	3	0	5,926
Total at 31 March 2016	**31,959**	**123,385**	**563**	**3,454**	**13,787 0**	**0**	**2,848**	**19**	**176,015**

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

Revaluation reserve balance for property, plant and equipment

At 1 April 2015	13,234	21,811	389	0	1,078	0	0	36	36,548
Movements due to annual revaluation	0	1,189	13	0	0	0	0	0	1,202
At 31 March 2016	**13,234**	**23,000**	**402**	**0**	**1,078**	**0**	**0**	**36**	**37,750**

Additions to assets under construction in 2015-16

Land				0					
Buildings excl dwellings				2,842					
Dwellings				0					
Plant and machinery				0					
Balance as at YTD				**2,842**					

15.2 Property, plant and equipment

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	37,369	151,039	409	13,307	33,107	6	8,479	1,352	**245,068**
Additions of assets under construction	0	0	0	1,215	0	0	0	0	**1,215**
Additions purchased	0	5,411	0	0	1,906	0	926	0	**8,243**
Additions - non cash donations (ie physical assets)	0	0	0	0	103	0	0	0	**103**
Additions - purchases from cash donations and government grants	0	0	0	0	0	0	0	0	**0**
Additions leased (including PFI/LIFT)	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	71	0	(1,107)	736	0	138	0	**(162)**
Reclassifications as held for sale and reversals	(1,612)	(585)	(53)	0	0	0	0	0	**(2,250)**
Disposals other than for sale	0	0	0	0	(1,702)	(6)	0	0	**(1,708)**
Revaluation	6,209	12,692	501	0	0	0	0	0	**19,402**
Impairments/negative indexation charged to reserves	(2,614)	(2,412)	0	0	0	0	0	0	**(5,026)**
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**39,352**	**166,216**	**857**	**13,415**	**34,150**	**0**	**9,543**	**1,352**	**264,885**
Depreciation									
At 1 April 2014	2,885	46,721	213	0	18,017	0	6,733	1,320	**75,889**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	(28)	(2)	0	0	0	0	0	**(30)**
Disposals other than for sale	0	0	0	0	(1,562)	(1)	0	0	**(1,563)**
Revaluation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation charged to operating expenses	4,508	123	0	0	0	0	0	0	**4,631**
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged during the year	0	5,374	50	0	2,676	1	552	7	**8,660**
At 31 March 2015	**7,393**	**52,190**	**261**	**0**	**19,131**	**0**	**7,285**	**1,327**	**87,587**
Net Book Value at 31 March 2014	**31,959**	**114,026**	**596**	**13,415**	**15,019**	**0**	**2,258**	**25**	**177,298**
Asset financing:									
Owned - purchased	31,959	109,631	596	13,415	13,512	0	2,251	25	**171,389**
Owned - donated	0	4,395	0	0	1,505	0	7	0	**5,907**
Held on finance lease	0	0	0	0	2	0	0	0	**2**
Total at 31 March 2015	**31,959**	**114,026**	**596**	**13,415**	**15,019 0**	**0**	**2,258**	**25**	**177,298**

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

15.3 (cont). Property, plant and equipment

Donations towards property and equipment assets have been received by the trust during the year by the following bodies:

Epsom & St Helier NHS Trust Charitable Funds: £208k

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

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

In line with these requirements during 2014-15 the trust commissioned a revaluation of its land and buildings, from Deloitte LLP, RICS qualified third party experts, as at 1 April 2014. The next formal revaluation is planned for 1 April 2019. Between the 1 April 2015 and 31 March 2016 the trust applied its revaluation indices as prepared by Deloitte LLP, RICS qualified third party experts, which lead to an increase of £2,552k in the carrying value of its buildings.

See Note 17 for information relating to movements on assets under construction.

16 Intangible non-current assets

16.1 Intangible non-current assets

2015-16	Computer licences	Total
	£000s	£000s
At 1 April 2015	**4,394**	**4,394**
Additions purchased	0	**0**
At 31 March 2016	**4,394**	**4,394**
Amortisation		
At 1 April 2015	**2,542**	**2,542**
Charged during the year	518	**518**
At 31 March 2016	**3,060**	**3,060**
Net Book Value at 31 March 2016	**1,334**	**1,334**
Asset Financing: Net book value at 31 March 2015 comprises:		
Purchased	1,229	**1,229**
Donated	105	**105**
Total at 31 March 2016	**1,334**	**1,334**

16.2 Intangible non-current assets prior year

2014-15	Computer Licences	Total
	£000s	£000s
At 1 April 2014	3,883	3,883
Additions - purchased	349	349
Reclassifications	162	162
At 31 March 2015	4,394	4,394
Amortisation		
At 1 April 2014	1,996	1,996
Charged during the year	546	546
At 31 March 2015	2,542	2,542
Net book value at 31 March 2015	1,852	1,852
Net book value at 31 March 2015 comprises:		
Purchased	1,707	1,707
Donated	145	145
Total at 31 March 2015	1,852	1,852

16.3 Intangible non-current assets

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

17 Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total
	£000s
Property, plant and equipment impairments and reversals taken to SoCI	
Abandonment of assets in the course of construction	8,542
Total charged to departmental expenditure limit	**8,542**
Total Impairments of property, plant and equipment changed to SoCI	**8,542**
Total Impairments charged to SoCI - DEL	**8,542**
Total Impairments charged to SoCI - AME	**0**
Overall Total Impairments	**8,542**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

During the year the trust's board has concluded that expenditure incurred to date on the proposed development of the St Helier site, previous held as an Asset Under Construction is no longer likely to generate economic benefits for the trust. It was therefore impaired in full. Note 15.3 gives full details.

The trust's Outline Business Case, approved by the Department of Health in 2010 was predicated on a £219 million redevelopment of St Helier Hospital. This project was to be delivered in four phases; decant (temporarily relocate outpatients and administrative office to Sutton and demolition of Ferguson House during the new hospital build at St Helier), a car multi-storey park, a new hospital building on the site of Ferguson House and refurbishment plus backlog maintenance of existing buildings at St Helier.

The trust incurred expenditure of £9.9 million between 2009-10 and 2012-13 relating to this programme on the following:

- An in-house project team plus management consultancy support, cost consultants, architects, engineers and other necessary professional fees, totalling £8.5 million
- Backlog maintenance totalling £1.4 million. This was spent on improving the trust's physical assets and would have been taken into account in the five year revaluation exercise conducted in 2014-15.

This programme was halted in 2014 due to the uncertainty of service re-configuration in south west London. These costs were classified as Assets Under Construction on the balance sheet.

During 2015-16, The trust's board concluded that there was no likelihood that the schemes in the original programme would obtain Full Business Case approval from the Department of Health and therefore that the expenditure incurred to date on the proposed redevelopment of St Helier was no longer likely to generate economic benefits. Consequently, the £9.9 million of expenditure held as an Asset Under Construction were written off (impaired) in full.

The costs were written off in 2015-16, with £8.5 million charged to the income and expenditure account and £1.4 million written off to the revaluation reserve.

17 Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	Total
	£000s	**£000s**
Impairments and reversals taken to SoCI	0	
Loss or damage resulting from normal operations	0	**0**
Over-specification of assets	0	**0**
Abandonment of assets in the course of construction	8,542	**8,542**
Total charged to Departmental Expenditure Limit	**8,542**	**8,542**
	0	
Total Impairments of Property, Plant and Equipment changed to SoCI	**8,542**	**8,542**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

18 Commitments

18.1 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	**3,036**	3,317
Intangible assets	**0**	0
Total	**3,036**	3,317

18.2 Other financial commitments

The trust has no other financial commitments.

19 Inventories

	Drugs	**Consumables**	**Work in progress**	**Energy**	**Loan**	**Other**	**Total**	**Of which held at NRV**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**1,599**	**2,305**	**0**	**30**	**0**	**26**	**3,960**	3,960
Additions	26,477	9,492	0	76	0	153	36,198	36,198
Inventories recognised as an expense in the period	(26,309)	(9,223)	0	(33)	0	(145)	(35,710)	(35,908)
Write-down of inventories (including losses)	(198)	0	0	0	0	0	(198)	0
Balance at 31 March 2016	**1,569**	**2,574**	**0**	**73**	**0**	**34**	**4,250**	**4,250**

All stock categories other than drugs were valued on or around 31 March 2016. There were no significant movements in stock received or utilised between the date noted and the end of the year. Hence the value of stock represents a fair estimate of the value disclosed above as at 31 March 2016. All stocks are held at Net Realisable Value. The drugs write down was as a result of fire.

20.1 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	**6,319**	5,626	**0**	0
NHS prepayments and accrued income	**5,725**	7,221	**0**	0
Non-NHS receivables - revenue	**2,638**	3,006	**295**	249
Non-NHS receivables - capital	**158**	151	**0**	0
Non-NHS prepayments and accrued income	**2,992**	2,532	**0**	0
Provision for the impairment of receivables	**(378)**	(345)	**(54)**	(47)
VAT	**1,720**	1,360	**0**	0
Other receivables	**641**	872	**0**	0
Total	**19,815**	20,423	**241**	202
Total current and non current	**20,056**	20,625		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with clinical commissioning groups and NHS England. As these NHS bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

20.2 Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**2,402**	2,833
By three to six months	**329**	419
By more than six months	**2,352**	1,563
Total	**5,083**	4,815

20.3 Provision for impairment of receivables

	31 March 2016	31 March 2015
	£000s	£000s
Opening Balance	**(392)**	(1,592)
Amount written off during the year	**0**	1,200
Amount recovered during the year	**1**	0
(Increase)/decrease in receivables impaired	**(41)**	0
Closing Balance	**(432)**	(392)

Debts are impaired if there is specific credit control information that suggests the value of the debt should be impaired. All debts for injury recovery costs are subject to a 18.9% (2013-14: 15.8%)

21 Cash and cash equivalents

	31 March 2016	31 March 2015
	£000s	£000s
Opening balance	**2,724**	2,724
Net change in year	**(55)**	0
Closing balance	**2,669**	2,724
Made up of		
Cash with Government Banking Service	**2,666**	2,721
Cash in hand	**3**	3
Cash and cash equivalents as in statement of financial position	**2,669**	2,724
Cash and cash equivalents as in statement of cash flows	**2,669**	2,724
Third party assets - bank balance (not included above)	**0**	0
Third party assets - monies on deposit	0	0

22 Non-current assets held for sale

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information Technology	Furniture and Fittings	Intangible	Financial	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	1,612	557	51	0	0	0	0	0	0	0	**2,220**
Less assets sold in the year	(1,612)	(557)	(51)	0	0	0	0	0	0	0	**(2,220)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	0	0	0	0	0	0	0	0

23 Trade and other payables

	Current		**Non-Current**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**5,471**	1,849	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**7,500**	5,184	**0**	0
Non-NHS payables - revenue	**12,371**	15,552	**0**	0
Non-NHS payables - capital	**1,311**	1,249	**0**	0
Non-NHS accruals and deferred income	**11,638**	12,664	**0**	0
Social security costs	**2,420**	62		
PDC Dividend payable to DH	**396**	0		
Tax	**2,439**	86		
Other	**3,607**	374	**0**	0
Total	**47,153**	37,020	**0**	0
Total payables (current and non-current)	**47,153**	**37,020**		
Included above:				
To buy out the lability for early retirements over 5 years	**0**	0		
Number of cases involved (number)	**0**	0		
Outstanding pension contributions at the year end	**3,127**	57		

24 Borrowings

	Current		**Non-Current**	
	31 March 2016 £000	31 March 2015 £000	**31 March 2016 £000**	31 March 2015 £000
Loans from Department of Health	0	0	24,600	0
Loans from other entities	0	38	0	0
Finance lease liabilities	0	1	0	0
Total	**0**	**39**	**24,600**	**0**
Total other liabilities (current and non-current)	**24,600**	**39**		

31 March 2016

Borrowings / Loans - repayment of principal falling due in:	**DH**	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	0	0	**0**
1 - 2 Years	0	0	**0**
2 - 5 Years	24,600	0	**24,600**
Over 5 Years	0	0	**0**
TOTAL	**24,600**	**0**	**24,600**

25 Deferred revenue

	Current		Non-Current	
	31 March 2016 £000	31 March 2015 £000	**31 March 2016 £000**	31 March 2015 £000
Opening balance	**517**	2,032	**0**	0
Deferred revenue addition	**53**	517	**0**	0
Transfer of deferred revenue	**0**	(2,032)	**0**	0
Closing balance	**570**	517	**0**	0
Total deferred income (current and non-current)	**570**	517		

26 Finance lease obligations as lessee

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Minimum lease payments/present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
Total			**0**	0

Amounts payable under finance leases (Land)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**0**	0	**0**	0
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Minimum lease payments / present value of minimum lease payments	**0**	0	**0**	0
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
Total			**0**	0

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**0**	1	**0**	1
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Minimum lease payments/present value of minimum lease payments	**0**	1	**0**	1
Included in:				
Current borrowings			**0**	1
Non-current borrowings			**0**	0
Total			**0**	1

Finance leases as lessee

	31 March 2016 £000s	31 March 2015 £000s
Future sublease payments expected to be received	**0**	0
Contingent rents recognised as an expense	**0**	0

27 Finance lease receivables as lessor

For the year ended 31 March 2015 or 31 March 2016, the trust did not have any finance lease receivables as lessor.

28 Provisions

	Total	Early departure costs	Legal claims	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**3,738**	2,065	75	1,598	0
Arising during the year	**150**	0	0	150	0
Utilised during the year	**(993)**	(251)	(7)	(735)	0
Reversed unused	**(130)**	(2)	(42)	(86)	0
Unwinding of discount	**34**	24	0	10	0
Balance at 31 March 2016	**2,799**	**1,836**	**26**	**937**	**0**
Expected timing of cash flows					
No later than one year	**511**	251	26	234	0
Later than one year and not later than five years	**1,340**	1,002	0	338	0
Later than five years	**948**	583	0	365	0
	2,799				

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:

	£000s
As at 31 March 2016	78,558
As at 31 March 2015	77,362

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

Legal claims
The amount included is based on the excess the trust would pay should the claim be successful.

Other provisions
This includes the following:

Injury benefits (£787,000) This category of provision represents the future liability of the trust for injury benefits. Payments are made to the NHS Pensions Agency for staff who retired from the trust due to a work related injury. The estimate of the full forecast liability is based upon an actuarial estimate from the Pensions Agency. Timings are based on the current rate of payments from this provision.

Employment tribunals (£150,000) This category of provision represents the future liability of the trust for employment tribunals.

29 Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
Other - legal claims	**(56)**	(43)
Net value of contingent liabilities	**(56)**	(43)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

30 Impact of IFRS treatment - current year

There is no difference between these financial statements as prepared using International Financial Reporting Standards and these statements if they were prepared using UK GAAP.

31 Financial instruments

31.1 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 commissioners and the way those commissioners are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. The trust's treasury activity is subject to review by 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. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations. The trust is exposed to a risk that its cost of borrowings - which are fixed over the life of the agreement - is in excess of the borrowing costs avaliable in the future.

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

Liquidity risk
During the current year the trust has been making operating losses and has no access to wider money markets to fund these losses. Losses are currently funded through Department of Health loans on which the trust pays interest of 3.5%. These loans are disclosed in Note 24. The trust has received assurances from the Department of Health that further loans - at a value covering the trust's operating losses - will be made available in 2016-17. See Note 1.32, Going Concern, for further details.

31.2 Financial assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		12,044		**12,044**
Receivables - non-NHS		3,936		**3,936**
Cash at bank and in hand		2,669		**2,669**
Total at 31 March 2016	**0**	**18,649**	**0**	**18,649**
Receivables - NHS		12,847		12,847
Receivables - non-NHS		4,872		4,872
Cash at bank and in hand		2,724		2,724
Total at 31 March 2015	0	20,443	0	20,443

31.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables	0	12,971	**12,971**
Non-NHS payables	0	28,357	**28,357**
Other borrowings	0	24,600	**24,600**
Total at 31 March 2016	**0**	**65,928**	**65,928**
NHS payables	0	7,144	7,144
Non-NHS payables	0	30,022	30,022
Other borrowings	0	38	38
PFI & finance lease obligations	0	1	1
Total at 31 March 2015	0	37,205	37,205

32 Events after the end of the reporting period

There have been no post balance sheet events.

33 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, has undertaken any material transactions with Epsom and St Helier University Hospital NHS Trust.

The trust is a member of the London Audit Consortium and the Chief Financial Officer is the nominated representative of the trust in the capacity of a non-executive director. Day to day operations are directed and controlled by the two executive directors and the full board set strategic direction and approve operations of the consortium. The trust has paid the Consortium £198,100 (2014-15: £198,000) for its Internal Audit Services.

The Department of Health is regarded as a related party and parent Department. During the year Epsom and St Helier University Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The main entities are listed below with the value of the transactions for 2015-16:

	Payable as at 31/3/2016	Receivable as at 31/3/2016	Revenue in the 12 months to 31/3/2016	Expenditure in the 12 months to 31/3/2016
	£000s	£000s	£000s	£000s
Surrey Downs CCG	402	2,619	101,919	14
Sutton CCG	0	1,412	105,110	-
HM Revenue and Customs	4,859	-	-	57,533
National Health Service Pension Scheme	3,607	-	-	37,124

The trust has also received donations from its charitable fund, of which it is the Corporate Trustee. These were:

Revenue
Epsom and St Helier University Hospitals NHS Trust Charitable Funds £215,000 (2014-15 £180,000)

Capital Additions
Epsom and St Helier University Hospitals NHS Trust Charitable Funds £208,000 (2014-15 £103,000)

34 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	25,309	68
Special payments	45,866	65
Total losses and special payments	71,175	133

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	25,280	8
Special payments	11195	49
Total losses and special payments	36,475	57

The losses disclosed above do not include stock write offs which are shown in Note 8 and Note 19.

35 Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

36 Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	272,854	296,498	315,020	327,548	334,761	331,320	343,567	356,010	365,769	**372,591**
Retained surplus/(deficit) for the year	(5,543)	827	4,902	(6,255)	3,332	(17,442)	(11,550)	(15,334)	(4,958)	**(34,535)**
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)	(1,718)									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	9,132	0	5,165	(450)	8,225	4,631	**8,542**
Adjustments for impact of policy change re donated/government grants assets						0	(94)	(291)	405	**205**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	0	0	0	0	**0**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	0	0	**0**
Break-even in-year position	**(7,261)**	**827**	**4,902**	**2,877**	**3,332**	**(12,277)**	**(12,094)**	**(7,400)**	**78**	**(25,788)**
Break-even cumulative position	**(6,725)**	**(5,898)**	**(996)**	**1,881**	**5,213**	**(7,064)**	**(19,158)**	**(26,558)**	**(26,480)**	**(52,268)**

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

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (ie is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-2.66	0.28	1.56	0.88	1.00	-3.71	-3.52	-2.08	0.00	**-6.92**
Break-even cumulative position as a percentage of turnover	-2.46	-1.99	-0.32	0.57	1.56	-2.13	-5.58	-7.46	0.00	**-14.03**

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.

37.1 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%.

37.2 External financing

The trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**22,764**	(120)
Cash flow financing	**22,055**	(911)
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**22,055**	(911)
Under/(over) spend against EFL	**709**	791

37.3 Capital resource limit

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

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**15,479**	9,907
Less: book value of assets disposed of	**(378)**	(2,365)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(208)**	(103)
Charge against the capital resource limit	**14,893**	7,439
Capital resource limit	**15,076**	9,772
(Over)/underspend against the capital resource limit	**183**	2,333

38 Third party assets

The trust did not hold any third party assets as at 31 March 2016 (31 March 2015 – nil)

Annual Governance Statement

The Annual Governance Statement (AGS) is part of the annual report and statutory accounts. It is a statement signed by the Chief Executive and is subject to external audit.

In signing the AGS, the Chief Executive has stated that the trust board has considered all of the organisation's risks (clinical and non-clinical) which may jeopardise the successful functioning of the organisation, and that appropriate steps have been taken to minimise them.

The statement also describes the systems and processes that the organisation has put in place to reach the conclusions made about risks. The statement is available on request from the Head of Corporate Governance by calling 020 8296 4990 or emailing **communications@esth.nhs.uk**.

Financial Statements

A full set of the trust's accounts, and the accounts for its charitable funds, can be obtained, free of charge, from:

Amanda Harris
PA to the Chief Financial Officer
St Helier Hospital
Wrythe Lane
Carshalton
Surrey, SM5 1AA

Email: **amanda.harris@esth.nhs.uk**
Tel: **020 8296 2960**

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