NHS
Croydon Health Services
NHS Trust

Annual Report & Accounts
2019/2020

Excellent care for all
Home | Community | Hospital

Professional
Compassionate
Respectful
Safe

ANNUAL REPORT AND ACCOUNTS 2019/2020

Croydon Health Services NHS Trust 2019/20: **Facts at a glance**

HIGH QUALITY CARE

Over **1,100** patients treated for COVID-19

232,865 patients treated in A&E

3,619 babies delivered

SUPPORTING OUR STAFF

3 in 5 staff would recommend CHS as a place to work

Over **300 nominations** for the Croydon Stars Awards

'Thirst Responders'
Staff recognition scheme launched

86% of staff had an appraisal in the last 12 months

SUSTAINABLE FINANCES

£11 million
cost improvement savings delivered

£9.3 million invested in estates, facilities and equipment

Achieved joint financial control total with Croydon CCG

£220 million
spent on paying our staff

IMPROVING HEALTH FOR ALL

Joint executive team appointed across Croydon's NHS

'One Croydon'
health and care plan launched

Planning for the SWL Integrated Care System

Over **1,600** patients treated at home by our integrated LIFE team

CHAIR FOREWORD

As we move into 2020, our 10th year as an integrated acute and community Trust, I have never been prouder to be a part of Croydon's NHS.

Over the past decade, we have seen teams change the way they work, joining up hospital and community services to provide integrated care to more people than ever before and more often, in the comfort of people's own homes. The need for this has never been more pronounced than during the Coronavirus pandemic.

The outbreak has revolutionised the way we provide care to our communities and patients. With more people being asked to remain at home but still requiring treatment, our staff needed to innovate and adapt, and they rose to the challenge. From telephone consultations, and running clinics on teams, to setting up our new Domiciliary Chemotherapy Service and caring for Croydon's homeless during their relocation to local hotels, our staff have refused to let distance interrupt caring for their patients.

The need for these changes has been clearly demonstrated in recent months, and to go back to 'the old ways' misses a chance for us to achieve an even better standard of care than before.

Part of our plans for recovery as we move into 2020/21 will allow us to permanently increase the Trust's capacity to deliver care, while also providing more comfortable and private areas for the borough's most severely ill patients and their families, using £12 million capital funding that we secured in August 2019 and completely modernising the Trust's critical care services.

COVID-19 taught us to that to be able to deliver high quality care, we need to be flexible, committed and collaborative. This was clearly demonstrated by the staff who were redeployed, and retrained to lend help where it was needed, from our frontline services right through to our corporate teams.

Keeping this momentum will allow us to embody the key factors identified within the NHS Long Term Plan, of integration, alignment and collaboration.

Before the pandemic we had already taken great steps in this direction, as we joined forces with Croydon NHS Clinical Commissioning Group (CCG) to appoint one executive leadership team across both organisations.

Now we can take forward the unity and teamwork we have developed, alongside our new ways of working, to build on this partnership across Croydon, setting an example for our health and care colleagues around the country.

In the coming year, we'll be looking to build on the results we've seen from helping our staff work across organisational boundaries to deliver more joined up care in the borough, and create opportunities for our staff working in the Croydon health and care system.

We will also be continuing to celebrate the efforts of our staff in recognition of the incredible work put in during COVID-19 across the NHS, while also joining forces with organisations across the world to highlight the contributions of our nursing, midwifery and care staff workforce, thanks to International Year of the Nurse and Midwife.

In line with this and launched in January 2020, is our first ever dedicated Nursing, Midwifery and Care Staff Strategy, it serves as a timely reminder of the commitment, dedication and passion of the NHS's largest staff group as they work harder than ever to keep the nation safe and well.

I continue to be inspired by the teams working across Croydon's NHS services - from our doctors and nurses to our porters and procurement teams, in their ability to deliver excellent care for all while demonstrating our Trust values - to be compassionate, professional, respectful and safe, and I thank each of them for all they have achieved in 2019/20.

Mike Bell

Chairman

CHIEF EXECUTIVE FOREWORD

This has been an unprecedented year for the NHS and especially for us in Croydon for many reasons, but none more so than the outbreak of COVID-19 which has dominated the headlines - and our hospitals - since February 2020.

I'd like to start this annual report with a tribute to our workforce, the people who have delivered care on the frontline to patients diagnosed with the virus, as well as those who have worked around the clock, often behind the scenes, to ensure we have the right tools to deliver this care.

It is the people within an organisation who shape its success and I am incredibly proud of every member of Team Croydon, each of whom has worked tirelessly to deliver our vision of excellent care for all as we respond to the biggest health crisis in a generation.

We have stepped up our support for our staff throughout this year and as we look to 2020/21, this will become even more vital, as we prepare for a "new normal" and a health system that continues to care for patients with thousands of illnesses and injuries each year, alongside COVID-19.

As part of this support, this year we introduced a number of schemes that empower our teams and recognise their efforts, while truly living our values as a compassionate, respectful, safe and professional Trust.

Over 1,000 of our peer to peer thank you cards have been distributed to colleagues who have gone the extra mile and we've taken our Thirst Responders tea trolley - complete with senior leaders and plenty of snacks - out to staff across the Trust over 40 times.

These initiatives are just one of the possible reasons that, for the first time in many years, we saw record numbers of our workforce responded to the annual NHS Staff Survey, with more staff recommending Croydon Health Services as a place to work.

And while we have upped our commitment to our staff, they have also upped their commitment to Croydon. Over 100 staff-led improvement projects have now been registered through Croydon Quality Improvement (CQI), highlighting their passion to make things even better and continually respond to the changing landscape of Croydon's health needs.

At the same time, we became the first borough in the country to bring together the leadership of both the Trust and our local CCG, leading the way for closer partnership working.

With this, we have been able to renew our focus on population health, and the wider factors that contribute towards health, as can be seen in the Croydon Health and Care Plan. The plan, developed together with Croydon CCG, Croydon Council and Age UK Croydon, sets out our ambitious and energising vision as a borough to keep our communities thriving, supported and reducing health inequalities for all.

The passion, commitment and diversity of our communities are our assets and while we reflect on our progress throughout this annual report, we can look confidently into the future and build on these strengths to truly make Croydon the best place it can be.

Matthew Kershaw

Chief Executive and Place Based Leader for Health


ZEISS
Carl Zeiss
Hospital Dentistry

PERFORMANCE REPORT

PERFORMANCE ANALYSIS

The purpose of this section is to provide an overview of the Trust. We set out our purpose, our progress and the challenges we have faced. Here you will also find a summary of the actions we have taken and how our services have performed during the year.

Our strategic priorities

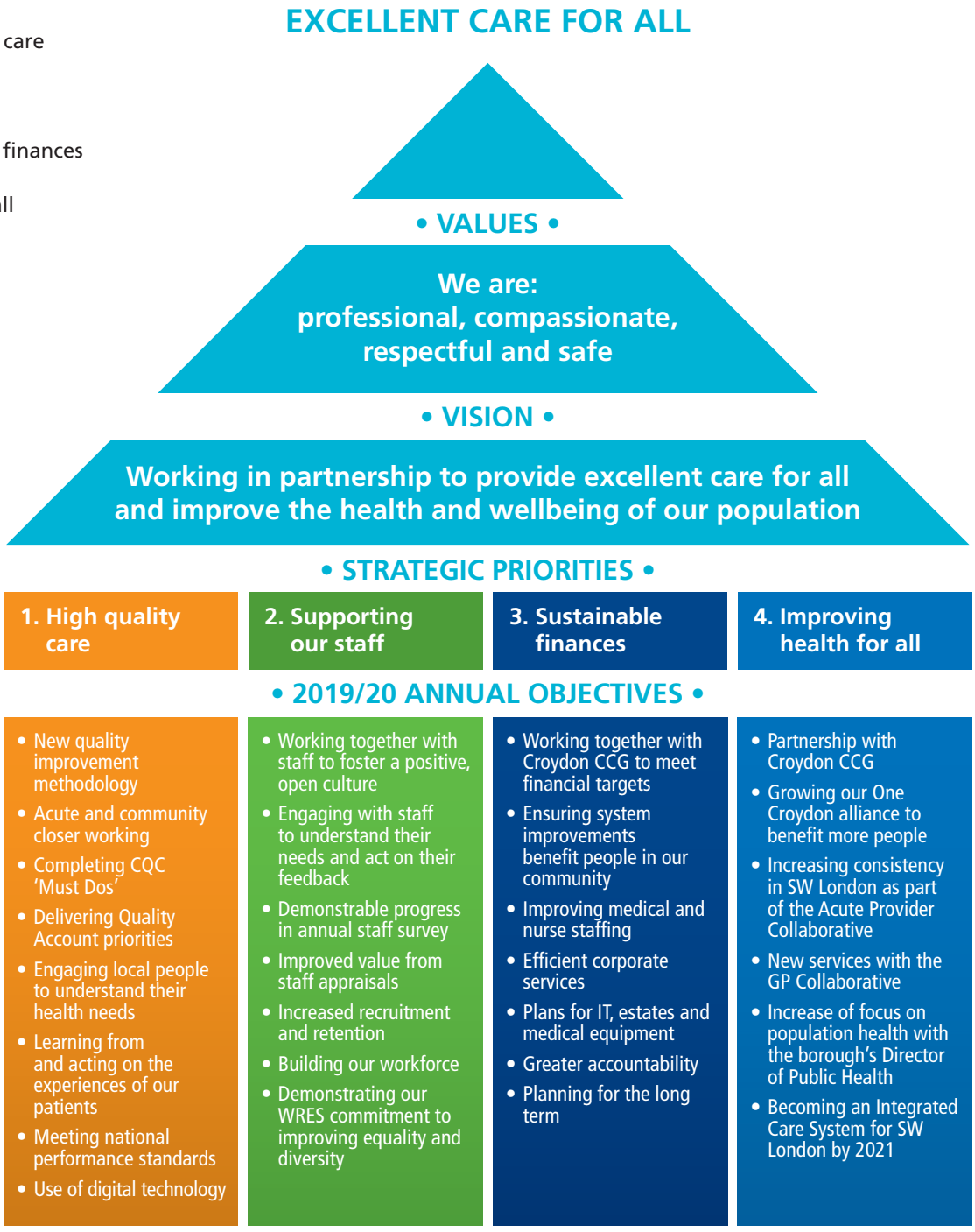
In 2019/20, we reset our annual objectives for the year ahead. Delivering our annual objectives are the foundations on which we will achieve our strategic vision for the Trust.

The new strategic priorities for Croydon Health Services NHS Trust are:

- Providing high quality care
- Supporting our staff
- Delivering sustainable finances
- Improving health for all

Setting this out means our staff understand the priorities for the Trust and importantly the role they all play in working together to deliver excellent care for people in Croydon and helping to improve the health and wellbeing of our population.

Underpinning all of this are our Trust values that shape everything we do. Our values determine the behaviours our colleagues can expect of each other and importantly, what our patients and local population can expect of the Trust.



OUR RESPONSE TO COVID-19

On 11 March 2020, we treated our first patient for COVID-19. That day, we knew that we were dealing with something incredibly serious, but we didn't know that we would soon be dealing with the biggest challenge that the NHS has ever faced.

This year we have adapted in a way we never thought possible, as we responded to the outbreak across Croydon. As one of the most affected Trusts in the country, our staff have worked tirelessly to continue to provide critical care to thousands of patients, while finding new and innovative ways to keep the rest of Croydon well.

The outbreak of COVID-19 hit Croydon particularly hard. In the first three months, we treated over 1,100 patients for the virus. Sadly, at the time of writing, over 300 of these people had passed away, a loss that we will feel in Croydon for years to come.*

We also lost some of our own in Croydon, including NHS colleagues Dr Paul Kabesele from Moorfields Eye Hospital Dr Krishan Arora, a local GP, local paramedic Ian Reynolds and much loved hospital porter Dennis Thorpe, all of whom dedicated their lives to the NHS. Sadly, two of our former volunteers, Sudesh Sidar and Daphne Mungaldass also passed away after contracting COVID-19. Our thoughts and condolences remain with their families.

Alongside these losses, we also saw some incredible moments of recovery, which spread hope far and wide. The story of the first patient we discharged from critical care, Jothy Kesavan, made the news around the world.

Jothy's recovery, after three weeks in our Intensive Care Unit, highlighted the endless commitment of our staff in providing the best possible care for every patient.

Meanwhile, behind the scenes, our other clinical teams, operational and support staff worked around the clock to ensure we were able to deliver that care.

In testament to the partnership working across Croydon's health and care system, this work also extended outside of the hospital walls. Our teams, particularly those in our community services, collaborated with colleagues in primary care, social care and the voluntary sector, working together to provide essential support for patients who needed them during the outbreak.

At unprecedented speed, we have implemented new technologies, recruited additional staff, adapted to new ways of working, while implementing additional support for staff and important guidance for patients.

Our response to, and recovery from, COVID-19 is likely to carry on for some years but we must learn from these changes, working with our staff, our patients and local people to understand what we should keep and what we can change to continue to improve healthcare for all.

Our response to COVID-19

- Over one million pieces of PPE, including masks, gowns, gloves and aprons distributed
- Thousands of outpatient appointments delivered virtually using video or telephone calls
- Hundreds of staff tested for COVID-19, ensuring they received timely guidance and treatment if needed

* From 11 March 2020 to 30 May 2020

CASE STUDY: JOTHY KESAVAN

51-year-old Mrs Jothy Kesavan was Croydon's first patient to head home after recovering from COVID-19 from the hospital's Intensive Care Unit. She was admitted to Croydon University Hospital on 17th March and was critically ill for a month before her discharge.

Mrs Kesavan's husband, Jason added:
"There are no words that can express the level of gratitude I have for the staff at Croydon University Hospital. When you saved my wife's life, you saved my life too and the lives of our family and friends who all love her so much. Thank you all."

Speaking about the care she received, Mrs Kesavan said:

> **"I'd like to thank all of the staff at Croydon Health Services NHS Trust for their endless compassion. The sacrifices you are making on our behalf in light of these unprecedented challenges are truly breath-taking. I feel blessed to have been in your care and will never forget you all. You saved my life.**
>
> **For most of my 30 odd days in hospital I was under heavy sedation, but when awake, I simply remember the kindness the nurses showed me. I remember for example my hair being tangled up in knots and two kind nurses taking time out of their busy schedules to untangle it for me. They were just so kind and the level of support was second to none."**

HIGH QUALITY CARE

The first pillar of our annual objectives, and without a doubt the most important, is our ability to deliver high quality care to every patient in the right place, at the right time.

Quality Improvement

Our vision is to deliver continuous improvements in the quality of care and a safety culture that is fully embedded and integral to our everyday work. Our quality priorities for 2019/20 were developed in discussion with our Clinical Directorates, the members of the Quality Improvement Programme, and our Quality Committee.

They are themed in line with the key areas of focus within the 2019-21 Quality Strategy, which looks at:

- **Safety:** ensuring that each patient receives the correct treatment or action the first time, every time
- **Clinical Effectiveness:** providing patient care that is amongst the best in the London, improving the effectiveness of our care through research and innovation
- **Experience:** supporting our patients and their families to have the best possible experience of our treatment and care.

This year we have developed our Integrated Quality and Performance Report (IQPR) which includes a wide range of qualitative and quantitative information to monitor our performance in these areas. A full summary of our work and our achievements this year can be found in our annual Quality Account 2019/20.

A key part of our success will be our ability to continually learn and improve from every experience, both as an organisation and as individuals. As such, we implemented a new quality improvement methodology this year to support teams across the Trust to make positive changes in their areas.

Meeting national performance standards

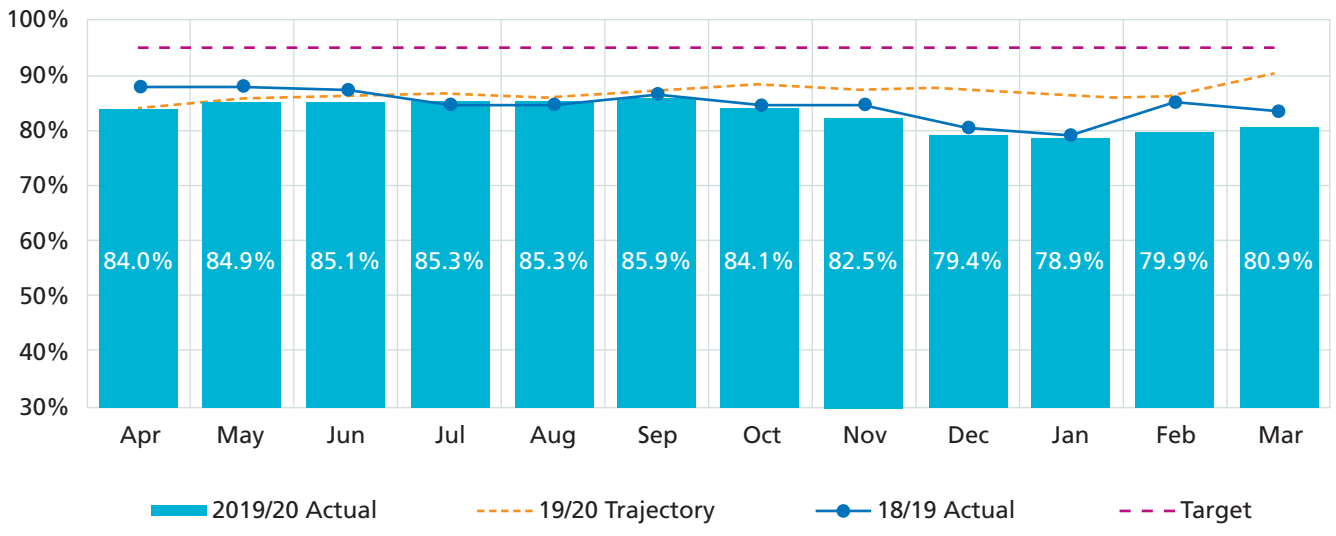
Emergency Care Standard performance

The NHS aims to treat and either admit, transfer or discharge 95% of the patients who visit an Emergency Department within four hours. While rising demand has made it challenging for Trusts around the country to reach this target, we agreed an improvement performance trajectory for 2019/20, with the aim of achieving 90.3% by March 2020. However, despite some improvements in the year, at the end of that period our performance was not where we need to be, falling around 10% below our target.

Our improving performance in the first six months of the year, was the result of improvement work delivered via the High Impact Improvement Programme for Emergency Pathways across the Trust, which encompasses emergency flow, models of care, discharge process, and mental health in the Emergency Department (ED).

Emergency Care Standard performance has been deteriorating over a number of years across London and England, and we continued to face challenges over the winter and into the early months of 2020, ending 2019/20 with our performance at 80.9%, down from 84% in April 2019.

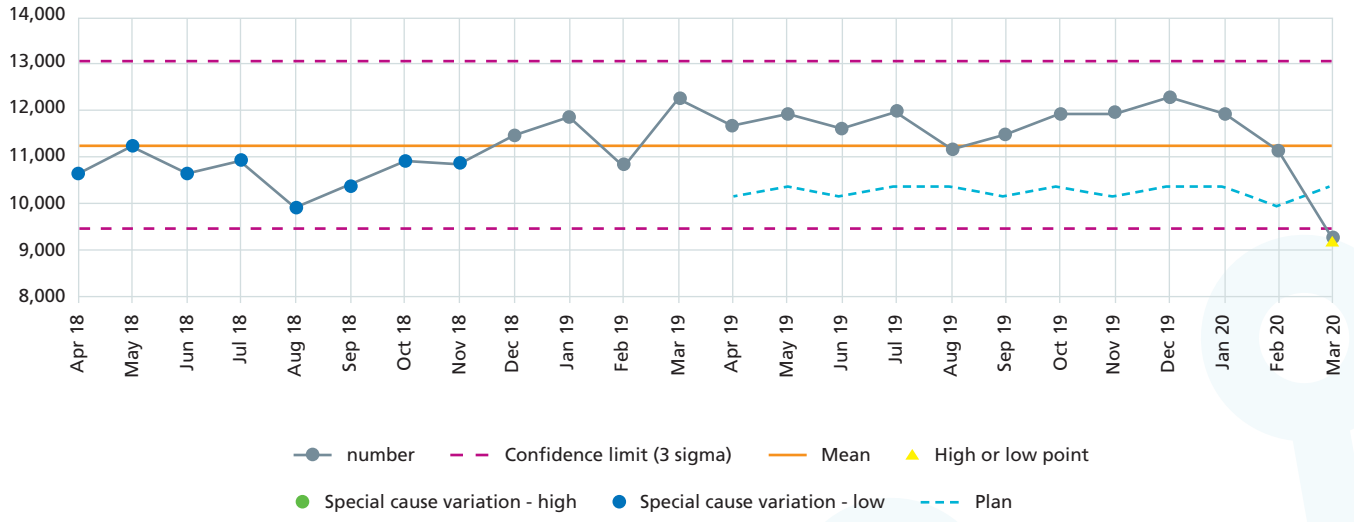
Our full 2019/20 performance is as follows



Continued demand pressure

Overall attendances to emergency and urgent care grew by 8% (compared to a planned reduction of 7%), peaking at above 12,000 in December 2019. In our Emergency Department, where performance was most challenged, growth was 11% - the equivalent of an extra 350 patients every week. March 2020 saw a sharp drop in attendances as a result of the COVID-19 outbreak.

CUH site All Type Attendances

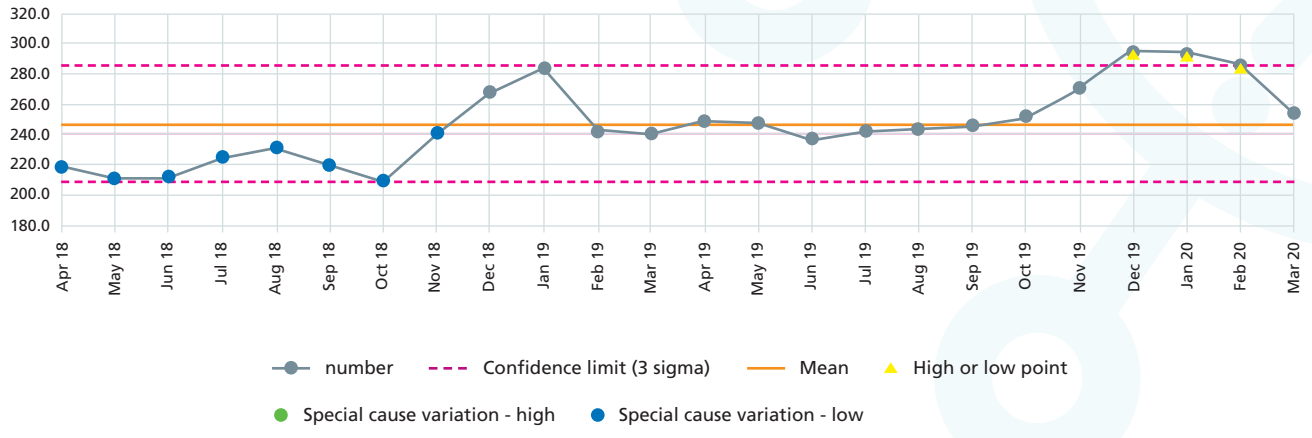


Length of stay in the emergency department

As well as increased attendances, challenged performance in the Trust's Emergency Department was also closely linked to a large number of inpatients across the hospital's wards.

The total time patients spent in the Emergency Department increased in 2019/20, with longer than expected waits over the winter months. The longest waits were experienced by patients requiring additional mental health support, as well as long waits for those who needed to be admitted to a medical ward and were waiting for space to become available.

Total time in A&E (average for all patients)

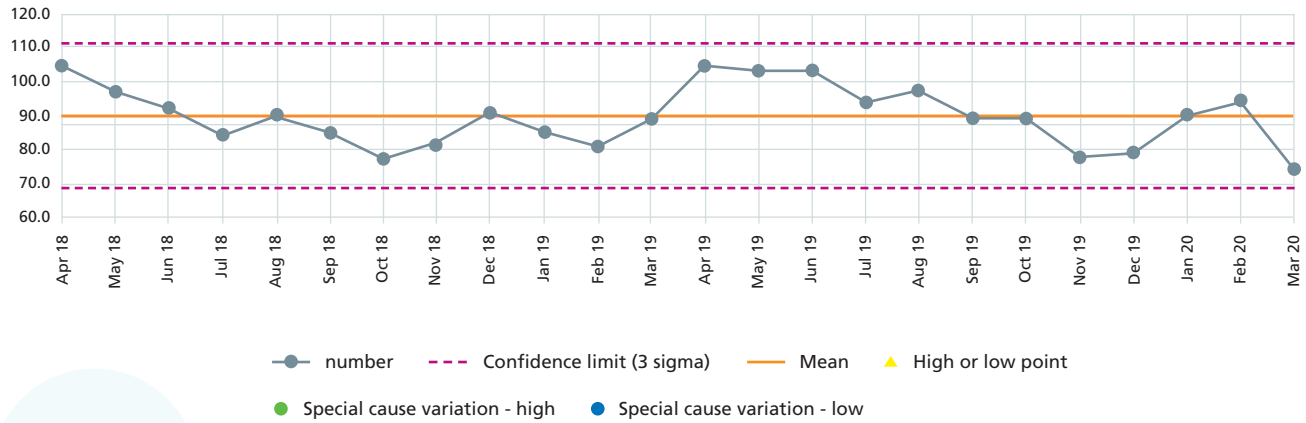


Extended length of stay

Throughout the year we also saw an increased number of patients experiencing extended hospital stays (21 days or longer in hospital), which meant that some patients were in hospital for longer than they needed to be, as well as impacting our ability to admit new patients from the Emergency Department.

We made progress with reducing the number of extended stays over the summer months through the High Impact Improvement Programme. Despite a challenging winter we continued to make rapid improvement at the beginning of 2020, resulting in the lowest number of patients with an extended hospital stay that we have experienced for almost two years.

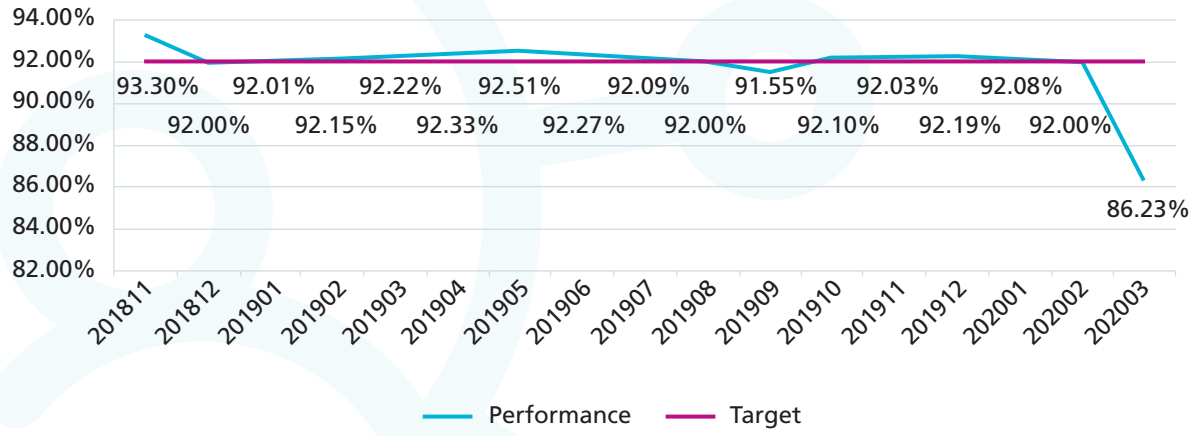
Extended length of stay (6 week average)



Referral to Treatment waiting times performance

We have performed well against the target to treat more than 92% of patients within 18 weeks, meeting or exceeded this target in ten out of the last twelve months. This equates over 19,523 patients receiving treatment in under 18 weeks.

Incomplete Pathways



As part of the performance management of access targets, NHS England introduced a zero tolerance policy on waiting times of more than 52 weeks this year.

In order to avoid any patient waiting this long, we have been working with clinical teams to help them to manage their waiting lists and coordinate and prioritise patient care. We also provide a support role in validating the information we hold on the waiting list as this needs to be kept up to date at all times. We were pleased to successfully end the year with no patients waiting 52 weeks or longer.

We have also focussed on the rest of the waiting list and implemented a number of strategies to better manage waiting times overall. This work has ensured that patients who were waiting over 18 weeks are identified much earlier and were then given priority appointments.

As such, we improved and maintained our performance within the London's NHS throughout 2019/20. At the end of the financial year, we were 8th out of 23 reporting Trusts for waiting list performance in London.

Cancer Waiting Times Performance

We have faced a number of challenges this year in delivering cancer services, which has resulted in variable performance against all of the cancer waiting times standards.

One of the main measures is how quickly we treat people diagnosed with cancer. The national target for this is to ensure that 85% of patients start treatment within 62 days of their first referral and across 2019/20, we reached this for 82.4% of our patients.

We regularly review the reasons that diagnosis and treatment delays occur, and review every patient that is not treated within the 62-day target.

Many of ours delays were due to insufficient diagnostic capacity, which increases the waiting times for scan such as CT and MRI, however we have also seen a year on year increase in referrals in the region of 10% from primary care.

We have a further target to ensure patients who are diagnosed with cancer are referred efficiently for specialist treatment. This is called the 38 day ITT target (Inter Trust Transfer).

Again, due to the waiting times associated with diagnostic services we have not always performed well against this target.

To address these challenges, we developed an enhanced recovery plan with support from our NHS colleagues within the South West London Cancer Alliance which provides the foundation to achieving sustainable performance from 2020. This includes learning from other hospitals and improving the way we co-ordinate healthcare across the sector.

The Trust had a successful year working in partnership with its Royal Marsden Partners to deliver the RAPID Prostate, Optimal Lung and Oesophago-Gastric (known as OG) pathways, and led the pilot for the Faecal Immunochemical Test (known as FIT) for symptomatic patients with suspected cancer. These are all faster ways of investigating suspected cancer and ensuring patients get the right treatment sooner.

To support the delivery of our cancer services we have also recruited additional senior nursing staff and patient care navigators, which has improved the co-ordination and delivery of diagnostic tests, enabling us to prioritise high-risk patients and provide a faster diagnosis for patients referred to us by their GPs.

Diagnostic Performance

For 11 out of the 12 months of 2019/20, we met the target of 99% of diagnostic tests being performed within 6 weeks of referral, despite a number staff vacancies and increased demand due to higher levels of referral.

This standard is essential in ensuring all patients have an early diagnosis, and to support delivery of 18-week treatment times as well as the cancer waiting time standards.

The COVID-19 pandemic resulted in a significantly reduced level of diagnostic activity, so we are actively working with the Royal College of Radiologists and other professional clinical bodies to ensure recovery plans are in place and that we are following their recommendations and national guidelines.

Croydon Quality Improvement (CQI)

Croydon Quality Improvement (CQI) was launched in July 2019 to train staff at every level on "the way we work", empowering them to facilitate and measure excellent care for all.

The programme's popularity is testament to our commitment to continuous improvement. Over 150 staff across Croydon's health and care system have already taken part in CQI training and almost 100 staff-led improvement projects have been registered, including:

- The development of assessment prompt cards for community clinicians working alone
- A multi-disciplinary approach to improving childhood immunisation rates in the borough
- An innovative video project to inform and guide patients through the Emergency Department
- Providing new mothers for whom English is not their first language with additional translated materials to offer support and reassurance.

My Improvement Fund

In addition, this year we launched My Improvement Fund, an initiative to help our staff take forward their ideas to improve the experience of our services for patients as well as for themselves and their colleagues.

Open to all staff - regardless of paygrade or position within the Trust - the Fund helps colleagues to bring their ideas to life. There are three grants available: £100, £500 or £1,000.

So far, successful applicants have included new initiatives to support lone workers, improve waiting room facilities for children and provide warm welcomes for new colleagues, as well as the addition of new artwork in our sexual health clinic to brighten the environment for patients and staff alike.

Responding to the latest Care Quality Commission (CQC) report

Our CQC inspection report, which focused primarily on our acute hospital services was published in February, following their visit in October 2019.

While we received a 'Requires Improvement' rating, the same as our previous rating in 2018, we were pleased to see that the report recognised the kindness and compassion that our staff showed to patients, as well as highlighting a number of other areas where we are doing increasingly well, including:

- Good performance in access to treatment waiting times
- Low mortality rates
- Improving care for patients with mental health needs; and
- Good multidisciplinary work in the services and with external partners, in line with our plans to bring together health and care in Croydon for the benefit of local residents.

There were a number of areas detailed by the CQC where improvements could be made including:

- The length of time some patients waited in our Emergency Department
- Robust auditing of some of our quality standards
- Sharing the learning and addressing issues from patient feedback across the Trust, including the inpatient survey, to improve peoples' experience of our care
- Ensuring all staff had annual appraisals and completed core skills training.

We took immediate action to address many of the issues highlighted by the CQC, including ensuring we implement robust systems and processes within the Emergency Department to improve patient experience, maintain safety and reduce waiting times.

There has also been a sustained recruitment drive both in the UK and overseas to improve staffing levels, which has resulted in more than 100 new nurses and doctors joining us since the inspection.

Alongside this, our leadership team has been strengthened with new roles, including the addition of a Deputy Chief Nursing Officer and Director of Nursing, as well as a Director of Allied Health Professionals and Community Services. This extra support ultimately gives us more capacity, freeing up clinical leaders to give them greater control in the daily running of their local services and more time to support our teams delivering front line care.

Learning and acting on the experiences of our patients

We take every opportunity to hear from people who use our services, their families, carers and visitors, and encourage their participation in shaping the way we provide our services. This includes involving people who use our services in decisions about their own care, seeking feedback about their experiences, having people who use our services on boards and committees making decisions about changes to services, and involving the public in planning future services, fundraising and volunteering. In this way we will make sure our services are delivering the care that people want in the way that works best for them.

As part of our commitment to delivering positive experiences for people who use our services we have developed our People's Experience, Engagement and Involvement Strategy. The strategy will ensure continuous improvement and learning from the feedback we receive.

This three year strategy is closely aligned to and underpins both the Quality Strategy 2019-2021 and the nursing, Midwifery and Care Staff Strategy 2019-2022.

The key principles of the strategy ensure we:

- Listen to people who use our services, their families and carers and visitors
- Put things right if they go wrong
- Use feedback to identify opportunities for quality and continuous improvement
- Work in partnership with people who use our services, their families, carers and visitors, and system partners in developing and co-designing services
- Establish standards of best practice, using mechanisms such as Always Events.

The Friends and Family Test (FFT) is an opportunity for family and friends to give feedback regarding their care and experience with us. In 2019-20 we introduced a text message (SMS) FFT to all of the acute services and this will roll-out to our community services throughout 2020-21. The SMS includes standard questions and a free text section for any comments. We are working with our external provider to analyse this year's free text themes which will enable feedback reports to be produced at both ward and service levels.

In June, the Care Quality Commission's annual inpatient survey was published. While just a snapshot of the care we provide, the survey outlines the experience of 343 patients who had overnight stay at Croydon University Hospital in July 2018.

We were encouraged to see that patients reported high levels of trust and confidence in the doctors and nurses caring for them. Patients also felt that the people involved in their care had a good knowledge of their medical condition and that they received consistent information, even if they were talking to different clinicians.

However, the survey highlighted a number of important areas for improvement, including reducing delays when discharging them home or transferring their care into the community and doing more to involve patients in decisions about their care. The report also highlighted the consistent need for good communication between patients and staff to ensure they were more involved in decisions about their care and future planning.

Since the publication of this survey we have introduced a number of changes to help improve our patients' experience of care going forward, including work to improve discharges home, twice-monthly quality meetings, new electronic quality rounds, daily environmental checks and comfort packs for inpatients.

In addition to the inpatient survey the Care Quality Commission's (CQC) national Maternity Survey was published in January 2020 highlighting the experiences of parents who gave birth in between January-February 2019.

For the first time, women were asked questions about the mental health support given by midwives throughout their maternity journey, with our Trust ranking within the top three Trusts in London for asking mothers about their mental health as part of their postnatal care. We were also placed in the top five in London for providing women with information about potential changes to their mental health after having a baby.

The feedback from new parents also praised other aspects of our maternity care, including:

- 97% of women felt they were treated with the highest levels of dignity and respect during birth
- 96% had confidence and trust in the teams supporting them
- 95% of women felt involved enough in the decisions that were made about their care during birth
- 98% reported that their hospital room or ward was clean and tidy.

However, the survey highlights areas for further improvement:

- Ensuring that any partner / companion is involved (during labour and birth)
- Women feel their concerns are taken seriously during labour and birth
- New parents given a choice about where to have check-ups
- Women feel that midwives are aware of their medical history during postnatal visits.

SUPPORTING OUR STAFF

Our culture

Our vision is to provide excellent care for all and to help people in Croydon live healthier lives. Working closely with staff across the organisation we have a set of values which represent the behaviours we strive to demonstrate, fostering a positive, open and honest culture.

- **Professional:** setting ourselves very high standards and share best practice, work in partnership to best support our community's needs and always use resources wisely without compromising quality or safety
- **Compassionate:** demonstrating kindness, dignity, empathy and compassion and making time for the people we are caring for, to understand their needs and wants
- **Respectful:** striving to always involve people in decisions about their care, listening to and respecting their wishes
- **Safe:** being open and honest in everything we do, sharing what we do well and admitting our mistakes, to constantly improve our care.

Staff engagement

As part of our ongoing commitment to engaging with staff to understand their needs and act on their feedback we communicate with staff regularly through a variety of channels. Over the past 12 months, staff engagement and support has been significantly enhanced and improved.

Examples of this include;

- Attendance at monthly staff briefings both in our community services and at CUH has notably increased, with good attendance across staff groups and professional disciplines
- Publishing weekly blogs from our Chief Executive and other executive colleagues issued to **over 3,800 staff** to help inform them of the priorities and developments in the Trust and create another platform on which to celebrate and share the best practice and achievements of our teams. Across the year, these blogs have been read over **22,800 times,** boosting our readership among staff **by 6%** in 12 months
- Use of a dedicated staff engagement digital media via Ryalto with **over 2,000** members of staff (over half the staff base) signed up. Since its launch in June 2019, **over 770 articles** have been posted on the app
- Increased the Trust's use of social media via Twitter and Facebook to connect with staff and celebrate our achievements, innovations and initiatives at the Trust. Our social media following has grown significantly, with views jumping from 91,000 per month in April 2019 up to 195,000 per month in March 2020. In addition, at the end of March, the Trust's social media accounts were officially verified, highlighting us as a trusted source of news information – a tool particularly vital in sharing important health advice during the COVID-19 pandemic.

CHS Croydon Stars awards

Our annual awards ceremony, Croydon Stars, celebrates the commitment of our staff and volunteers, who work and give up their own time to care for the people of Croydon. This year saw the highest ever number of nominations, with over 300 submitted by CHS staff highlighting the hard work of our colleagues. The ceremony, held at the home of Crystal Palace Football Club, gives us the opportunity to say thank you to our staff that provide outstanding care in the community, clinics, people's homes and our hospitals. Our volunteers are also celebrated for giving up their own time to perform a number of different roles across the Trust.

Former Crystal Palace and England striker Mark Bright alongside Trust Chief Executive Matthew Kershaw presented awards to the winners including:

- Amazing Achievement, Fleur Mosley
- Tremendous Teamwork, The Croydon Community Learning Disabilities team
- Landmark Leadership, Caroline Walker
- The Volunteer of the Year award was presented to the volunteer-led exercise group for stroke patients.

This year the Croydon Health Services Star of the Year was awarded to Midwife Rachel Martin. Rachel was nominated by a Croydon couple, whose daughter was born at 18 weeks after being diagnosed with Alpha Thalassemia Major, a genetic condition which often results in unborn babies dying before delivery or shortly after birth. The couple wanted to recognise Rachel after the support, compassion and care she gave them during a difficult time.

Thirst responders

As part of the action we are taking in response to last year's staff survey results we launched a new initiative in September 2019 to support our teams called 'Thirst Responders,' we wanted to help our teams who said they were often too busy to take their breaks.

Suggested by our Chief Nurse, Elaine Clancy, our Trust Thirst Responders involves members of our senior team visiting wards and departments both in the hospital and the community to serve our teams teas, coffees and refreshments. This is just a small measure of our appreciation but an opportunity to say thank you to our many hardworking staff across the Trust.

To increase this further, we have also introduced new 'Thank You' cards for our staff. Issued in recognition of staff living our Trust values of Professional, Compassionate, Respectful and Safe, these cards have proved very popular with more than 1,000 distributed so far. There are too many people to namecheck here, but a few recent examples include colleagues from our podiatry team, midwifery, learning and disability, homeless health, critical care outreach - even the painters who have been making improvements to some of our wards.

Staff survey

This year more than 1,800 members of staff completed the NHS staff survey, double the number of respondents from the previous year.

The results were published in February 2020 and showed that Croydon Health Services has made some substantial improvements with staff reporting they are feeling less stressed, more valued and more supported in their jobs to give the quality of care they aspire to.

Almost three out of five employees would now recommend Croydon Health Services as a place to work - a big improvement from the previous year.

Key positive finding include:

- Our staff feel valued: 72% felt valued by their managers - up 5% from last year and just 1% below the 73% national average
- Our staff look forward to coming to work: 62% of staff in the survey said they look forward to coming to work - 3% above the national average
- We are supporting staff to deliver the best care: Our staff that said objectives were made clear during appraisals jumped 12% compared to 2018 - 5% above the national average
- Reducing work-related stress: There was a three per cent decrease in the number of staff that felt unwell due to work-related stress - better than the national average.

The results also highlighted some areas where further progress is needed, giving the Trust clear direction for further improvements.

Key areas for improvement include:

- Over 13 per cent of our staff reported that they had experienced physical violence from a patient or member of the public
- We need to act on the experiences of our staff to ensure that we are meeting the highest standards of equality for all.

We are performing notably better than other similar organisations across a wide range of questions about training and appraisals. 86% of our staff reported that they had an appraisal in the last 12 months with 40% agreeing that they had clear work objectives set and agreed.

Diversity, equality and inclusion

Our commitment to diversity, equality and inclusion starts with our senior leaders. We have one of the most diverse Boards in the NHS. Our ambition is to ensure that our entire workforce is representative at every level of the Trust and is reflective of the people we serve.

More than 50 per cent of our staff come from a BAME background, and the majority of our staff live and work in Croydon.

Our Trust should be open to everyone based on their skills, abilities and aspirations to progress in their careers, but we know from the NHS staff survey and by listening to experiences of our colleagues, that some have experienced inequalities in their day-to-day roles.

Getting equality in our workplace is essential, so we are working towards improving our outcomes for the Workforce Race & Disability Equality Standard and to ensure we value the contribution that every one of us makes, regardless of race, beliefs, background or disability.

This important work is led by the very top of the organisation, including the Trust Chairman, Chief Executive and Medical Director, alongside colleagues from Human Resources and Workforce Development.

This year saw the launch of four new support networks for our staff:
- BAME Forum
- LGBT+ Forum
- Disability Forum
- Religious Beliefs Forum

To address this, we have invested in the EDI Team, introducing two more members of the team to drive forward the agenda in the Trust through our new EDI Strategy and Action Plan for 2020-2023 which will shortly be published.

We have also introduced initiatives such as the Recruitment Inclusion Specialists and launched a new BAME Reverse Mentorship Scheme, where staff can have the opportunity 'mentor' senior leaders to broaden and deepen their understanding of the lived experience of others, and of how obstacles can be overcome to support career progression at CHS.

Since April 2019, all NHS trusts are now mandated by the Workforce Disability Equality Standard (WDES) set of ten specific measures (metrics). This enables us to compare the workplace experiences of disabled and non-disabled staff. We used the metrics data to develop an action plan and to demonstrate progress against the indicators of disability equality.

Key to this is ensuring that staff feel supported to declare their disability or long term conditions, so that we can ensure their voices are heard and that everyone has the opportunity to be involved with improving the experience of disabled staff. In order to improve our diversity data collection and monitoring we will be implementing a Disability Staff Declaration campaign in 2020-2021.

The strategy also looks at other elements including training for colleagues and managers, as well as improving the reasonable adjustments we provide, so that we are able to provide an equal, open and inclusive environment for all.

Freedom to Speak Up Guardians

Freedom to Speak Up Guardians play a vital role in ensuring that any member of staff is able to raise concerns, with the support of the Trust and with access to independent resources and expertise.

Successful FTSU programmes are championed at every level in an organisation, and in February 2020, we bolstered that support from our Chairman Michael Bell, who was appointed the Non-Executive Director ambassador for the Guardians, alongside Executive lead and Chief Nurse, Elaine Clancy.

Led by the Trust's Reverend Andy Dovey, we also increased the number of Freedom to Speak Up Guardians available for our staff to contact and appointed two additional champions across the Trust, who will be responsible for promoting not only the benefits of speaking up, but providing reassurance and signposting for those who need it. Working with other acute hospitals in south west London, we have also expanded the number of resources and expertise available to our staff.

As we look ahead to 2020/21, the programme is set to expand even further. We are actively recruiting even more guardians, with the aim of ensuring a diverse mix of roles, genders, and ethnicities to ensure they can provide the best possible support to all.

Chaplaincy and spiritual care

Our chaplaincy and spiritual care team is another essential support function for staff, patients and relatives alike. Led by a small team of chaplains and bolstered by over 100 multi-faith volunteers, they completed over 8,000 ward visits in 2019/20, providing 24/7 religious and spiritual support to those who requested it.

As well as delivering their work on our wards, the team also held a number of important services in the St Barnabas Worship Centre, including a renewal of promises and long service award ceremony for volunteers, as well as a major Butterfly service, attended by families who had lived through the loss of a baby.

EU Exit

On 31 January we the UK left the European Union (EU) and moved into an 11 month "transition period" in which the country's future arrangements with the EU will be determined. The UK will then exit the transition period which ends on 31 December 2020.

We worked closely with our staff from EU countries to make sure they were kept informed of latest developments and to reiterate how valued they are as members of Croydon's NHS family.

In readiness for the UK's exit from the EU, we tested our supply chains and prepared our resilience plans, including a communications and engagement plan to reassure and inform our patients and staff.

As we continue through the transition period, our focus will to be on ensuring we are prepared for every eventuality so that our services can run as normal.

SUSTAINABLE FINANCES

Aligning Croydon's NHS: Joint Financial Performance ('Control Total')

As part of the Trust and CCG's alignment, we agreed a single budget and financial plan including a combined target for 2019/20 in order to fund service improvements and help to return the local health economy back into financial balance.

This was not only a first for Croydon but a first for London, helping us to make the most of the Croydon pound and make the resources we have go further for the people we care for in our borough.

As part of the delivering the overall joint control total, the Trust achieved its financial control total of £13.2m deficit before central funds and a small surplus of £0.4m after accounting for central funds. We also achieved compliance with other financial targets. More information on these can be found in the annual accounts later in this report.

We all want to see a sustainable Croydon Health Services that can meet the health needs of our growing community.

To do this, we have to work smarter within the existing resources we have, so we are seeking to make continual improvement in the use of financial resources in each year as an essential feature of our sustainability plans. In 2019/20, Cost Improvements of over £11m were delivered, helping us to deliver services the population of Croydon within available financial resources.

Looking ahead, both the Trust and CCG are planning together to deliver a joint control total to breakeven in 2020/21.

South West London Procurement Partnership

As part of our joint work across the four acute hospitals in south west London, we have come together to form the South West London Procurement Partnership, a more efficient use of our services to provide the right quality of goods and services at the right time, in the right quantity, at the right place and at the right price.

The partnership among the four procurement teams in the region will allow us to provide expert category and contract management, centralised data and systems - including Scan4Safety, and one harmonised supply chain and logistics function across five sites.

Two Directors of Procurement (Commercial and Operations) were appointed in March 2020 to lead the delivery of our plans to standardise and rationalise products and services procured, reduce overall contracts by 10% and ultimately to support and enable the delivery of excellent patient care across south west London.

Refreshing our estates strategy

The Trust's estates strategy been developed in conjunction with our clinical teams, our executive team and our stakeholders, who came together to agree a plan for how we will enhance, manage and maintain the Trust's estate for the next five years (2019-2024). This strategy takes stock of where we are now and where we want to be, setting the priorities for refurbishment and development to help our services meet increasing demand as population continues to grow.

The Trust currently occupies 9.38 hectares of land and 100,000m^2 of space across 73 buildings with an annual spend of £5.4m to maintain our services in the borough. Over the last two years' considerable work has been carried out to improve and maintain our services to deliver the highest standards of care for people in Croydon, both in hospital and in the community.

In May 2019, we officially opened the borough's brand new Emergency Department at Croydon University Hospital with the help of Secretary of State for Health and Social Care, Matt Hancock MP. This modern facility is 30% bigger than the previous Department, and at a cost of more than £21m now offers many benefits to our community, including a dementia-friendly design and treatment rooms with doors, rather than curtained cubicles, to improve privacy for patients. A plaque was unveiled at the official launch of the Department, honouring the lives of two beloved nursing colleagues who are sadly no longer with us - Hassina Fowle and Audrey Cross.

In addition to this, more than £6m has been spent refurbishing the Trust's:

- Dental unit
- Cardiology services, now known as the "Croydon Heart Centre"
- Obstetric theatres
- CT scanner
- Child Development Centre at the Tollgate School
- Endoscopy decontamination.

As part of our continued efforts to improve our estate and services the strategy also sets out plans for our refurbished critical care units, which will be expanded to allow us to deliver critical care to more patients, closer to home, while providing a more comfortable environment for all.

Alongside this, work has now begun on our highly anticipated new Paediatric Integrated Unit (PIU), which is due to open in 2021. Specifically designed to meet the needs of children and their families, the unit will allow us to consolidate our children's services, bringing together our children's inpatient, day surgery and short stay wards into one dedicated space

and making caring for Croydon's children as seamless as possible.

Reducing our energy consumption

Earlier this year we were successful in securing almost £860,000 funding from NHS England and Improvement, to install eco-friendly LED lighting across the Croydon University Hospital site.

This change, which not only improves the environment for our patients and for our staff, will also reduce our overall carbon emissions and generate a saving of 2,440,000 kWh of energy each year - the equivalent of 800 homes' electricity. This change is also estimated to account for £205,000 in cost savings per year.

We've also reduced our overall electricity usage by 9% in the last three years, despite an increasing demand for our services.

Waste management and the NHS Plastic Pledge

We are committed to reducing waste and in particular waste sent to landfill. For the past two years, we have successfully achieved zero waste to landfill and 31% of all waste produced was recycled. We have also completed a full review of our waste management with the aim of increasing recycling rates. This year we expanded our collaboration across south west London, working together to procure services and products to support our sustainability plans, including our waste facilities.

In addition to this, we have signed up to the NHS Plastic Pledge, a nationwide commitment to cut the amount of single-use plastics in hospitals, as part of a package of measures in the NHS Long Term Plan to lessen the environmental impact of the health service.

Supporting sustainable travel

The NHS accounts for almost 10 billion road journeys across the country each year, around 3.5% of all road travel. Alongside our colleagues at Croydon Council and the wider NHS, we are committed to improving the health of our staff and our community by reducing pollution, improving local air quality and promoting active travel wherever possible.

This year, we launched our Travel Plan, which outlines how staff can commute safely and sustainably, with support from our Cycle to Work scheme.

We also recognise the impact that patient transport has on the environment and have clear guidelines on the use of patient transport. Through engaging with our staff on our wards and those responsible for discharge planning, we have been able to reduce unnecessary trips, with emissions from patient transport reducing by 51% in the last five years.

Implementing digital transformation

In 2019/20, we continued to build upon the work of the south west London 'Connecting your Care' programme, which joined up together acute, community and primary care technology to enable sharing of patient information among healthcare professionals, supporting improved care for patients across the region. Phase 2 of the project, which will launch in 2020/21, will see the addition of some social care and mental health providers, again expanding the knowledge of those providing care to enabling them to make more informed decisions about treatment.

This year our IT team was also awarded a grant of over £240,000 to complete research in order to help improve the cyber security of medical equipment. This research project will enable us to test and strengthen our defences to keep our data and clinical information safe in the digital age.

Alongside this, we have implemented a number of upgrades to our IT infrastructure and equipment, including the roll out of the Health and Social Care Network (HSCN), our improved WiFi services across both our hospital and community sites and a refresh of hardware including workstations on wheels and medication trolleys, making it easier for clinical staff to access and update information directly at the point of care.

Looking ahead, we have made investments not only in our IT services, but also our in-house experts. Working with the Director of IT, a new team is being structured to continue to provide operations support while creating a dedicated digital transformation team, ensuring we have the skills we need to drive our IT strategy forward into 2020/21.

Emergency Preparedness

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act 2004 and the NHS Emergency Planning Guidance 2005.

As part of our Emergency Planning, Resilience and Response activity, we ran a Trust-wide flu pandemic exercise in February 2020, bringing together clinical, operation and corporate teams to test our action plans and ensure the robustness of our responses.

These plans were tested in real time in March 2020 and we stood up the Trust's Gold Command team as we began to treat patients with COVID-19. Supported by a 24/7 incident response team, we have continued to provide essential services to our population while facing the pandemic.

IMPROVING HEALTH FOR ALL

Growing our 'One Croydon' alliance to benefit more people

In October 2019 a partnership between the local NHS, Croydon Council and Age UK Croydon named One Croydon launched a new five-year plan to support residents to stay well for longer by making services more accessible in the heart of their communities.

The Croydon Health and Care Plan outlines a fresh vision for how health and social care will be delivered across the borough, particularly for those with the greatest need, to transform the health and wellbeing of local people.

The plan emphasises three clear priorities:

- Focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early
- Unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer
- Develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community.

The Health and Care plan builds on a number of successful schemes already in place in Croydon, including social prescribing, which makes it easier for GPs and nurses to connect people with a range of non-clinical services to help improve the emotional, mental and general wellbeing of people suffering from conditions such as depression and anxiety.

The positive impact of One Croydon is continuing to expand and this year we looked at other ways to support our communities, starting with a pilot of the borough's first Integrated Community Network+ (ICN+), which launched in Thornton Health in March.

The pilot builds on the fantastic work already happening in communities, bringing it together with the help of local facilitators to align local community support and services with the needs of its population.

Supported by an Integrated Manager and a Network Facilitator, multi-disciplinary teams of health and care professionals meet weekly, as well as having a shared space with IT facilities and hot desks so that the team can work collaboratively across disciplines and organisational boundaries, to deliver improved healthcare for all.

We know, even in Croydon, that the needs are different from one side of the borough to the other, which is why we're also working smarter, not harder, with the data we have available to us, so that we can make sure our work has a positive impact on the health and wellbeing of every resident.

To ensure that the network we're building is fit for purpose, this work is being delivered in tandem with local residents and tested with a community reference group to understand residents' views. And in Thornton Heath's ICN+, there's a number of schemes helping to tackle some of the key issues.

To support those living in low income families and a number of people struggling with social isolation, we are working alongside local groups and Croydon Council as part of the community network to host a 'Talking Point' every Monday morning in Parchmore Community Centre. Members of the public are able to drop in without an appointment to talk to about healthy living support, housing and benefits advice and connections into community activities.

They can also to access the Food Stop - an incredible food sharing club open to local residents that allows them to access a selection of fresh fruit, vegetables and meat at a heavily discounted cost, helping low-income families to reduce their debts while continuing to make healthy meal choices.

Aligning Croydon's NHS

This year saw us become the first borough in the country to bring together the leadership of both the Trust and our local CCG in order to improve the health of local people - by providing better quality, more joined-up care and reducing duplication to work more efficiently.

As part of the alignment a number of senior appointments were made throughout the year to create a single executive leadership team between the Trust and CCG including:

- Matthew Kershaw, Trust CEO and Place Based Leader for Health
- Elaine Clancy, Joint Chief Nurse
- Mike Sexton, Joint Chief Financial Officer
- Josh Potter, Director of Strategy and Transformation
- Dr Neil Goulbourne, Director of Integration

We want to bring together more common functions - removing duplication and freeing-up resources for the frontline and to support clinical staff including:

- Shared forums for certain key functions including finance and quality
- Shared functions and/or roles that are employed jointly by both organisations, as well as joint executive posts
- Shared strategic priorities and a single delivery plan
- A single budget and financial plan including a combined financial target for 2019/20.

For patients, this approach ensures high quality joined-up care, wherever they seek treatment. For staff, it delivers greater opportunities to develop their careers, while increased alignment between the two organisations also reinforces the financial future for health care in Croydon.

Moving Forward Together

In October last year, we received confirmation from NHS England that the application for the six South West London CCGs (Croydon, Merton, Kingston, Richmond, Sutton and Wandsworth) to merge was approved. Since then, the six organisations having been moving forward plans to create a single entity from 1 April 2020.

A key milestone in the preparation to become a single CCG was the appointment to the new Governing Body of the following posts, whose role will be to ensure that the new SWL CCG has arrangements in place to exercise its functions effectively, efficiently and economically:

- Dr Andrew Murray, Clinical Chair
- Dr Naz Jivani, Clinical Vice Chair (Kingston)
- Dr Nicola Jones, Clinical Vice Chair (Wandsworth)
- Dr Jeff Croucher, GP Borough Lead / Borough Committee Chair (Sutton)
- Dr Agnelo Fernandez, GP Borough Lead / Borough Committee Chair (Croydon)
- Dr Patrick Gibson GP Borough Lead / Borough Committee (Richmond)
- Dr Vasa Gnanapragasam GP Borough Lead / Borough Committee (Merton)
- Paul Gallagher, Audit Chair Lay Member
- David Smith, Finance Chair Lay Member
- Susan Gibbin, Patient and Public Involvement Lay Member
- Les Ross, Secondary Care Doctor
- Pippa Barber, Registered Nurse.

Meanwhile we continue with other programmes of work to prepare for a single CCG including setting up a new staff intranet, new HR and payroll systems and doing the ground work to launch a new South West London CCG website. We believe that coming together offers benefits for our staff – with more career progression across a larger organisation, and with more opportunities for training and development. Working in a more integrated way will also deliver better outcomes and experiences for our patients.

Developing an Integrated Care System

Building on the preparations to merge the six south west London CCGs, the ultimate ambition has always been to create one Integrated Care System (ICS) for south west London, building on three years of partnership working and delivery care across the six boroughs.

An ICS allows us to build on the strong collaborative foundations we have already developed in Croydon by bringing closer together the NHS, local councils and the voluntary sector to ensure we are able to deliver the best possible support for the people of Croydon to stay well and the best possible care for them when they need our care.

This was implemented on 1st April 2020 and now allows us to move into 2020/21 as a strengthened partnership, furthering our collaborative working, and giving greater access support, funding and expertise across the system to deliver our ambitious plans for the health and wellbeing of our local residents.

STATEMENT FROM DIRECTORS

The Trust's directors consider that this annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for readers to assess our performance, business model and strategy.

Signed by the Chief Executive and Place Based Leader for Health for Croydon on behalf of the Trust Board of Croydon Health Services NHS Trust.

Matthew Kershaw

Chief Executive and Place Based Leader for Health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ACCOUNTABILITY REPORT

ACCOUNTABILITY REPORT

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

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

Directors' report and role of the Trust Board

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

Leadership

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

Non-Executive Directors

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

Leadership effectiveness and appraisal

The Board met in public throughout the year with meetings held in April 2019, July 2019, October 2019 and January 2020. Attendance was monitored at all meetings and there were six authorised absences from Non-Executive Directors and two authorised absences from Executive Directors.

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

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

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

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

The Board's Register of Interests was maintained throughout 2019/20 and is included as a standing agenda item at each Trust Board meeting. The Chairs of each of the Board committees present written reports to the Board supplemented by verbal updates.

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

Profiles of our Board

Mike Bell

Chairman

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

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

Mike has held a number of senior positions across the NHS, including Chair of the London Mental Health & Employment Partnership and Vice Chair of NHS London.

He is the director of a consultancy company, MBARC Ltd, which works with central and local government and various NHS bodies on issues relating to both social exclusion and quality assurance.

Matthew Kershaw

Chief Executive and Place Based Leader for Health

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

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

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

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

Dr Nnenna Osuji

Deputy Chief Executive and Medical Director

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

Nnenna oversees the Trust's medical workforce providing professional leadership, support and accountability. Together with the Director of Nursing and Allied Health Professionals, Nnenna leads on delivery of continuous quality and safety improvements at CHS. Nnenna also leads on promoting Research and Development and is the Caldicott Guardian for the Trust, providing senior advice and direction on the ethical and correct use of information.

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

Elaine Clancy

Joint Chief Nurse and Executive Director of Midwifery and Allied Health Professionals

Croydon Health Services NHS Trust and NHS Croydon Clinical Commissioning Group (CCG) appointed Elaine as Joint Chief Nurse in April 2019. Working across both organisations, this was the first shared executive post between the Trust and CCG.

Elaine Clancy is a trained A&E nurse by background and has 30 years of experience within the NHS this year. She has held senior nursing and managerial roles at various London teaching hospitals, including previously being the Deputy Chief Operating Officer at Croydon Health Services.

The Director of Nursing, Midwifery and Allied Health Professionals was previously held by Michael Fanning who left the Trust in April 2019, after leading our nursing workface in Croydon for more than five years.

Lee McPhail

Chief Operating Officer

Lee McPhail was appointed as our Chief Operating Officer in September 2019, and is the latest senior leadership position to bring our Trust and NHS Croydon Clinical Commissioning Group (CCG) closer together to maximise the resources available for the frontline.

Lee has more than 20 years' experience within the NHS, including leading operational roles at Lewisham and Greenwich NHS Trust, Bart's Health NHS Trust and prior to this, North Middlesex University Hospitals NHS Trust.

Lee first joined us in October 2018 as the Programme Director for Integration. He became the Trust's Interim Chief Operating Officer in November 2018.

Mike Sexton

Chief Financial Officer

Mike Sexton was appointed in November 2019 as the Joint Chief Financial Officer, across both Croydon Health Services NHS Trust and NHS Croydon Clinical Commissioning Group (CCG). Prior to this appointment, Mike had been Chief Finance Officer at Croydon CCG since April 2013.

Mike's leadership was instrumental in the 7-year financial recovery of the CCG, with all special measures withdrawn in 2019. Mike will continue his commitment to Croydon in working across both organisations, helping to ensure best value as we continue closer working to improve the health and care of one London's largest boroughs.

With professional accounting qualifications awarded in both New Zealand and the United Kingdom, Mike brings a wealth of experience having held NHS board-level finance roles in both commissioner and provider organisations in south west London.

Azara Mukhtar

Director of Finance (until January 2020)

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

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

Michael Burden

Director of Human Resources and Organisational Development

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

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

Josh Potter

Joint Director of Strategy and Transformation

Josh was appointed Joint Director of Strategy and Transformation across both Croydon Health Services NHS Trust and NHS Croydon CCG in November 2019.

Appointed to lead the closer integration of health and care in Croydon, Josh was previously the Director of Commissioning for NHS Merton and Wandsworth CCGs and prior to that, acted as the Director of Integrated Commissioning at Tower Hamlets CCG, responsible for delivering models of care for NHS England as forerunners for delivering more coordinated local health and care services.

Dr Neil Goulbourne

Director of Planning, Integration and Performance

Dr Neil Goulbourne joined Croydon Health Services in January 2020 as the Trust's Director of Planning, Integration and Performance.

His role will support us in our plans to help local people get more seamless care and make it easier for staff to work together with GPs, mental health services and social care to look after the community's health and wellbeing.

Neil was previously the Deputy Director of Improvement at Guy's and St Thomas' NHS Foundation Trust where he was the lead for quality improvement and service transformation. A trained doctor by background, Neil spent five years as a medical trainee at King's College Hospital before caring for people as a GP in London and the West Midlands. In 2012, Neil was the head of service development at Virgin Care Plc. After three years in this role, Neil went to NHS England to support the national programmes and implementation of the NHS Five Year Forward View.

Dr James Gillgrass

Non- Executive Director

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

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

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

Godfrey Allen

Non-Executive Director

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

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

Richard Oirschot

Non-Executive Director

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

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

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

Louise Cretton

Non-Executive Director

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

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

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

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

Mike Bailey

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

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

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

Steven Corbishley

Non-Executive Director

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

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

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

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

Hannah Miller

Non-Executive Director

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

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

She was awarded an OBE for services to the welfare of children in 2009. She is a Senior Associate at the Social Care Institute for Excellence and a NED at L&Q Living, a care and support housing association. Hannah is a member of the Trust's Finance & Performance Committee, which played a significant part in the Trust's exit from Financial Special Measures. She also forms part of the Trust's Remuneration Committee which is responsible for determining the policy of executive pay.

Adam Womersley

NExT Non-Executive Director, CHS

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

In June 2018, Adam joined CHS on a 12-month placement as a NExT Director, leaving the Trust in summer 2019. The scheme is designed to give individuals the senior skills and expertise necessary to make a contribution in the NHS as a Non-Executive Director.

Jamal Butt

Associate Non-Executive Director

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

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

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

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

Attendance at Board meetings

The Trust Board met in public on four occasions as agreed. The level of attendance by Trust Board members is included in the Annual Governance Statement, which can be found within this section of the report.

Committee structure

As part of the continuing integration work with Croydon Clinical Commissioning Group (CCG) the membership of the Quality Committee was strengthened to ensure it adequately included CCG colleagues as part of integrated approach to Quality based on Croydon as a Borough.

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

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

- Public money is safeguarded and properly accounted for, in accordance with NHS guidelines
- The risks to achieving our Trust Objectives are managed effectively
- Our Annual Report and Accounts, including our Quality report and those of our Charitable Funds, are prepared in accordance with appropriate professional standards and scrutinised before being presented to the Trust Board
- Effective internal audit arrangements are in place that meet NHS Internal Audit Standards
- Effective external audit arrangements are in place that meet appropriate professional standards; and
- Recommendations made by our auditors and other contributors are taken forward by management as appropriate.

In achieving these aims, inter alia, the Committee considers the Board Assurance Framework, the Corporate Risk Register and the Assurance Map at every meeting and maintains oversight of the Trust's Counter Fraud arrangements. It also undertook a number of deep dives on specific areas during the year, including recruitment and retention and safeguarding.

Finance, Investment and Transformation (FIT) Committee: oversees the Trust Board in its efforts to maximise its healthcare provision subject to financial constraints. The committee considers patient safety to be of paramount importance and seeks to support the development of plans that will transform the way in which the Trust delivers services which will achieve long term sustainability.

The Committee's role is to provide challenge, critical review and assurance of the Trust's performance delivery and the quality of the services that it provides. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure:

- There is detailed consideration of the Trust's sustainability in respect of financial, investment and performance issues
- There is adequate information available on key issues to enable clear decisions to be made in compliance with regulatory requirements e.g. NHS Improvement and the Care Quality Commission
- The achievement of the Trust's strategic aims and objectives
- The signing off of business cases
- Appropriate oversight of the Capital Budget
- Oversight of strategies and plans to transform and deliver services.

Following the decision to have a Joint Control System between the Trust and the CCG, the finance teams from both organisations worked together to provide robust data and assurance in an aligned way to support this joint aim. To provide the appropriate level of scrutiny, during the financial year, the FIT meetings were held at the same time and with the same agenda as the finance meeting of the CCG. This enabled a more rounded approach to discussions that sought assurance around the system as a whole and which recognised the risks of actions on other parties. By working in this integrated way both parties were able to achieve the Joint Control Total.

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

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

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

- The delivery and reporting of the Trust's Quality Account and the Quality priorities
- An effective review and scrutiny on all aspects of quality to ensure any aspects of concern are satisfactorily addressed
- Relevant independent reports and enquiries are responded to

- Monitoring of progress and completion of action plans as a result of Care Quality Commission Inspections and other external body assessments or accreditations

- Provide the forum where clinical matters between the Trust and the CCG can be addressed. This will include reviewing escalated events and exceptions to performance.

The Remuneration Committee: is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for the termination of contracts and for approving any variations to pay. The Committee ensures that:

- Appropriate performance management arrangements are in place for Executive Directors and works with the Chief Executive to relate performance judgements where necessary to pay.

The Charitable Funds Committee: is responsible for overseeing the management, investment and disbursement of the CHS Charitable Funds (Registered Charity No. 1054824). The Committee must ensure:

- Compliance with statutory or other legal requirements or best practice required by the Charity Commission. This is a delegated duty carried out on behalf of CHS (the Trust), which is the sole corporate trustee of the charity.

People and Place Committee: is responsible for overseeing all matters relating to people, be it staff or the people of Croydon, as well as having oversight for all matters relating to Croydon as a place including but not limited to sustainability, health inequalities and areas specific to Croydon's demographics.

The committee is responsible for ensuring that there are appropriate systems in place to:

- Deliver the workforce strategy and develop an integrated workforce

- Improve the health and well-being of our staff and the wider population in Croydon

- Ensure that the Trust acts as a socially responsible corporation.

Membership of committees

Audit Committee

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

Finance, Investment & Transformation Committee

- Louise Cretton (Chair)
- Matthew Kershaw
- Richard Oirschot
- Hannah Miller until December 2019
- Jamal Butt
- Azara Mukhtar until 29 November 2019
- Mike Sexton from 1 November 2019
- Michael Burden
- Dr Nnenna Osuji
- Michael Fanning until 30 April 2019
- Elaine Clancy from 1 May 2019
- Josh Potter from 18 November 2019

Quality Committee

- Godfrey Allen (Chair)
- Mike Bailey
- James Gillgrass
- Hannah Miller
- Dr Nnenna Osuji
- Michael Fanning until 30 April 2019
- Michael Burden
- Elaine Clancy Initially as a representative for Croydon CCG but from 1 May 2019 as the Joint Chief Nurse.
- Dr Tom Chan (Croydon CCG) until March 2019
- Emily Symington from April 2019
- Matthew Kershaw

Remuneration Committee

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

Charitable Funds Committee

- Mike Bailey (Chair)
- Azara Mukhtar until 29 November 2019
- Mike Sexton from 1 November 2019

People and Place Committee

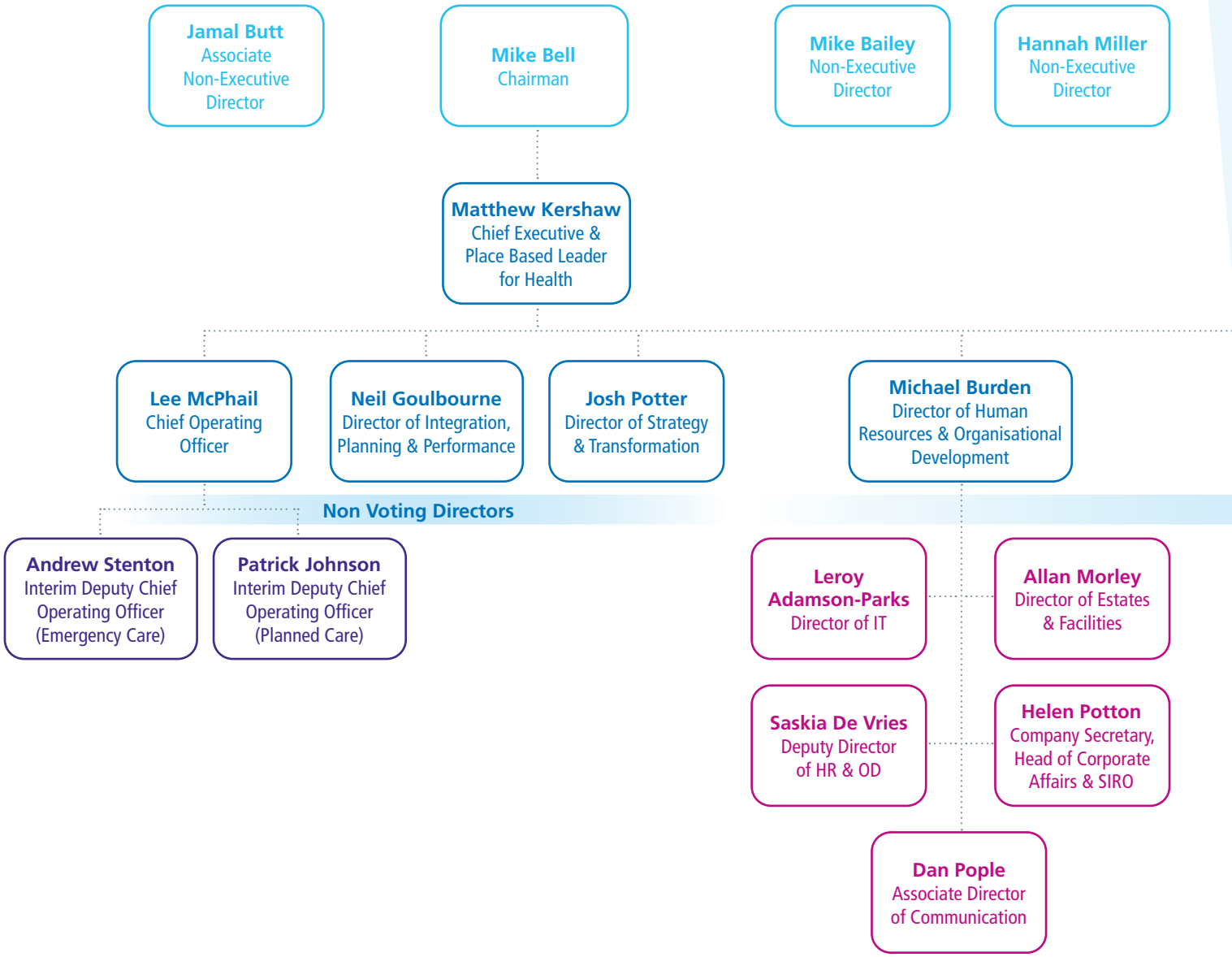
- Louise Cretton (Chair)
- Hannah Miller
- Mike Bailey
- Michael Burden
- Josh Potter from 18 November 2019

Declaration of Interests (as at 31 March 2020)

Name	Role Type	Declaration Status YES/NO	Declaration Details
Godfrey Allen	Non-Executive Director	No	None
Dr. Michael Bailey	Non-Executive Director	No	None
Mike Bell	Chairman	Yes	MBARC Ltd holds a contract with NHS England which commissions services from CHS NHS Trust Strasys - Senior Associate Consultant ZPB Consulting Ltd - Senior Adviser University Hospitals Bristol Foundation Trust - Independent Chair of the Unity Sexual Health Partnership
Michael Burden	Director of Human Resources & Organisational Development	No	None
Jamal Butt	Associate Non-Executive Director	Yes	Med Advisor UK - Commercial Director Psyomics Ltd - Board Advisory Role Strasys Ltd - Board Advisor
Elaine Clancy	Chief Nurse	Yes	Langley Park School for Girls - Parent Governor NHS Croydon Clinical Commissioning Group - in a joint post
Steven Corbishley	Non-Executive Director	Yes	National Audit Office - Principle employment Various small shareholdings in former public utilities as part of privatisation programmes
Louise Cretton	Non-Executive Director	No	None
Michael Fanning	Director of Nursing, Midwifery and Allied Health Professionals	Yes	Senior Clinical Fellow, Faculty of Health, Social Care and Education, Kingston University
Dr James Gillgrass	Non-Executive Director	Yes	Trustee Croydon Post-Graduate Medical Centre Member Whitgift Foundation Care Committee
Neil Goulbourne	Director of Integration, Planning and Performance	No	None

Name	Role Type	Declaration Status YES/NO	Declaration Details
Matthew Kershaw	Trust Chief Executive and Place Based Leader for Health	No	Visiting Senior Fellow, Kings Fund Place Based Leader for Health across Croydon NHS CCG
Lee McPhail	Chief Operating Officer	No	None
Hannah Miller	Non-Executive Director	Yes	Director - Hannah Miller Ltd Non-Executive Director - L&Q Living Non-Executive Director - Hesley Group Ltd Independent Chair - Adult and Children Safeguarding Boards, London Borough of Hounslow Social Care Institute for Excellence - Periodic consultancy projects Hill Dickinson - Associate through her own company with their Health and Social Care consultancy arm Kisimul - Non-Executive Director of organisation running services for children and adults with autism. This is an extension to NED role with Hesley Group as the two organisations are in process of merging
Azara Mukhtar	Director of Finance	No	None
Richard Oirschot	Non-Executive Director	Yes	Director of R Oirschot Ltd Non-Executive Board member of the Insolvency Service MHS Homes Group - Independent member of the Finance Risk and Audit Committee Puma Alpha VCT plc - Non Executive Director
Dr Nnenna Osuji	Medical Director	Yes	Shirley Oaks Hospital - Haematology
Josh Potter	Director of Strategy and Transformation	Yes	NHS Croydon Clinical Commissiong Group - in a joint post
Mike Sexton	Chief Financial Officer	Yes	NHS Croydon Clinical Commissioning Group - in a joint post

MANAGING CROYDON HEALTH SERVICES

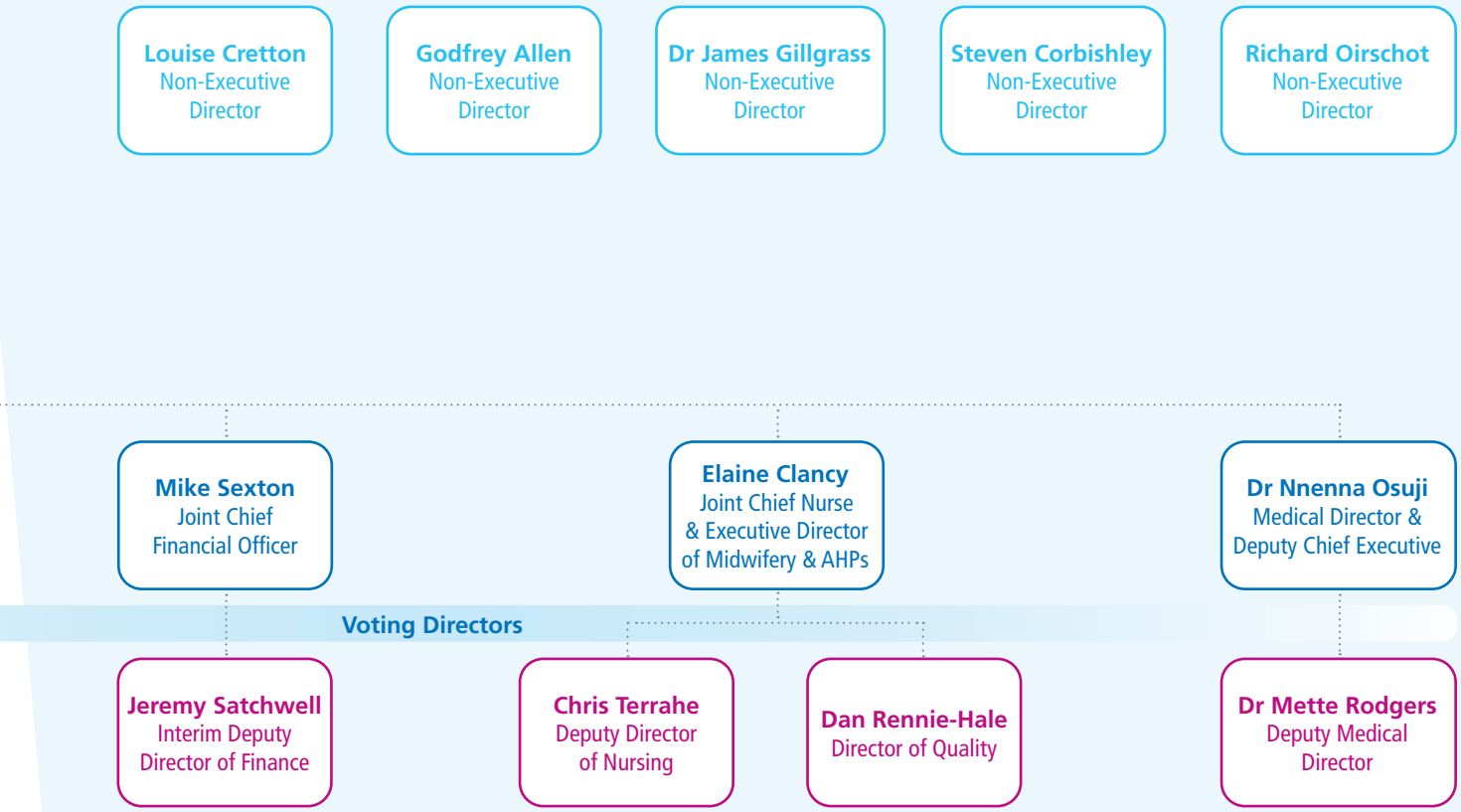


ADO - Associate Director of Operations
ADN - Associate Director of Nursing

Integrated Adult Care Directorate

Reza Motazed
Clinical Director

Angus Norton ADO
Maria Knopp ADO
Maija Hansen ADN



Integrated Surgery, Cancer & Clinical Support Directorate

Stella Vig
Clinical Director

Shaheen Vesamia
ADO

Stephen Lord
ADN

Louise Coughlan
Chief Pharmacist

Integrated Women's, Children's & Sexual Health Directorate

Rosol Hamid
Clinical Director

Manjit Roseghini
Director of Midwifery

David Garrett
ADO

Andrea Bellot
ADN

CORPORATE GOVERNANCE REPORT

Annual Governance Statement 2019/20

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Croydon health Services NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Croydon Health Services NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

Matthew Kershaw

Chief Executive and Place Based Leader for Health

The Trust Board approved framework for risk consists of the following:

- Risk Management Strategy which seeks to ensure that appropriate systems of internal controls are in place to oversee, monitor and manage risk within the Trust
- Risk registers which document risks at every level of the Trust alongside actions to control, mitigate or resolve each risk
- The Board Assurance Framework which focuses on assurance and links the high level risks to each of the Trust's objectives
- The Assurance Map which identifies where assurance is provided and the strength of the level of assurance provided
- The Risk Assurance and Policy Group is responsible for monitoring risk and discussing and advising in relation to the risk escalation process and undertakes a programme of deep dives across all the directorates with appropriate challenge and scrutiny
- The Executive Management Board, which was replaced by the Health Management Board in January 2020, has operational oversight for risk ensuring that risk management is seamlessly integrated into all policies, processes and procedures and seeks to embed the right leadership and behaviours to support effective risk management. It also receives recommendations from the Risk Assurance and Policy Group and approves the escalation of risk onto the Corporate Risk Register
- The Audit Committee receives and discusses the Corporate Risk Register, Board Assurance Framework and Assurance Map and undertakes a number of deep dives into areas of concern
- The Public Trust Board meeting receives and discusses the Corporate Risk Register, Board Assurance Framework and Assurance Map.

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

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

As part of good risk management practice, the Trust has undertaken an annual refresh of the Corporate Risk Register which included a top down and bottom up approach to risk and has worked with all directorates to ensure that their risk registers reflect all risks and that the cause and effect of risks are fully understood. As part of this process, and in recognition that as part of the management of risk there is a need to understand the broader themes of risk to enable the Board and staff to fully articulate their top three or four risks, the risks have been considered with a view to grouping them together in themes. This has enabled a better understanding of the links and interdependences between the risks and has sought to drive more effective mitigations.

The Trust Board held a risk workshop on 26 June 2019, as part of the annual review which considered a high level Board to Ward approach to corporate risks, linking each risk to the Strategic Priorities thereby identifying any gaps not already considered. The workshop also discussed the Board's approach to risk appetite in relation to three broad areas which were Financial, Compliance and Regulatory and Reputation. The discussion used the Good Governance Institute matrix to identify the level of risk appetite ranging from seek to minimal or as little as reasonably possible.

A new Risk Management Framework and Strategy was approved in September 2019 by the Risk Assurance and Policy Group with discussions across the Trust and specifically with the Audit Committee. The Strategy introduced a formal escalation and de-escalation process for managing risk in respect of approval of risks onto the Corporate Risk Register.

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

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

The risk and control framework

The Trust Board and its Committees

The Trust Board is accountable through the Chairman and Chief Executive to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. The Trust Board at 31 March 2020 consisted of the Chairman, seven Non-Executive Directors, a Chief Executive who is also Place Based Leader for Health, Medical Director, Joint Chief Nurse, Joint Chief Finance Officer and a Director of Human Resources and Organisational Development as outlined below. Although not voting members of the Board the Chief Operating Officer, Director of Strategy and Transformation and the Director of Integration, Planning and Performance attend all Board meetings.

In recognition of moving to a broader Croydon based meeting, Croydon Borough Council's Director of Public Health and a representative from Healthwatch have been Formal Observers on the Board throughout the year and although they are not voting members of the Trust Board, they are encouraged to participate in our public and private discussions.

The membership of the Trust Board is balanced and appropriate and members possess a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. To enable greater integration in the move towards a Croydon Borough place based system of health and care, which would provide health and care specifically focused upon the needs and demographics of the people of Croydon, the Trust has made a number of joint appointments with Croydon Clinical Commissioning Group both to the voting cohort of the Board and the non-voting cohort. Moving into the new financial year of 2020/21 the Trust has also welcomed two more associate Non-Executive Directors who were lay members in Croydon Clinical Commissioning Group in a further move to strengthen the understanding, knowledge and breadth of the Trust Board as it moves towards an Integrated Care Provider approach for Croydon, within an Integrated Care System across South West London.

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

Michael Fanning, the Director of Nursing, Midwifery and Allied Health Professionals left the Trust on 30 April 2019. As part of the integration work the first joint appointment was made between the Trust and Croydon Clinical Commissioning Group with the appointment of Elaine Clancy as the Joint Chief Nurse on 1 May 2019.

Following the decision to work on a joint financial control total with Croydon Clinical Commissioning Group, we further aligned the finance functions within the Trust and Croydon Clinical Commissioning Group and appointed Mike Sexton as the Joint Chief Finance Officer on 1 November 2019. Azara Mukhtar, Director of Finance for the Trust left the Trust on secondment, on 20 November 2019.

The Trust Board undertook a review of its effectiveness, as part of the preparation for the Well Led assessment, by an external assessor who met with all Trust Board members as part of the assessment. The results from the review formed part of the development work undertaken in preparation for the formal Well Led review by the Care Quality Committee.

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

		24 April 2019	24 July 2019	30 October 2019	20 January 2020	
Michael Bell	Chairman	✓	✓	✓	✓	4/4
James Gillgrass	Non-Executive Director	✓	✓	✓	✓	4/4
Louise Cretton	Non-Executive Director	✓	✗	✗	✓	2/4
Hannah Miller	Non-Executive Director	✓	✓	✓	✓	4/4
Godfrey Allen	Non-Executive Director	✓	✓	✓	✓	4/4
Michael Bailey	Non-Executive Director	✓	✓	✗	✓	3/4
Steven Corbishley	Non-Executive Director	✗	✓	✓	✓	3/4
Richard Oirschot	Non-Executive Director	✓	✗	✓	✓	3/4
Matthew Kershaw	Chief Executive and Place Based Leader for Health	✓	✓	✓	✓	4/4
Nnenna Osuji	Medical Director and Deputy Chief Executive	✓	✓	✓	✓	4/4
Elaine Clancy	Joint Chief Nurse		✗	✓	✓	2/3
Azara Mukhtar	Director of Finance	✓	✓	✓		3/3
Mike Sexton	Joint Chief Finance Officer				✓	1/1
Michael Burden	Director of Human Resources and Organisational Development	✓	✓	✓	✓	4/4
Michael Fanning	Director of Nursing	✓				1/1

The meeting in January 2020 was a meeting in common with Croydon Clinical Commissioning Group as part of the integration work that the Trust has been engaged with moving to a place based approach to health and care management and delivery.

Further work took place before the end of the year to align our governance with Croydon Clinical Commissioning Group, ahead of implementation from 1 April 2020. On that date Croydon Clinical Commissioning Group was subsumed into the new South West London Clinical Commissioning Group which covers six boroughs. The intention was that most powers and budget would immediately be delegated back to six Borough Committees. In Croydon the Borough Committee would have formed one half of what we have called the "Health Board" a meeting in common with the Trust Board. However, the COVID-19 emergency has delayed

the delegation of powers, which in turn has delayed our local plans. We have proceeded nevertheless to create the Health Board, which includes the members of the Croydon Borough Committee, in anticipation of the delegation after the COVID-19 crisis. The Health Board has met twice in the new financial year with attendance from a broader Croydon based membership.

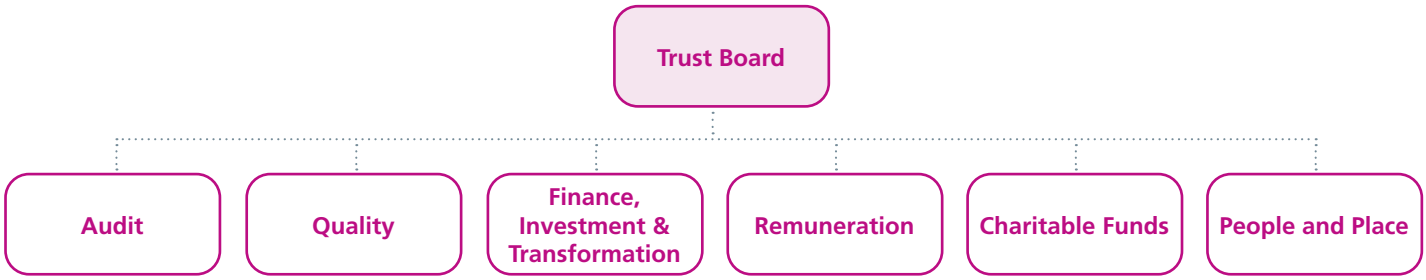
The lack of delegation has not had any impact upon the Quality Committee or the People and Place Committee. Insofar as the Finance, Investment and Transformation Committee is concerned members from the Borough Committee still attend the meetings so that they have appropriate oversight and are able to fully participate in the meetings.

The Trust continues to be an active member of the One Croydon Alliance, a partnership with the Local Authority, Croydon Clinical Commissioning Group, voluntary sector and other local providers. Through the Alliance, we have integrated care for the Over 65s, developing stronger out of hospital services. Over the next year, we will extend this to all adults and seek to develop a "shadow" pooled budget and create joint business plans for 2021/22.

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

		24 Apr 2019	29 May 2019	26 Jun 2019	24 Jul 2019	25 Sep 2019	30 Oct 2019	27 Nov 2020	18 Dec 2020	29 Jan 2020	26 Feb 2020	25 Mar 2020
Michael Bell	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
James Gillgrass	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louise Cretton	Non-Executive Director	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Hannah Miller	Non-Executive Director	✓	✓	✓	✗	✓	✓	✓	✗	✓	✗	✓
Godfrey Allen	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Michael Bailey	Non-Executive Director	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗
Steven Corbishley	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Richard Oirschot	Non-Executive Director	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Matthew Kershaw	Chief Executive and Place Based Leader for Health	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
Nnenna Osuji	Medical Director and Deputy Chief Executive	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓
Elaine Clancy	Joint Chief Nurse		✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Azara Mukhtar	Director of Finance	✓	✓	✓	✓	✓	✓	✓				
Mike Sexton	Joint Chief Finance Officer							✗	✓	✓	✓	✓
Michael Burden	Director of Human Resources and Organisational Development	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michael Fanning	Director of Nursing	✓										

The Trust Board has six committees that directly report to it:



These Committees have been established on the basis of the following principles:

- The need for Committees to strengthen the Trust's overall governance arrangements and support the Board in the achievement of the Trust's strategic aims and objectives
- The requirement for a Committee structure that strengthens the Board's role in strategic decision making and supports the Non-Executive Directors in scrutiny and challenge of Executive management action
- The need to maximise the value of the input from Non-Executive Directors, given their limited time, and providing clarity around their role
- The need to ensure that the Board is supported in fulfilling its role, given the nature and magnitude of the Trust's wider integration agenda, to support background development work and to perform scrutiny in more detail than may be possible at Board meetings. Wherever possible, Committees should be joint forums with Croydon Clinical Commissioning Group and our wider stakeholders including the Local Authority
- The Chair of each Board Committees present a report to the Public Trust Board, highlighting significant issues of interest to the Board, including key risks identified and other issues considered, and decisions made at their meetings. In addition, each Committee undertakes an annual review of the effectiveness of the Committee. Finally, the Private Board receives copies of all approved minutes for additional scrutiny.

As part of the continued approach to integration, and the adoption by the Trust and Croydon Clinical Commissioning Group of a process of joint planning, wherein both organisations share both the risks and the benefits to enable a more integrated approach to healthcare, the Trust and Croydon Clinical Commissioning Group were able to agree a Joint control total with the respective regulators which will continue to be the approach as we enter into a new financial year.

To facilitate this, the Finance, Investment and Transformation Committee has, since the beginning of the financial year met in common with Croydon Clinical Commissioning Group's Finance Committee. The meetings whilst remaining separate have adopted a protocol which sets out the framework under which the meetings would be held in common. The protocol makes it clear that the definition of finance meetings in common is a meeting with the same agenda, which takes place at the same time, in the same venue. Discussions will take place collectively but any decisions made will be taken by the individual finance meetings.

During the year, the Trust Board reviewed the governance structure and made some changes. Recognising the need for additional focus and scrutiny in respect of workforce, the health and well-being of the population of Croydon, and the need to act as a socially responsible corporate body, the People and Place Committee was established in October 2019 to address these areas. The membership for this meeting is wider than the Trust which recognises that delivery of the aims will require a place based approach and therefore includes the Director of Public Health together with other key stakeholders.

Following on from the changes in the previous year, the Quality Committee has continued to meet with members of Croydon Clinical Commissioning Group playing a full role in the meeting. From January 2020 this was developed further and the Quality Committee adopted a protocol to meet in Common with the Croydon Clinical Commissioning Group's Quality Committee which had a broader, Croydon focus which enabled there to be a more robust and effective quality discussions to take place, for the benefit of the people of Croydon.

The Quality Committee also has oversight of the Quality Improvement Programme which monitors the implementation of recommendations made by the Care Quality Commission. The Trust was inspected by the Care Quality Commission in October 2020 who rated the Trust as requires improvement, which was the same as the previous year's rating. The Care Quality Commission also undertook a focused inspection in August 2019 following concerns raised from patients and relatives about the nursing care provided in medical and surgical services and the results of the 2018 inpatient survey. The inspection did not highlight any significant concerns but indicated that improvements needed to be made to services.

The Audit Committee, whose membership includes the Chairs of the Quality Committee, Finance, Investment and Transformation Committee and the People and Place Committee, has remained Trust focused and considered Corporate Risk Register and Board Assurance Framework and provided challenge where appropriate at each of its meetings. The Assurance Map was considered until November 2019 but it was recognised that a refresh was required to enable it to remain focused and effective for it to continue into the new financial year. The Audit Committee undertook a number of deep dives during the year on key areas identified including looking at recruitment and safeguarding issues.

The Committee also considered the Trust's annual report and accounts and considered key changes, such as the impact of the adoption of the new accounting standards: IFRS 16 in relation to leases. Finally, the Committee also appointed a new Internal Audit provider from 1 April 2020.

The Remuneration Committee has also remained Trust focused but has had oversight of the joint appointments and has been fully involved in the process of remuneration and appointment to the Joint Executive Team including the appointment of the Chief Executive and Place Based Leader for Health.

The Charitable Funds Committee has also remained Trust focused and continued to have oversight of the charitable funds available to the Trust and how these are spent in a way to add value. In particular the Committee has been actively involved in supporting the need for funding for the Paediatric Village.

From an operational perspective the Trust has operated an Executive Management Board to undertake transactional and operational business at a senior management level within the Trust. From January 2020 this meeting has been replaced by the Health Management Board which, in keeping with the approach taken for the People and Place Committee and the Quality Committee has a wider place based focus with discussions that are Croydon specific rather than just Trust specific.

The Cost and Quality Oversight Board reports to the Trust Board via Executive Management Board (latterly Health Management Board) and Croydon Clinical Commissioning Group's Senior Management Team and has responsibility for ensuring the delivery of all Quality, Innovation, Productivity and Prevention and the Cost Improvement Plans. All Quality, Innovation, Productivity and Prevention and the Cost Improvement Plans Programmes are expected to improve, or at least maintain, quality for lower cost. They should be key enablers to the delivery of the joint control total whilst ensuring that patient experience, safety and operational standards are delivered, maintained or ideally improved.

As the impact of COVID-19 has become more significant, and in line with national guidance, the Trust has sought to reduce the time spent in meetings without adversely impacting the ability of the Trust to ensure that its governance structure remains robust and effective. Meetings have become virtual in nature, making use of digital platforms to enable members to come together and transact Committee and Board business effectively.

Meetings are also shorter and focus on the issues that need to be transacted in recognition of the significant pressures on operational staff at this challenging time. Notwithstanding this impact the governance structure has continued to be effective but is administered in a manner that enables the Trust to adhere to national "safe distancing" guidance and not require attendees to undertake unnecessary travel to attend a meeting.

Risk Management Process

The new Risk Management Strategy recognised that risk management needed to move from a process required by management into an essential tool that could be used to effectively undertake everyday activity whilst having oversight of the bigger picture. This is particularly important when moving into a more integrated way of working as it is essential to identify early on any obstacles or risks that may impact upon the desired outcome and effectively mitigate as appropriate.

The Strategy describes the approach the Trust will take to identifying, articulating, managing and mitigating risk but also sets out an escalation and de-escalation process as described above. Each directorate maintains a risk register which sets out risks identified across the directorate to ensure that risks are identified by all staff including clinical staff. The Strategy sets out how risks are scored ensuring that risks are managed and controlled with appropriate oversight at the appropriate level. Risks are escalated for inclusion on the Corporate Risk Register where the level of risk is identified to have a significant impact on the Corporate Objectives and thereby the running of the Trust. These would be risks that score 15 or above on the risk matrix. This process is effectively managed from an operational perspective by the Risk Assurance and Policy Group and Executive Management Board/Health Management Board to ensure that there is appropriate scrutiny and challenge.

The Committees provide internal assurance to the Trust Board that the mitigations and controls in place are effective and that the risks are well managed. As part of the Committees role in risk, those risks articulated on the Corporate Risk Register are reviewed by the Executive Team with a view to their being allocated to each of the Committees to have oversight of depending on the nature of the risk. Some risks may be allocated to more than one Committee and it is the role of each Committee to consider the risk in the context of their particular Terms of Reference to gain assurance that the risk is being appropriately and effectively managed. In addition, each Committee has an agenda item entitled "Risks identified in the meeting" whereby any new risks identified in the meeting are captured and an action to develop any new risk is allocated to an Executive. The Audit Committee considers all risks and takes assurance from each of the other committees where appropriate.

The Assurance Map provides additional assurance indicating where the Trust Board can seek and obtain assurance from. The Trust's Internal Audit programme and external reviews of the organisation are all sources used to provide assurance that the processes are effective and risk monitoring is fully embedded within the Trust.

Risks can be identified through many sources including proactive risk assessments, strategic planning, performance data, patient and public feedback, incident reporting, clinical benchmarking and external stakeholders including the Care Quality Commission, NHS Improvement Getting it Right First Time, Friends and Family Test, the Picker Inpatient Survey and Dr Foster Intelligence. There are clear examples of risk being identified at all levels of the Trust showing that risk is "ward to Board" and vice versa.

Risks to the Trust's strategic objectives and priorities are identified and tracked in the Board Assurance Framework which includes details of mitigations and controls in place and the current level of risk after the controls are already in place. The Board Assurance Framework also identifies the need for further actions and the effectiveness of actions and controls. The Board Assurance Framework received significant assurance following the March 2020 internal audit report.

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

Risk Theme - Information Technology

Risk Description	Risk Mitigation and Control
IT Infrastructure and operating practices unable to meet existing and increasing business needs.	The IT department monitors risks monthly and reports on plans to improve the infrastructure at the IT Programme Group and IT Steering Committee. The IT restructure introduced a Deputy Director of IT role with responsibility for Infrastructure to scope, identify funding requirements for and deliver an Infrastructure Improvement Plan. This postholder will work with the Deputy Director of Digital Transformation to identify emerging infrastructure requirements based on the Trust's service developments, including those of the One Croydon Alliance. A draft IT Infrastructure strategy has been developed to inform an investment plan, which is being developed into a multi-organization bid by the Acute Provider Collaborative. A process of daily checks has been in place since May 2019 to proactively identify issues and monitor trends.
Decreased operational efficiency and organisational performance due to aged and not fit for purpose hardware.	The Trust has put in place a phased rolling refresh programme for all end point device types including desktop PCs, which aims to ensure no device used at the Trust is more than 5 years old. This programme is prioritized annually in the Trust's capital programme with progress routinely monitored by the IT department to ensure progress. The Trust was successful in gaining Sustainability and Transformation Partnership (STP) and NHS England funding in 2019/20 to expedite this programme, bringing forward investment for workstations on wheels. The Trust is also reviewing its approach to funding hardware for new starters.
If the Trust was to be targeted by a Cyber-attack or hack this could lead to an outage of critical clinical systems and confidential data.	The Trust received a range of free support packages, commissioned by NHS Digital in 2019/20, to develop an overarching Cyber Security Action Plan. The Cyber Steering Group provides progress updates to the IT Steering Committee. An IT Security Manager post was introduced in August 2019 to manage this area for the IT department, and is responsible for leading on the delivery of the Action Plan, and responding to any cyber security incidents as and when they happen.
Lack of adherence to controls for fall back cards means a full audit trail is not possible in the case of a clinical incident. **NB A fall back card is issued to a member of staff, when they are not in possession of their own card, to enable them to access and update the clinical systems.**	The Trust has put in place a number of controls including the provision of logs to all areas that hold fallback cards to ensure that they are issued in accordance with the proper process. Regular audits are undertaken and missing fallback cards identified and cancelled. Updates are provided to the Information Governance Committee for assurance.

Risk Theme - Sustainability

Risk Description	Risk Mitigation and Control
If there is a lack of effective leadership at senior and middle management then there is a risk to the quality of clinical care.	The Human Resources & Organisational Development delivery plan 2020-2021 objectives are - develop leadership programmes for all levels, utilising existing packages including apprenticeship levy funded training and consider designing a bespoke, modular leadership programme.
If the Croydon health and social care system is unable to work together to create a sustainable plan for all the organisations within it, there is a risk that one or more organisations will not be able to demonstrate financially sustainable plans resulting in actions being taken by their regulator.	This risk was overseen by the Cost and Quality Oversight Board which was chaired jointly by the Joint Chief Finance Officer of Croydon Health Services and Croydon Clinical Commissioning Group. By bringing the teams together and working from one data source, achievement of the Joint Control Total was successful resulting in the payment of the Provider Sustainability Funding which has enabled the Trust to achieve break even. Further arrangements have been agreed to support the next steps of financial integration of health and social care in Croydon so that service and financial risk management are aligned across the system to optimise outcomes for residents and patients within available resources.
If the Trust is unable to effectively manage the emergency care pathway and the level of emergency demand, it may fail to meet the type 1 and type 3 trajectory agreed with NHSE for 2019/20. This will have a negative impact on patient wait times and experience, and the Trust's reputation.	The Trust has implemented a High Impact turnaround plan which was devised in conjunction with the Emergency Care Intensive Support Team (ECIST) and NHS Improvement. The plan has been split into two phases with the second phase commencing in October 2019. There had been signs of improvement particularly in respect of patients with an extended length of stay, and these have been accelerated by the Trust's response to COVID-19. As part of the plan time spent in the Emergency Department has been tracked recognising the impact that has on patient welfare and experience. Work is monitored by and reported to the A&E Delivery Board.
If Croydon Health Services fails to become the provider of choice for the people of Croydon, then it will be unable to deliver the repatriation work which will have a detrimental impact upon the sustainability of the Trust.	As part of becoming and Integrated Care Provider the Trust needs to ensure that its services are such that GPs are happy to refer patients to the Trust. Part of the Trust's plans to achieve financial sustainability focus upon a significant level of repatriation work which will fail if the Trust is not an appropriate provider of choice. During the year the work undertaken on repatriation increased market share from 70% to 80%.
If the Trust fails to deliver a place based delivery model for Croydon it could result in the further integration work being unsuccessful, which would impact the quality of services available for the people of Croydon.	An initiative (the Blue Button) has been put in place to encourage GPs to send all referrals to the Trust which has resulted in the majority of GPs using the Blue Button for referrals. This has enabled 95% of all referrals to be directed to the Trust. As the integration agenda continues and with the development of SWL CCG the model developed is one of place based delivery on a Borough basis. The Trust is working with its partners and other key stakeholders to ensure that the Borough basis enables delivery of appropriate services to the People of Croydon.
If the Trust is unable to effectively deliver good patient experience of its services then the people of Croydon will not want to use the Trust which will impact upon the Trust's reputation and sustainability and the continued integration of services for the benefit of the people of Croydon.	The Trust has developed a patient engagement and experience strategy following extensive workshops with key stakeholders, this has an action plan to support delivery of the strategy. Part of this piece of work is the introduction of a ward accreditation scheme which will be commenced in 2020 on 3 wards as a pilot to then further develop across the Trust. The Trust monitors complaints, compliments and the Friends and Family Test to triangulate the data relating to patient experience and identify any areas of concern.

Risk Theme - Workforce

Risk Description	Risk Mitigation and Control
If there is a reduction in staff engagement there may be a reduction in the quality of our care to the people of Croydon as it is recognised that engaged staff deliver better quality services.	The HR&OD delivery plan 2020-2021 objectives on staff engagement are - Communication, Reward and Recognition, Career Development, Leadership and Management Development, Health and Wellbeing and innovation. Delivery is monitored by the Executive Team and overseen by the People and Place Committee.
Difficulty retaining clinical staff in 'hard to fill areas' leading to increased vacancies and system vulnerability.	Directorate workforce plans include succession planning and talent management with a dedicated Nurse for Professional development to ensure training and development opportunities are maximised. Managers hold regular 1:1s with all staff to ensure that any concerns or issues are identified at an early stage and exit interviews are offered.
Clinical vacancies remain unfilled in hard to recruit or specialist areas - i.e. Nurses/ midwives, sonographers, cardiac physiologists.	Controls include the Recruitment and Retention Strategy, succession planning, talent management and a Rotation and Secondment Policy. New roles are being researched. An Apprenticeship Provider Contract with Croydon College has now been awarded offering a range of 34 Apprenticeships which will provide employment opportunities.
Clinical Capacity issues in the Paediatric Audiology Department resulting in a reduced level of service for patients with additional wait times which could impact the care of the patient.	The Trust put in place a review of all new referrals, by the lead clinician, to prioritise cases as appropriate. Patients with a high or urgent need were offered a follow up appointment at the time of their initial appointment. Following successful mitigating actions being in place the risk likelihood reduced and was removed from the Corporate Risk Register and managed locally on the Directorate Risk Register.

NB: The narrative of some risk descriptions have been amended to enable the reader to better understand the nature of the risk within this document.

The identification of the key risks faced by the Trust is an important process and one that has been undertaken at Board and Directorate level to ensure that it is as comprehensive and robust as possible.

Potential Significant Issues for 2020/21

The following significant issues are areas that have been identified that the Trust is likely to face in 2020/21:

1. Accident & Emergency performance

Although compliance with the Constitutional Standards has been suspended nationally, the Trust has continued to monitor its performance against the four-hour standard which has significantly improved whilst dealing with COVID-19. However, the Trust recognizes that as non-COVID-19 activity returns, there may be additional pressure on capacity with the need to segregate increasing numbers of patients to manage infection control. This may in turn adversely impact on the Emergency Department's performance and we are focusing on how to address that as a priority going forward in the Trust and across the system.

2. System Integration

Following the declaration of a National Major Incident the planned integration between the Trust and the Croydon Borough Committee for NHS South West London Clinical Commissioning Group, has not been able to formally take place following the implementation of a Command and Control approach by NHS England which was resulted in the planned delegation not taking place. Currently it is not clear how long the present situation will continue for but it is a significant barrier to the planned integration work and the development of a Health and Social Care Board that takes a Borough based approach to the health and care of the people of Croydon.

3. Workforce Challenges

The Trust continues to have high levels of vacancies, particularly in respect of Band 5 nurses. The Trust had developed a successful overseas recruitment plan which had been progressing well but which was put on hold following COVID-19. This has also had an adverse impact upon Trust Staff who have been working in very challenging circumstances. Whilst a number of steps have been taken to support staff health and wellbeing as the pandemic continues this will become more challenging.

4. Financial Sustainability

Integrated financial planning for the NHS in Croydon identified a significant underlying deficit challenge for 2020/21, arising from a combination of historic efficiencies not achieved recurrently, cost pressures and annual efficiency requirement. Against a system challenge of £27m, of which £17m relates to the Trust, some efficiencies have been identified, but a further £10m-£15m is required. With income to the system largely capped for the population, the entire focus is on transforming services and the cost base.

However, before the planning process was completed, all clinical and back office resources were diverted to the COVID-19 Response and the NHS Planning process was suspended indefinitely on 17 March 2020. At the time of reporting, the Trust continues to maintain expenditure within 2019/20 run rate levels against block cash funding based on the same.

Having had external support to improve operational productivity and efficiency in the previous year, the Trust completed its transition away from external support, to integrated local arrangements which continued to improve quality and efficiency.

The Trust continues to identify efficiency opportunities in anticipation of returning to the previous financial regime.

Recovery and returning to a new Business as Usual

The Trust has established a recovery programme that will work across all modalities of care and with other partners. This programme approach will support us in planning all the elements of recovery including how the new infection control measures will affect capacity and how we provide patient facing services. We will ensure that a robust workforce strategy underpins this programme, taking into account new ways of working for healthcare professionals. Our aim is to re-start patient care in a planned and safe way, and in doing so improve the performance of the organisation against constitutional standards relating to access.

A key aim during recovery is that Croydon exits the COVID-19 major incident as a highly performing integrated health system. There is considerable learning and improved ways of working that were implemented during the COVID-19 response. Where this has demonstrated improved impact and transformational change we should harness this and ensure sustained delivery across the health system.

Workforce

Identification of workforce metrics to be monitored is determined working with directorates and is reviewed by the People and Place Committee and the Trust Executives to inform the workforce plan

The workforce plan supports the Trust strategy and its operational plan and the long-term financial model agreed by the Trust Board. Workforce key performance indicators are set and monitored at Trust Board and directorate level and encompass a number of different areas including care hours, pay expenditure, temporary workforce expenditure, sickness absence rates, stability index rates, compliance with mandatory and statutory training and appraisal rates.

The Finance, Investment and Transformation Committee reviews progress against the workforce strategy. It reviews the Integrated Quality and Performance Report report on a monthly basis.

The Quality Committee receives and discusses information from quarterly reviews at directorate level, relevant Key Performance Indicators and Care Quality Commission outcome data.

Strategic risks to the workforce plan are identified in the Operating Plan and monitored as part of the Board Assurance Framework and Corporate Risk register, which are routinely reviewed by the Trust Board.
The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Disclosures

Register of Interests

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. To facilitate this the Trust has implemented an online electronic system for making declarations.

Fit and Proper Persons

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

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. In recognition of the concerns expressed by staff of the tapered tax allowance on pensions the Trust commissioned a Pensions Advisory Service to enable all employees to seek advice from a Regulated Pensions Advisor.

Equality, Diversity and Human Rights

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

Sustainability

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18) which is due to be fully implemented within the next three months. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Modern Slavery Act 2019/20 Annual Statement

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

Emergency Preparedness

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act 2004 and the NHS Emergency Planning Guidance 2005.

Demand and Capacity Internal Audit Report

As part of its reporting programme, Internal Audit carried out an audit on Demand and Capacity Management. There were four control objectives all of which were deemed to have limited assurance, with an overall assessment of limited assurance. The report concluded that there were 12 high, and 3 medium level recommendations and highlighted gaps in the overarching control arrangements and instances of existing controls not being consistently and evidently applied. However, the report did not suggest that the Trust was putting patient safety at risk but recognised the challenges in respect of bed capacity and the four hour target for transfer to a ward from the Emergency Department. Following the response to COVID-19, a number of the recommendations have been implemented and the Trust has been able to demonstrate a more robust process in a challenging environment. The limited assurance audit has not adversely impacted the Head of Internal Audit Opinion which remains reasonable assurance.

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

The Board, on a monthly basis, keeps under review the Trust's use of resources, financial performance and cost effectiveness through the monthly Integrated Finance Report and Efficiency Programme (QIPP/CIP) Report. These reports are reviewed in detail by the Finance, Investment and Transformation (FIT) Committee and also received by the Board. Financial risks, including mitigations and controls, are considered by the FIT committee with deep-dive reviews as appropriate.

To further optimise use of NHS resources across the Croydon system, the Finance, Investment and Transformation committee met each month in common with the Finance Committee of Croydon CCG. Having agreed a joint financial control total and efficiency programme across the two organisations, monthly integrated reporting and monitoring was established.

The two organisations established a joint Cost and Quality Oversight Board (CQOB) which met weekly to oversee the delivery of the system efficiency programme. The membership included managers and clinicians from the whole system, including social care. CQOB was supported by a joint Programme Management Office.

The performance management structure at Executive Management level and below provides opportunities for specific directorate and divisions to be challenged on their use of resources within the respective services which they provide.

The oversight role of the Board and the Finance & Investment Committee is supplemented by the annual internal audit programme which includes a comprehensive review of the Trust's financial systems and controls.

Having had external support to improve operational productivity and efficiency in the previous year, the Trust completed its transition away from external support, to integrated local arrangements which continued to improve quality and efficiency.

For 2019/20, the system wide efficiency programme, including the Trusts Cost Improvement Programme was built on external benchmarking analysis, including Model Hospital, GIRFT reviews, procurement benchmarking, and RightCare analysis.

The Trust delivered cost improvements of £11m (3%) across a range of areas including recruitment and retention of staff, prescribing, reducing long lengths of stay, increasing community base care (e.g. IV antibiotics) optimising elective capacity (theatres/outpatients) and improving value for money on supplies and sub-contracts.

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

The CQC undertook a Use of Resources Assessment in November 2019 which involved reviewing the Trust against the Use of Resources key lines of enquiry. Despite progress as outlined above, the final conclusion was "Requires Improvement" which reflects the journey the Trust and system are on.

Information governance

Data Security and Protection Toolkit (DSPT)

Annually the Trust completes the Data Security and Protection toolkit, an online self-assessment of its performance against the national data security standards.

Due to the COVID-19 outbreak submission for the Data Security and Protection Toolkit has been delayed from its normal submission date of March 2020 to September 2020. The Trust has plans in place to enable it to submit its assessment in September 2020 and anticipates that it will be awarded the required assurance of 'standards met' against the measured national standards. To support this view the Trust received 'Reasonable Assurance' for the Data Security and Protection Toolkit following an independent external assessment (undertaken in January 2020) as part of the Trust's Internal Audit programme.

Reported Data Protection and Security incidents

The Trust continues to promote and encourage data protection incident reporting to support and build secure systems and processes. The Trust self-reports breaches categorised as potentially capable of causing harm (level 2 incidents) to NHS digital using the Data Security and Protection toolkit reporting facility.

The table below shows the level two breaches reported to NHS digital during the financial year:

Description of breaches	No. of incidents
Lost or stolen paperwork	5
Data emailed to the incorrect recipient	1
Unauthorised access to patient record	1
Network infrastructure affecting data availability	1

Two incidents (included in the above table) were identified as breaches that met the threshold for notifying to the Information Commissioner Office. One breach related to unauthorised access to a patient record (the shared GP record), the other related to lost paperwork (a patient hand over shift containing contact details of nine patients). The Information Commissioner's decision for both breaches was that no further action would be taken against the Trust.

The Trust continues to monitor, improve and implement advice and lessons learned from reported breaches and incidents. Following each incident the Information Governance team provides recommendations, guidance and training to staff to minimise and mitigate the risks of similar incidents from reoccurring.

Freedom of Information Act (FOIA) Requests

The Trust's compliance rate measured by the percentage of requests completed within twenty calendar days, as required by the Freedom of Information Act, improved over the last year. The Trust achieved an average compliance rate of 79% for 2019/20 which was a significant increase upon the previous year where the Trust had self-reported to the ICO following a significant backlog of requests that had not been responded to. The number of request received increased to 686 from the previous year representing an increase of 15%.

Subject Access Requests

The Trust continues to perform exceptionally well in its response to individuals' requests for their health records. The compliance rate measured by the percentage of requests completed within the statutory time frame was maintained at 99%. The number of requests received was 2,542 which was a similar number to those received in the previous year.

Data quality and governance

A draft Information Strategy has been produced by the Information Team and is currently being reviewed at Senior Trust Management level. The Strategy will be developed into a final working version in partnership with stakeholders from across the Trust. An important part of the strategy is the 'Ownership of data and Information.' The focus of this will be working with the with Directors, operational staff, service managers, clinicians etc. to enable them to:

- Access the information that they require
- Understand the information they are looking at
- Carry out basic manipulation of data
- Know which data is reported where and when (both externally and internally)
- Understand the implications of incorrect data
- Understand the origin of the data.

The importance of ownership of data was highlighted by the Care Quality Commission by the must-do action 'The Trust must ensure that the quality of the data being collected and submitted to external organisations is accurate and scrutinised adequately.'

One area where ownership of data has worked well is the Referral Time to Treatment elective waiting list. The 'live' Patient Tracking List developed during 2018/19 continues to be used and supports validation of data to ensure accuracy.

Review of effectiveness

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

In support of this:

- The Head of Internal Audit has provided me with reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. Internal audits carried out have provided assurance from substantial assurance through to limited assurance and management have accepted and taken action to address recommendations made.
- The Trust Board, the Audit Committee, Executive Management Board/Health Management Board, Directorate Performance Reviews and the Risk Assurance & Policy Group reviews risks to the delivery of the Trust's priorities through monthly monitoring and discussion of the performance in the key areas of finance, activity, national targets, patient safety, quality and workforce.
- The Board Assurance Framework, Corporate Risk Register and Assurance Map provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives which are regularly reviewed. Internal audit has rated the risk management framework as providing reasonable assurance with the Board Assurance Framework as providing significant assurance.
- The Audit Committee overseas the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust Board it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate. The committee regularly receives reports on internal control and risk management matters from the internal and external auditors.
- The Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively.
- NHS Improvement's Single Oversight Framework provides a structure for overseeing trusts and identifying potential support needs. The framework looks at five things: quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability (well led).
- Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; patient led assessments of the care environment.

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

Conclusion

The Trust Board remains committed to continuous improvement of its governance arrangements so that systems are in place that ensure risks are correctly identified and managed and that serious incidents and incidence of non compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action so that the patients, staff, public and stakeholders of Croydon Health Services NHS Trust can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

With the exception of the internal control issues that are outlined above, as Accountable Officer and based on the above assurances, I am content that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues identified have or are being addressed.

The governance arrangements in place have enabled a more integrated approach to health in Croydon by way of the integration work between the Trust and Croydon Clinical Commissioning Group, demonstrated by joint meetings, meetings in common and a number of joint appointments. This enabled delivery of a Joint Control Total which provided financial and quality benefits to Croydon. These good working relationships were already in place and enabled our response to COVID-19 to be effective and timely.

As the Trust moves forward into the new financial year, the pandemic has effectively paused the integration plans with South West London Clinical Commissioning Group's Croydon Borough Committee and the Local Authority. However, the Trust remains committed to further integration within the Borough of Croydon so that all aspects of health, social care and wellbeing can be co-ordinated and delivered effectively and within our delegated powers. Although COVID-19 has had a significant impact on the implementation of our Borough based approach to health care provision, it has also demonstrated the significant benefits of an integrated approach which has enabled partners to effectively work together for the benefit of Croydon in these difficult times.

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

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF CROYDON HEALTH SERVICES NHS TRUST

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Croydon Health Services NHS Trust (the 'Trust') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

Material uncertainty related to going concern
We draw attention to Note 1.2 in the financial statements, which indicates that the Trust relied on non-recurrent funding and savings in 2019/20 which has contributed to the £17.2m (5%) efficiency challenge in 2020/21, in addition to the £16.4m financial support required to deliver the Trust's financial plans in 2020/21. Whilst some schemes, totalling £9.8m of potential savings, are identified to meet this efficiency challenge, and there is temporary financial relief during the COVID Response, there is every expectation that the Trust will be required to address the underlying run rate issues that existed pre-COVID. Achievement of the Trust's 2020/21 financial plans requires delivery of ambitious budgets and a challenging Cost Improvement Programme. If the Trust's financial deficit is greater than planned in 2020/21 then further cash support will need to be provided through established mechanisms. Confirmation of such support has not been requested or confirmed.

These events or conditions, along with the other matters as set forth in note 1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's/ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Emphasis of Matter - effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 1.26 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As disclosed in Note 1.26 to the financial statements, the outbreak of Covid-19 has caused uncertainties in the markets. As a result, the Trust's valuer has declared a "material valuation uncertainty" in their valuation report which was carried out in March 2020 with a valuation date of 31 March 2020. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. Our opinion is not modified in respect of this matter.

Other information

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

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 23 May 2019 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act in relation to the Trust setting a deficit budget for the year ending 31 March 2020.

On 5 June 2020 we referred a matter to the Secretary of State:

- under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2020

- under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the Trust setting a deficit budget for the year ending 31 March 2021 and the resultant ongoing breach of the Trust's breakeven duty for the three-year period ending 31 March 2021.

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, except for the effects of the matters described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects, Croydon Health Services NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion

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

- The Trust reported an adjusted financial performance surplus of £0.4 million in 2019/20. However, this was only delivered because of gains on disposals of assets and other one-off transactions. The Trust estimates that it had an underlying deficit of £19.1 million at 31 March 2020. In making this surplus, the Trust delivered efficiency savings of £11.8 million in 2019/20 against a target of £14.3 million.

- The Trust has initially set a break even budget for 2020/21, which includes delivery of a challenging £17.2 million savings programme and anticipated receipt of £16.4 million of Financial Recovery Funding (FRF). The Trust will only receive Financial Recovery Fund funding if it meets the break even financial target agreed with NHS Improvement. There is a risk that the Trust will not make all of the targeted efficiency savings, which would have a significant impact on the Trust's ability to recover the underlying deficit.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. These matters are evidence of weaknesses in the proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

The Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

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

Use of our report

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

Paul Grady

Paul Grady

Key Audit Partner
for and on behalf of Grant Thornton UK LLP,
Local Auditor

London
24 June 2020


R1
R2

REMUNERATION REPORT

REMUNERATION REPORT

Remuneration policy

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

During 2019/20, the committee was chaired by Non-Executive Director Louise Cretton.

Other members during the 2019/20 year were:

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

The committee also monitors and evaluates the performance of the Executive Directors. This approach is consistent with the overall performance management ethos of the Trust, and ensures linkage to national targets and local priorities. The committee's role is to ensure that the Executives are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.

Annual data comparison will continue to be made with other Trusts of a similar size to ensure that Croydon Health Services continues to pay what is generally considered to be the market rate. The Chief Executive's remuneration is subject to their performance and an element of their salary is made up of a performance related payment. The facility for clawback is in place.

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

Matthew Kershaw

Chief Executive and Place Based Leader for Health

Salary and pensions of senior managers

2019 - 20

Name & Title	a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	e) All pension related benefits (bands of £2,500)	(f) Total (a to e) bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Matthew Kershaw Chief Executive and Place Based Leader for Health. The salary for 2019-20 is part year only. From 1 October 2019 his role expanded to include place based leader (health); hence 50% of the total remuneration from the appointed date has been recharged to Croydon CCG.	160 to 165	0	5 to 10	0	0	165 to 170
Mike Sexton Chief Financial Officer. The salary for 2019-20 is part year only. Appointed as CFO on 1 November 2019 oversees both CHS and Croydon CCG, hence 50% of the total remuneration has been recharged to Croydon CCG.	30 to 35	0	0	0	70 to 72.5	105 to 110
Azara Mukhtar Director of Finance (on secondment from 6 January 2020). The salary for 2019-20 is part year only. Remuneration during her secondment has been recharged to Oxleas NHS Foundation Trust.	100 to 105	0	0	0	20 to 22.5	120 to 125
Michael Burden Director of Human Resources & Organisational Development	120 to 125	0	0	0	0	120 to 125
Dr Nnenna Osuji Medical Director	205 to 210	0	0	0	40 to 42.5	245 to 250
Elaine Clancy Chief Nurse. The salary for 2019-20, is part year only. Appointed as chief nurse on 1 May 2019 oversees both CHS and Croydon CCG, hence 50% of the total remuneration has been recharged to Croydon CCG.	60 to 65	0	0	0	0	60 to 65
Michael Fanning Director of Nursing, Midwifery and Allied Health Professionals (resigned 30 April 2019)	5 to 10	0	0	0	0	5 to 10

Salary and pensions of senior managers

2019 - 20

Name & Title	a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	e) All pension related benefits (bands of £2,500)	(f) Total (a to e) bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Melissa Morris Director of Business Development, Strategy & Performance (resigned 19 May 2019)	10 to 15	0	0	0	2.5 to 5	15 to 20
Joshua Potter Director of Strategy & Transformation (appointed 18 November 2019). The salary for 2019-20 is part year only. Oversees both CHS and Croydon CCG, hence 50% of the total remuneration has been recharged to Croydon CCG.	20 to 25	0	0	0	30-32.5	55 to 60
Lee McPhail Chief Operating Officer (appointed 1 Apr 2019).	145 to 150	0	0	0	0	145 to 150
Michael Bell Chairman	40 to 45	0	0	0	0	40 to 45
Godfrey Allen Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Dr James Gillgrass Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Louise Cretton Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Jamal Butt Associate Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Mike Bailey Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Hannah Miller Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Richard Oirschot Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Steven Corbishley Non-Executive Director (not remunerated)	NA	NA	NA	NA	NA	NA

Note - Sharing Arrangements: The following governing body members have roles with other organisations and their total remuneration is shown below for completeness.

2019 - 20

Name & Title	a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	e) All pension related benefits (bands of £2,500)	(f) Total (a to e) bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Matthew Kershaw Chief Executive and Place Based Leader for Health	215-220		10-15			230-235
Mike Sexton Chief Financial Officer	135-140				70-72.5	205-210
Elaine Clancy Chief Nurse.	130-135				0	130-135
Joshua Potter Director of Strategy & Transformation	110-115				30-32.5	140-145

Salary and pensions of senior managers

2018 - 19

Name & Title	a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	e) All pension related benefits (bands of £2,500)	(f) Total (a to e) bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston Chief Executive (retired 30 September 2018)	90 to 95	0	0	0	0	90 to 95
Matthew Kershaw Interim Chief Executive (appointed 1 October 2018)	105 to 110	0	0	0	0	105 to 110
Azara Mukhtar Director of Finance.	125 to 130	0	0	0	12.5 to 15	140 to 145
Jayne Black Deputy Chief Executive & Chief Operating Officer (resigned 19 April 2018)	5 to 10	0	0	0	0	5 to 10

Salary and pensions of senior managers

2018 - 19

Name & Title	a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	e) All pension related benefits (bands of £2,500)	(f) Total (a to e) bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Michael Burden Director of Human Resources & Organisational Development	120 to 125	0	0	0	0	120 to 125
Dr Nnenna Osuji Medical Director	200 to 205	0	0	0	47.5 to 50	250 to 255
Michael Fanning Director of Nursing, Midwifery and Allied Health Professionals	115 to 120	0	0	0	0	115 to 120
Lisa Chesser Director of Planning & Informatics (redundant 7 September 2018)	105 to 110	0	0	0	0	105 to 110
Melissa Morris Director of Operations (Planned) - (1 April 2018 to 30 November 2018), Acting Director of Business Development, Strategy & Performance - (1 December 2018 to present)	90 to 95	0	0	0	45 to 47.5	135 to 140
Sam Goldberg Director of Operations (Emergency) (resigned 3 February 2019)	85 to 90	0	0	0	0	85 to 90
Michael Bell Chairman	40 to 45	0	0	0	0	40 to 45
Godfrey Allen Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Dr James Gillgrass Non-Executive Directo.	5 to 10	0	0	0	0	5 to 10
Steven Corbishley Non-Executive Director (not remunerated)	NA	NA	NA	NA	NA	NA
Louise Cretton Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Jamal Butt Associate Non-Executive Director	5 to 10	0	0	0	0	5 to 10

Salary and pensions of senior managers

2018 - 19

Name & Title	a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	e) All pension related benefits (bands of £2,500)	(f) Total (a to e) bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Mike Bailey Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Hannah Miller Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Richard Oirschot Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Adam Womersley Non-Executive Director (not remunerated) (appointed 28 June 2018)	NA	NA	NA	NA	NA	NA

Pension benefits

2019 - 20

Name & Title	Real increase/ (decrease) in pension at pension age (bands of £2,500)	Real increase/ (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real increase/ (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's Contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Azara Mukhtar Director of Finance (on secondment from 1 January 2020)	0 to 2.5	-2.5 to 0	45 to 50	95 to 100	744	44	806	19
Mike Sexton Chief Financial Officer (appointed 1 November 2019)	2.5 to 5	0 to 2.5	40 to 45	90 to 95	678	76	771	19
Michael Burden * Director of Human Resources & Organisational Development	-12.5 to 15	-42.5 to -40	40 to 45	120 to 125	1,265	301	994	16

* To comply with the required reporting arrangements the pension sharing order has not been deducted from the figures shown.

Pension benefits

2019 - 20

Name & Title	Real increase/ (decrease) in pension at pension age (bands of £2,500)	Real increase/ (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real increase/ (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's Contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr Nnenna Osuji Medical Director	2.5 to 5	-2.5 to 0	55 to 60	120 to 125	902	61	984	27
Elaine Clancy Chief Nurse (appointed 1 May 2019)	-2.5 to 0	-2.5 to 0	35 to 40	95 to 100	655	7	677	19
Joshua Potter Director of Strategy & Transformation (appointed 18 November 2019)	0 to 2.5	0 to 2.5	20 to 25	35 to 40	222	23	250	15
Michael Fanning Director of Nursing, Midwifery and Allied Health Professionals (resigned 30 April 2019)	-2.5 to 0	-2.5 to 0	50 to 55	155 to 160	1,179	28	1,236	1
Melissa Morris Director of Business Development, Strategy & Performance (resigned 19 May 2019)	2.5 to 5	2.5 to 5	15 to 20	30 to 35	204	33	243	2

Pension benefits

2018 - 19

Name & Title	Real increase/ (decrease) in pension at pension age (bands of £2,500)	Real increase/ (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase/ (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's Contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
John Goulston Chief Executive	-5.0 to -2.5	-2.5 to 0	60 to 65	190 to 195	1,506	-1,540	0	13
Azara Mukhtar Director of Finance	0 to 2.5	-2.5 to 0	40 to 45	95 to 100	626	104	744	19
Dr Nnenna Osuji Medical Director	2.5 to 5	0 to 2.5	50 to 55	115 to 120	737	148	902	27
Jayne Black Deputy Chief Executive and Chief Operating Officer	-2.5 to 0	-5.0 to -2.5	50 to 55	150 to 155	1,063	84	1,171	1
Michael Burden Director of Human Resources & Organisation Development	0 to 2.5	0 to 2.5	50 to 55	155 to 160	1,1128	111	1,265	15
Lisa Chesser Director of Planning & Informatics	-5.0 to -2.5	0 to 2.5	10 to 15	0 to 5	179	-29	154	6
Michael Fanning Director of Nursing, Midwifery and Allied Health Professionals	0 to 2.5	0 to 2.5	50 to 55	150 to 155	1,042	113	1,179	17
Melissa Morris Director of Operations (Planned) and Acting Director of Business Development, Strategy & Performance	2.5 to 5.0	2.5 to 5.0	15 to 20	25 to 30	142	59	204	12

Pay multiples

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

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

This is shown in the table below:

	2019/20	2018/19
Band of Highest Paid Director's Total Remuneration	£230k to £235k	£210k to £215k
Median Total Remuneration of all staff	£27,846	£24,748
Remuneration Ratio	8.28	8.69
Number of employees who received remuneration in excess of the highest paid director	0	0
Remuneration for these staff ranged from:	NA	NA

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

Numbers of senior staff (by band)

The Trust employs the following senior staff in the organisation:

Band	2019/20 Headcount	2019/20 WTE	2018/19 Headcount	2018/19 WTE
Associate Specialist	12	10	13	12
Band 8A	156	147	143	134
Band 8B	54	54	44	44
Band 8C	23	22	20	18
Band 8D	17	17	16	16
Band 9	3	3	3	3
Consultant	211	193	208	192
Specialty Doctor	40	30	30	22
Staff Grade Practitioner	4	3	4	3
Very Senior Manager	9	9	6	6
Total	**531**	**488**	**487**	**450**

Staff costs

Band	Permanent £000	Other £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	141,140	6,298	147,438	129,242
Social security costs	15,807	289	16,096	14,715
Apprenticeship levy	724	0	724	675
Employer's contributions to NHS pensions	25,419	64	25,483	16,400
Temporary staff		31,510	31,510	38,385
Total gross staff costs	**183,090**	**38,161**	**221,251**	**199,417**
Of which Costs capitalised as part of assets		849	849	876

Staff numbers

We will only achieve delivery of our strategy by ensuring that we attract and retain the right people, working together to create a culture that enables us to learn and thrive.

In 2018/19 we employed a total of 4,030 permanent and temporary staff, up 3% from the previous year, in the following staff groups:

Staff grouping	2019/20 WTE	2018/19 WTE
Administration & Estates Staff	457	459
Healthcare Assistants & Other Support Staff	1,246	1,169
Medical and Dental	539	517
Nursing and Midwifery Registered	1,362	1,348
Scientific, therapeutic and technical staff	426	419
Grand Total	**4,030**	**3,912**

The gender mix of our directors, senior managers and staff was:

Trust Total	2019/20 %	2018/19 %
Female	78	79
Male	22	21
Grand Total	**4,030**	**3,912**

Director (Board level)	2019/20 Headcount	2019/20 %	2018/19 Headcount	2018/19 %
Female Executive	2	40%	3	50%
Male Executive	3	60%	3	50%
Female Non-Executive	2	25%	2	20%
Male Non-Executive	6	75%	8	80%
Total Female	4	31%	5	31%
Total Male	9	69%	11	69%
Total	**13**		**16**	

Ethnic Origin	2019/20 Headcount	2018/19 Headcount
Asian or Asian British	686	555
Black or Black British	982	849
Chinese	32	37
Filipino	18	7
Mixed	144	124
Other ethnic group	171	159
Unknown	485	583
White	1,385	1,361
Trust Total	**3,903**	**3,675**

TRUST-WIDE

Category	BME	White	Unknown
Trust workforce	52%	35%	12

AT BOARD LEVEL

Category	BME	White	Unknown
Directors	20%	40%	40%
Non Execs and Chair	13%	87%	0%

Sickness absence data

Information can be obtained from NHS digital site as per the link:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff disability policies

We embrace our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do. We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve.

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

These include:

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

Reasonable adjustments might include but not limited to:

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

Expenditure on consultancy

Throughout the year consultants were hired to undertake work in relation to staffing strategy and theatre implementation. The Trust also recruited consultants to undertake an in depth critical analysis of Trust strategy, the total spend on consultancy was £0.6m.

Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months	2019/20 Number	2018/19 Number
Number of existing engagements as of 31 March 2020	4	11
Of which, the number that have existed:		
For less than one year at the time of reporting	2	5
For between one and two years at the time of reporting	0	3
For between 2 and 3 years at the time of reporting	1	0
For between 3 and 4 years at the time of reporting	0	1
For 4 or more years at the time of reporting	1	2

New off-payroll engagements

All new off-payroll engagements or those that reached six months in duration, between 1 April 2019 and March 2020, for more than £245 per day and that last for longer than six months.

	2019/20 Number	2018/19 Number
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1	9
Of which No. assessed as caught by IR35	0	0
No. assessed as not caught by IR35	1	9
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0	0
No. of engagements reassessed for consistency / assurance purposes during the year	0	0
No. of engagements that saw a change to IR35 status following the consistency review	0	0

Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

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

Exit packages

	2019/20						2018/19					
	Compulsory Redundancies		Other Departure		Total		Compulsory Redundancies		Other Departure		Total	
	No.	£000	No.	£000	No.	£000	No.	£000	No.	£000	No.	£000
Exit package cost band (including any special payment element)												
<10,000	0	0	0	0	0	0	2	13	0	0	2	13
£10,000 - £25,000	0	0	0	0	0	0	1	19	0	0	1	19
£25,001 - £50,000	0	0	0	0	0	0	2	67	0	0	2	67
£50,001 - £100,000	0	0	0	0	0	0	3	215	0	0	3	215
£100,001 - £150,000	0	0	0	0	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0	0	0	0	0
Total by type	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**314**	**0**	**0**	**8**	**314**

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

	2019/20 Payment agreed		2018/19 Payment agreed	
	No.	£000	No.	£000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**0**	**0**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary.	**0**	**0**	**0**	**0**

Counter Fraud

The Trust's management takes seriously the potential threat and losses associated with possible fraudulent activity. The Trust has complied with the Secretary of State's Directions on countering fraud in the NHS and nominated a professionally accredited Local Counter Fraud Specialist (LCFS) who undertakes a programme of work designed to raise awareness amongst staff of possible fraud and to carry out investigations of any suspicions of fraud. LCFS provide reports to each Audit Committee of the progress of on-going investigations.

The annual work plans of our LCFS cover a wide range of activities and follow the recommended plans produced by NHS Protect. Included within these plans are specific exercises, known as proactive reviews, which seek to identify the risk of fraud. Our LCFS has undertaken a number of these exercises under the direction and overall management of NHS Protect.

Our staff are encouraged, through the Trust's counter fraud and whistleblowing policies, to raise and refer any concern about fraud to the LCFS who will undertake an appropriate investigation. This encouragement is reinforced through the regular awareness presentations given by the LCFS to Trust staff.

Modern Slavery Act Annual Statutory Statement 2019/20

Croydon Health Services NHS Trust is committed to ensuring modern slavery or human trafficking does not take place in any part of our business or our supply chain. The Trust supports and complies with the Government's objectives to combat modern slavery and understands the significant role the NHS has to play in supporting victims. This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015.

Who we are

Croydon Health Services NHS Trust is an organisation providing acute and community health services across the largest London Borough, with a population of over 380,000 residents. The Trust employs over 3,900 staff and has a dedicated team of 400 volunteers. More than a third of our staff work within our community services, alongside our partners in primary care and social services, to care for our diverse community in and out of hospital. The Trust runs two hospital sites covering both north and south of the borough: Croydon University Hospital is our main hospital and includes one of busiest Emergency Departments in South London. Our community services include nursing, health visiting, podiatry, MSK, home therapies, LIFE, school nursing, homeless health, sexual health and Children's Hospital at Home.

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

Policies and initiatives

The Trust provides a programme of advice and training on slavery and human trafficking in respect of adults and children. Through our Safeguarding Team, front line staff can access guidance and advice to ensure they are aware of and are able to respond to potential incidents of modern slavery within care settings. There are Trust wide policies for safeguarding adults and children which were ratified in July 2017. Flow charts are available throughout the wards to help staff identify and escalate concerns. We have improved our level 2 safeguarding adults training from 63% in 2017 to 88% in 2018 and are looking to reach our target of 90% this year.

People

The Trust adheres to the National NHS Employment Checks / Standards which includes employees UK address, right to work in the UK and suitable references. The Trust follows NHS Agenda for Change Terms and Conditions which provides staff with fair pay rates and contractual terms. Our Dignity at Work, ABC, Grievance, Whistleblowing and Freedom to Speak Up policies provide additional platforms for staff to raise concerns. Trust activities and polices are required to have an Equality Impact Assessment completed. During our CQC inspection in July 2018, inspectors confirmed they saw excellent supervision arrangement in our Community Hospital at Home Team and staff were supported with their safeguarding cases. Staff spoken to knew how to recognise abuse and how to report it.

Procurement & Supply Chain

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

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

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

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

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 entitiy's auditors are aware of that information.

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

Matthew Kershaw

Chief Executive and Place Based Leader of Health

Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board.

Matthew Kershaw

Chief Executive and Place Based Leader of Health

Mike Sexton

Chief Finance Officer

FINANCIAL REPORT

FINANCIAL REPORT

Croydon Health Services (CHS) and Croydon Clinical Commissioning Group (CCCG) have been working together throughout 2019/20 to increase alignment and to deliver place based care to the Croydon population, while improving the quality of care and returning the system to financial balance.

This has allowed both organisations to move from transactional arguments about money to transformational delivery of quality and service changes for the benefit of patients. At the latter end of the Financial Year, the COVID-19 Pandemic situation has introduced new challenges for the Croydon System in 2020/21 but it is important to recognise the achievements and progress that CHS made with partner organisations in 2019/20.

The two organisations (as the Croydon System) agreed a Joint Control Total for 2019/20 with a Risk Share. The Joint Control Total was achieved and is a pleasing result.

In addition, CHS achieved its Financial Control Total of £13.2m deficit before Central Funds and a small surplus of £0.4m after accounting for Central Funds. The Trust also achieved compliance with other financial targets which are summarised in the Financial Review 2019/20 section.

We all want to see sustainable Croydon Health Services that can meet the health needs of our growing community. To do this, we have to work smarter within the existing resources we have and CHS seeks to make continual improvement in the use of financial resources in each year as an essential feature of its sustainability strategy. In 2019/20, Cost Improvements of over £11m were delivered, helping the Trust to deliver services the population of Croydon within available financial resources.

To achieve these improvements, we have worked with our staff to help us make the right choices, asking for their suggestions on how we could save money or reduce waste - without impacting on the quality of our care. All cost saving initiatives are quality assessed by the Trust's most senior clinicians to ensure that our standards of safety and performance are maintained.

Capital Investments of £9.3m were made during the year, improving the hospital environment, facilities, IT and medical equipment.

In common with other NHS Trusts, almost two thirds of the Trust's overall expenditure budget is spent on staffing. In 2019/20, we spent £1.1m more on agency and locum staff compared to 2018/19. Recruitment of staff continues to be a focus for the Trust, with a large number of (circa 80) overseas nurses joining the Trust in 2019/20 and more planned to join in 2020/21.

Our accounts

The Trust prepares its accounts in accordance with International Financial Reporting Standards (IFRS). There have been no significant amendments to the accounting standards in 2019/20 and HM Treasury requirements, so our accounting policies remain largely unchanged.

In 2019/20, the Trust achieved most of its annual financial targets. The Trust achieved a surplus of £0.4m 2019/20 after application of central funds against a breakeven target (£12.8m deficit before central funds). This includes additional funding of £1.6m from NHSI for COVID-19 pandemic in M12.

Going Concern

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

In 2019/20, the Trust did not ask for cash support from the DHSC and have a strong closing cash balance of £17.3m. The Trust has a reasonable expectation that adequate resources, from a cash perspective, will be available to continue in operation for at least 12 months from the date of preparation of the 2019/20 accounts.

Although the COVID-19 situation has introduced material uncertainties to the balance sheet, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

2020/21 Outlook

In response to the COVID-19 situation, The Department of Health and Social Care has made temporary changes to the NHS funding regime in 2020/21. As a result of these changes, the Trust has been allocated cash funding for the first 4 months of 2020/21.

This is based on the following principles:

- Block contracts would be agreed with NHS providers to cover the period 1 April to 31 July; and
- A national top-up payment will be provided to providers to reflect the difference between the actual costs and the income from the block contracts
- COVID-19 expenditure (revenue and capital) to be claimed monthly from March
- Commissioner allocations for 2020/21 had already been notified as part of the operational planning and will not be changed

- For hospital discharge - £1.3bn allocated to CCGs / £1.6bn allocated to councils. Croydon's share is £8.5m and £9.4m respectively.

Financial planning for the remainder of 2020/21 will be in accordance with further DHSC directions when these are available.

Prior to the suspension of the 2020/21 planning process, the Trust faced a significant challenge to manage its cost based within the funding available. A combination of historic savings not achieved, cost pressures and new efficiency requirements, create a £17m (5%) efficiency requirement. The size of this challenge, alongside pressures in the care system, cannot be under estimated. Clinically led service redesign to address the run rate issue will commence as soon as practicable.

Financial Review 2019/20

The table below sets out Croydon Health Services NHS Trust's financial targets, and its performance against these, in the 2019/20 Financial Year:

Metric	Target	Performance	Target met?
Croydon System (CHS and Croydon CCG) Joint Control Total	£2.1m surplus (adjusted)	£2.6m surplus	✓
Breakeven on revenue and operating costs		After £6.4m support from the Croydon NHS risk share agreement, the Trust posted the following:	✓
Control Total (Pre PSF/MRET)	£13.2m deficit	£13.2m deficit	✓
Financial Performance (Breakeven Duty)	£0.6m	£1.0m surplus	✓
Financial Performance (in-year)	Breakeven	£0.4m surplus	✓
Keep within the capital resource limit (CRL)			
CRL (excl COVID-19)	£9.3m	£9.3m	✓
CRL (incl COVID-19)	£9.5m	£9.5m	✓
Remain within the external financing limit (EFL)	£1.6m	Favourable self-financing by £17.8m	✓
Keep within a Capital Cost Absorption Rate (CCAR)	3.50%	The Trust kept within the 3.5% CCAR. This has resulted in dividend payments of £1.147m to the Department of Health and Social Care	✓
Cost Improvement Programme	£14.8m	£11.8m incl £5.3m non-recurrent	✗
Public Sector Payment Policy	95%	72%	✗

Where our money comes from

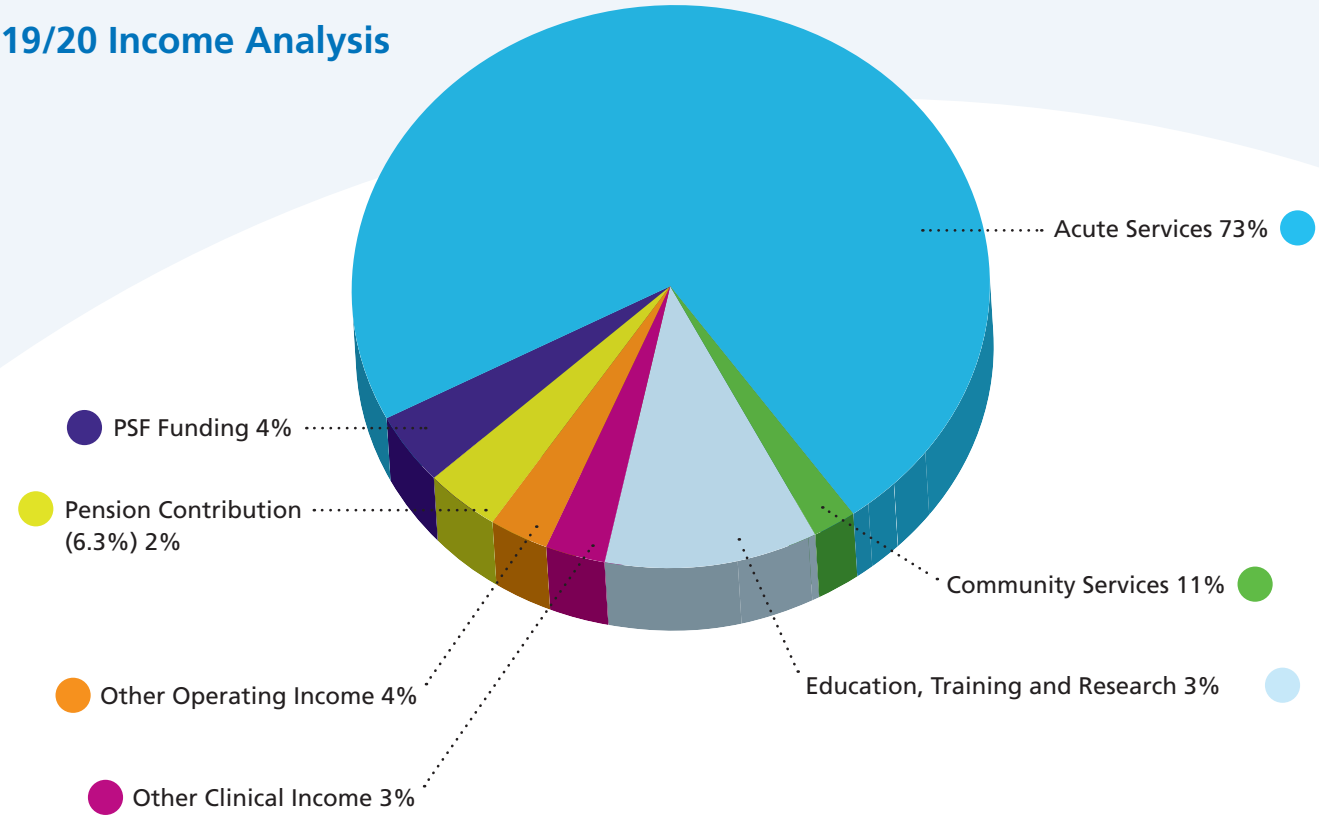
The Trust's total income has grown by 8.3% to £345.4m, due to significantly increased in activity (from 2018/19), as well as additional Croydon CCG riskshare of £6.4m, Pension funding increase of £7.7m and £1.6m of funding for COVID-19.

The revenue generated from NHS and non NHS clinical activity is £290.9m. This principally comes from the following sources of income: CCGs for delivery of acute and community patient care activities, NHS England for specialised services and local authorities for acute and community services. There are a number of other income sources such as the Education and Training income that pays for the training of doctors, nurses and other healthcare professionals – which, in doing so, supports the quality of the care we provide. The remainder of the Trust's income sources are not directly linked to patient care and include items such as catering, accommodation revenues and income for services provided to other third parties.

Income is classified as follows:

Income	%	£000
Acute Services	73	254,415
Community Services	11	36,529
Education, Training and Research	3	10,856
Other Clinical Income	3	8,818
Other Operating Income	4	14,778
Pension Contribution (6.3%)	2	7,737
PSF Funding	4	13,209
	100	346,342

2019/20 Income Analysis



What we spend money on

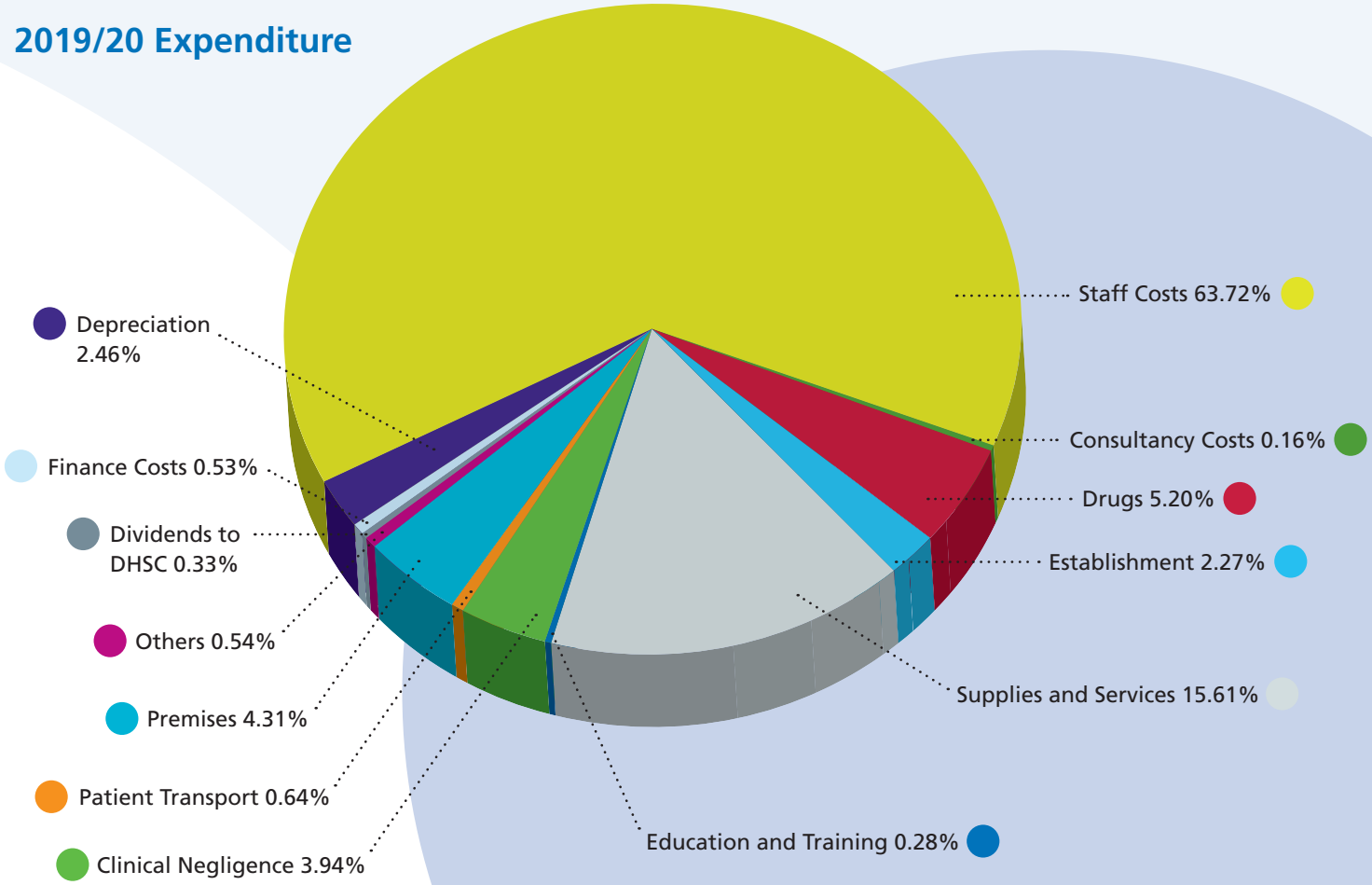
Our Trust's total expenditure in the year was £345.9m - an increase of £26.2m (8.2%) from the previous financial year. The key drivers for the increase are pay, linked with escalation beds and enhanced care being above plan. There has also been an initiative to increase planned care activity in Croydon, resulting in an increase in both pay and non-pay costs. In addition, bad debt provision for overseas visitors and equal pay provision also increased the overall spend.

Staff costs are the largest component of expenditure, accounting for 62% of operating expenses followed by supplies and services for clinical and drugs costs. As part of the efficiency scheme, the Trust was required to deliver £14.3m of Efficiency saving in 2019/20. A detailed programme of schemes across all divisions has been monitored throughout the year with reports to the Financial Improvement & Transformation Board. The programme is a combination of schemes identified by divisions and Trust-wide initiatives.

The spend is summarised as follows:

Expenditure	%	£000
Staff Costs	63.72	220,402
Consultancy Costs	0.16	566
Drugs	5.20	17,999
Establishment	2.27	7,859
Supplies and Services	15.61	53,989
Education and Training	0.28	980
Clinical Negligence	3.94	13,612
Patient Transport	0.64	2,226
Premises	4.31	14,911
Others	0.54	1,872
Dividends to DHSC	0.33	1,147
Finance Costs	0.53	1,842
Depreciation	2.46	8,492
	100	345,897

2019/20 Expenditure



Capital investment

The Trust capital investment strategy is focusing on supporting operational challenges while ensuring there is sufficient investment to deliver the longer-term ambitions which will require securing innovative funding sources to support delivery of our clinical and digital innovations.

There are multiple pressures which require careful management to ensure scarce capital is invested wisely. Our investment priorities are primarily centred around:

- Business continuity - where capital schemes are required to ensure that the Trust is able to operate 'business as usual' in the event of a current or predicted failure of equipment, system failure etc.
- CQC requirements - where the Trust is in danger of failing to meet CQC standards on clinical care, patient safety etc.
- Invest to save - a scheme may be approved if it can demonstrate that it will deliver savings or generate revenue sufficient to cover its capital cost within three years and will continue to create savings/revenue in subsequent years.

The Trust invested £9.5m including COVID-19 spend of £0.2m (2018/19: £14.0m) in its capital programme in 2019/20 of which £3.1m on Estates, £4.2m on IT infrastructure, £2.3m on medical equipment.

The capital programme was funded by £7.6m of the Trust's own internally generated resources, £0.2m donations and grants, and £1.7m PDC funding from Department of Health and Social Care (DHSC).

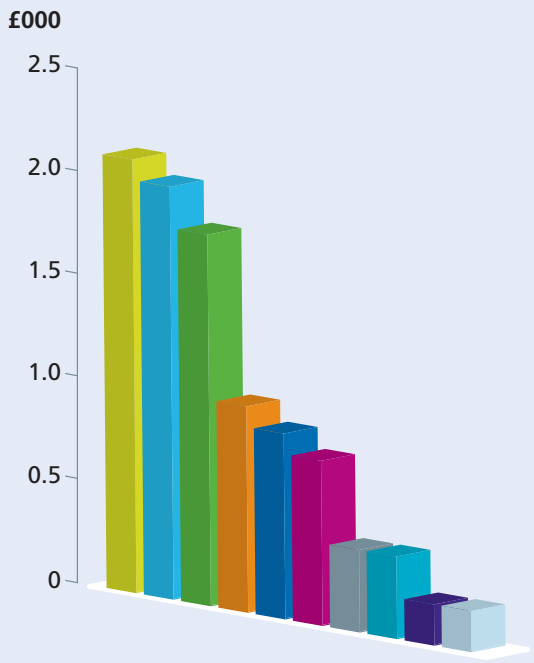
The Trust continues to make substantial capital investments to improve the ward environment to benefit patients, visitors and staff and to address the mechanical, electrical and infrastructure risks to improve the efficiency and security of patient data and to deliver excellent patient care.

The basis of the Estates capital works has always been to alleviate backlog maintenance issues, reduce risks associated to the estate and its infrastructure, ensure compliance to current guidance and standards (including legislative and CQC required works), spend to save schemes and to provide service improvements as directed by the Trust strategy. In 2019/20 £3.1m was spend in Estates and one of the notable project is modernising and expansion of the paediatric services to create an excellence care for the future generation and the project is expected to complete by 2020/21.

£1.3m capital PDC funding from DHSC was spent on modernising and enhancement of NHS digital programme for inventory management system, cyber resilience and heath service lead investment (HSLI). The Trust also received £0.4m grants from NHS England to invest in estates technology and transformation (ETTF). The Trust also spent £1.2m on intangible assets, mostly software licences and applications upgrade. Other spends of £1.6m on IT rolling replacement for desktop equipment, Cerner upgrade and back end infrastructure to enhance cyber security and minimise cyber-attack vulnerability, receiving digital medical information, faster processing data that makes the back office runs more efficiently.

The Trust spent £0.8m on X-ray equipment, theatre equipment, ultrasound units, bladder scan, theatre stack and scopes. There is a continuous plan to upgrade endoscopy unit over the coming years and for this current year £0.4m has been spent on this equipment and this has been managed efficiently to provide good quality care of patients at least cost. Investing in modern medical devices is essential to improve the diagnosis and treatment and care of patients.

The capital programme for 2020/21 continues with the on-going investment in patient care and well-being mostly from self-funded capital programme. These have been scored and prioritised based on patient safety and risk to develop a programme for the Trust for the coming year. Outside of the Trusts internally generated capital programme the Trust continues to work with the local Croydon Estates Board and other SWL Trusts as part of the STP to develop Outline Business Cases for Critical Care and Theatre refurbishments as part of the wider refreshed STP Estates Strategy for South West London.



Notable 2019/20 Capital

IT infrastructure/application refresh	2.1
Other IT projects	2.0
Other backlog maintenance	1.8
Other medical devices	1.0
Paediatric Unit	0.9
X-ray, theatre equipment	0.8
Endoscopy	0.4
LED lighting	0.4
COVID-19	0.2
Cerner Upgrade	0.2

FINANCIAL STATEMENTS AND ACCOUNTS

Summary of 2019/20 financial performance

The table below sets out Croydon Health Services NHS Trust's financial targets, and its performance against these, in the 2019/20 Financial Year:

Metric	Target	Performance	Target met?
Croydon System (CHS and Croydon CCG) Joint Control Total	£2.1m surplus (adjusted)	£2.6m surplus	✓
Breakeven on revenue and operating costs		After £6.4m support from the Croydon NHS risk share agreement, the Trust posted the following:	✓
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Financial Performance (Breakeven Duty)	£0.6m	£1.0m surplus	✓
Financial Performance (in-year)	Breakeven	£0.4m surplus	✓
Keep within the capital resource limit (CRL)			
CRL (excl COVID-19)	£9.3m	£9.3m	✓
CRL (incl COVID-19)	£9.5m	£9.5m	✓
Remain within the external financing limit (EFL)	£1.6m	Favourable self-financing by £17.8m	✓
Keep within a Capital Cost Absorption Rate (CCAR)	3.50%	The Trust kept within the 3.5% CCAR. This has resulted in dividend payments of £1.147m to the Department of Health and Social Care	✓
Cost Improvement Programme	£14.8m	£11.8m incl £5.3m non-recurrent	✗
Public Sector Payment Policy	95%	72%	✗

Further copies of these accounts can be obtained from:

PA to the Director of Finance
Croydon Health Services NHS Trust
530 London Road
Croydon
CR7 7YE

Tel: 020 8401 3563

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	306,869	284,017
Other operating income	4	38,537	34,827
Operating expenses	6, 8	(341,289)	(349,750)
Operating surplus/(defict) from continuing operations		**4,117**	**(30,906)**
Finance income	11	144	84
Finance expenses	12	(1,842)	(1,864)
PDC dividends payable		(1,147)	(2,508)
Net finance costs		**(2,845)**	**(4,288)**
Other gains	13	1,356	2,210
Surplus/(deficit) for the year from continuing operations		**2,628**	**(32,984)**
Surplus/(deficit) for the year		**2,628**	**(32,984)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments charge to revaluation reserves	7	7,832	(44,468)
Revaluations charge to revaluation reserves	17	440	505
Total comprehensive income/expenditure for the period		**10,900**	**(76,947)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		2,628	(32,984)
Remove net impairments not scoring to the Departmental expenditure limit		(1,721)	34,564
Remove I&E impact of capital grants and donations		102	(73)
Adjusted financial performance surplus (breakeven duty):		**1,009**	**1,507**
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(564)	0
Adjusted financial performance surplus (including PSF, FRF and MRET funding)		**445**	**1,507**
Adjusted financial performance surplus (including PSF, FRF and MRET funding)		**445**	**1,507**
Less: PSF, FRF and MRET funding		(13,209)	(16,562)
Less: other gains		(1,356)	0
Add: COVID-19 annual leave accrual		918	0
Adjusted financial performance deficit (excluding PSF, FRF and MRET funding) for control total basis		**(13,202)**	**(15,055)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	2,030	487
Property, plant and equipment	15	179,316	169,626
Receivables	20	1,541	1,008
Total non-current assets		**182,887**	**171,121**
Current assets			
Inventories	18	2,833	2,662
Receivables	20	21,934	33,516
Cash and cash equivalents	21	17,341	5,832
Total current assets		**42,108**	**42,010**
Current liabilities			
Trade and other payables	22	(44,039)	(38,887)
Borrowings	24	(103,582)	(57,024)
Provisions	26	(4,070)	(5,445)
Other liabilities	23	(2,332)	(1,042)
Total current liabilities		**(154,023)**	**(102,398)**
Total assets less current liabilities		**70,972**	**110,733**
Non-current liabilities			
Borrowings	24	0	(52,994)
Provisions	26	(1,160)	(556)
Total non-current liabilities		**(1,160)**	**(53,550)**
Total assets employed		**69,812**	**57,183**
Financed by			
Public dividend capital		117,609	115,880
Revaluation reserve		60,924	53,722
Income and expenditure reserve		(108,721)	(112,419)
Total taxpayers' equity		**69,812**	**57,183**

The notes on pages 88 to 123 form part of these accounts.

Matthew Kershaw

Chief Executive and Place Based Leader of Health

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,117	(30,906)
Non-cash income and expense:			
Depreciation and amortisation	6	8,492	8,398
Net impairments	7	(1,721)	34,564
Income recognised in respect of capital donations	4	(244)	(449)
(Increase) / decrease in receivables and other assets		9,758	(11,619)
(Increase) / decrease in inventories		(171)	88
Increase / (decrease) in payables and other liabilities		4,894	1,863
Increase / (decrease) in provisions		(768)	3,379
Other movements in operating cash flows		0	(168)
Net cash flows from operating activities		**24,357**	**5,150**
Cash flows from investing activities			
Interest received		144	84
Purchase of intangible assets		(1,757)	(15)
Purchase of PPE and investment property		(6,427)	(15,160)
Sales of PPE and investment property		1,356	4,000
Receipt of cash donations to purchase assets		244	449
Net cash flows used in investing activities		**(6,440)**	**(10,642)**
Cash flows from financing activities			
Public dividend capital received		1,729	1,139
Movement on loans from DHSC		(6,370)	11,619
Interest on loans		(1,889)	(1,815)
Interest paid on finance lease liabilities		(22)	(27)
PDC dividend (paid) / refunded		143	(4,025)
Net cash flows from / (used in) financing activities		**(6,408)**	**6,891**
Increase in cash and cash equivalents		**11,509**	**1,399**
Cash and cash equivalents at 1 April - brought forward		**5,832**	**4,433**
Cash and cash equivalents at 31 March	21	**17,341**	**5,832**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**115,880**	**53,722**	**(112,419)**	**57,183**
Surplus for the year	0	0	2,628	**2,628**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	0	0	0	**0**
Other transfers between reserves	0	(1,070)	(1,070)	**0**
Impairments	0	7,832	0	**7,832**
Revaluations	0	440	0	**440**
Public dividend capital received	1,729	0	0	**1,729**
Taxpayers' and others' equity at 31 March 2020	**117,609**	**60,924**	**(108,721)**	**69,812**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**114,741**	**99,982**	**(81,732)**	**132,991**
Surplus/(deficit) for the year	0	0	(32,984)	**(32,984)**
Other transfers between reserves	0	(1,199)	1,199	**0**
Impairments	0	(44,468)	0	**(44,468)**
Revaluations	0	505	0	**505**
Transfer to retained earnings on disposal of assets	0	(1,098)	1,098	**0**
Public dividend capital received	1,139	0	0	**1,139**
Taxpayers' and others' equity at 31 March 2019	**115,880**	**53,722**	**(112,419)**	**57,183**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

NOTES TO THE ACCOUNTS

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.2 Going concern

As directed by the 2019/20 Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements. It is important to note financial sustainability is a material uncertainty to the going concern assumption.

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

In preparing the financial statements the Directors have considered the Trust's overall financial position and expectation of future financial support. In particular, the Trust relied on non-recurrent funding and savings in 2019/20 which has contributed to the £17.2m (5%) efficiency challenge in 2020/21, in addition to the £16.4m financial support required to deliver the Trust's financial plans in 2020/21.

Whilst some schemes, totalling £9.8m of potential savings, are identified to meet this efficiency challenge, and there is temporary financial relief during the COVID Response, there is every expectation that the Trust will be required to address the underlying run rate issues that existed pre-COVID. Achievement of the Trust's 2020/21 financial plans requires delivery of ambitious budgets and a challenging Cost Improvement Programme. If the Trust's financial deficit is greater than planned in 2020/21 then further cash support will need to be provided through established mechanisms. Confirmation of such support has not been requested or confirmed.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements.

Note 1.3 Interests in other entities

Risk share arrangement with Croydon CCG
In 2019/20, Croydon CCG and Croydon Health Services NHS Trust entered into a novel financial risk share arrangement that pooled the financial resources of both organisations – creating a joint budget with a joint financial target ("joint control total") for the Croydon health system. This was further underpinned by joint governance arrangements and joint executive appointments (Note 19.1).

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.

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

The Croydon Health Services Charitable Fund is the only subsidiary of the Trust. The Trust Board is the Corporate Trustee. The value of the Trust's charitable funds is £1.25m; because the value of the funds are not material the Trust has not consolidated these in to its annual accounts on the basis of materiality (Note 19.3).

Joint operations

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

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

The operation is under joint control: its board is made up of the three chief executives and finance directors of each trust, none of whom have overall authority, ownership is divided based on expected usage: Croydon University Hospitals NHS Trust 25.8%; Kingston NHS Foundation Trust 27.5%; St George's University Hospitals NHS Foundation Trust 46.7%.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

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

Revenue from NHS contracts

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

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

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

Note 1.6 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Local Government Pension Scheme
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.
The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income.

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, these components are treated as separate assets and depreciated over their useful economic lives. The components, such as fittings, form part of the modern equivalent asset

(MEA) building values within the elemental Depreciated Replacement Cost (DRC) approach under Royal Institute of Chartered Surveyors (RICS) mandatory rules on valuations.

Subsequent expenditure

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

Measurement

Valuation

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

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

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

- Land and non-specialised buildings - market value for existing use.

There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Their basis of valuation is however current value in existing use, having regard to comparable market evidence and early commentary as it exists regarding direction of travel tends to suggest and support a downward movement in value. It is too early at this stage to accurately evidence this impact and it is the DV opinion at the date of valuation on the information then available that the assessed impact falls within normal valuation tolerances.

- Specialised buildings - depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

There has been no diminution identified in the public sector's ongoing requirement for thee operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Regarding the BCIS cost indices, BCIS have stated that they consider new construction output is likely to fall in 2020 as a result of the COVID-19 outbreak, as it affects labour availability on sites and delays or leads to cancellation of projects in the pipeline. However, at the present time, BCIS have advised that it is too early for COVID-19 related issues to impact on BCIS indices published and adopted in this valuations.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

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

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

Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset.

The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	NA	NA
Buildings, excluding dwellings	5	87
Dwellings	15	71
Plant & machinery	1	15
Transport equipment	1	5
Information technology	1	9
Furniture & fittings	1	15
COVID-19 spend	1	2

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

Note 1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset.

The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	1	8
Software licences	5	7

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

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

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

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

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

Financial assets and liabilities are classified as subsequently measured at amortised cost.

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

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

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

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust does not hold any financial assets at fair value through other comprehensive income or financial liabilities held for trading.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust does not hold any financial assets at fair value through other comprehensive income or financial liabilities held for trading.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

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

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

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

Derecognition

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

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

Note 1.13 Leases

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

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in

the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

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

Note 1.14 Provisions

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

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years, up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates.

The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Nominal rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discounted rate of 1.27%.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.1 but is not recognised in the Trust's accounts.

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

Note 1.15 Contingencies

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

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated and grant funded assets

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

(iii) any PDC dividend balance receivable or payable.

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

Note 1.17 Value added tax

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

Note 1.18 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Note 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. [For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset

value and the calculated lease liability will be recognised in the income and expenditure reserve on transition]. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

The finance team has collated a lease register indicates that 19 of the existing contracts need to be reviewed. They are, 11 for Estates (rental), 4 for medical equipment, 3 lease vehicles and 1 peppercorn lease. The Trust will continue to monitor and update the lease register toward the transaction period in 2021/22.

The trust has estimated the impact of applying IFRS 16 in 2020/21 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2021 statement of financial position	
Additional right of use assets recognised for existing operating leases	8,090
Additional lease obligations recognised for existing operating leases	0
Net impact on net assets on 1 April 2021	**8,090**
Estimated in-year impact in 2021/22	
Additional depreciation on right of use assets	(1,429)
Additional finance costs on lease liabilities	(73)
Lease rentals no longer charged to operating expenditure	1,490
Estimated impact on surplus / deficit in 2021/22	**(12)**
Estimated increase in capital additions for new leases commencing in 2021/22	**0**

The District Valuer (DV) carried out a revaluation on Purley Hospital land which is a peppercorn lease. The Trust may need to revisit the valuation due to the Global Pandemic. The pandemic will have a major impact on its current value and volatility in the real estate market in the future.

IFRS 17 Insurance contracts
The effective date for adoption of IFRS 17 is 2023/24. Work has not yet started on understanding its impact in the NHS unless work has been undertaken as requested by NHS England and NHS Improvement.

Note 1.25 Critical judgements in applying accounting policies

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

Going concern (see note 1.2)
The Trust assumed to be going concerns where the services currently provided will continue to be provided in the foreseeable future, as evidenced by inclusion of financial provision for that service in published documents.

Non consolidation of charity accounts (see note 1.3)
The Trust does not consolidate the charity accounts on the basis of materiality.

Finance leases (see note 1.14)
The Trust has made a critical judgement regarding the treatment of asset that is finance lease. This finance lease asset relates to equipment used by the Trust.

Financial Instruments (see note 1.13)
IFRS 9 contains new requirements for the classification, measurement and derecognition of financial assets and liabilities, replacing the recognition and measurement requirements in IAS 39.

Revenue from contracts with customers (note 1.4)
IFRS 15 supersedes the current revenue recognition standards including IAS 18 Revenue, IAS 11 Construction Contracts and their related interpretations. Although IFRS 15 is principles based, it is a significant change from the previous revenue requirements and involves new judgements and estimates as revenue is recognised when control of a good or service transfers to a customer, or on satisfaction of performance obligations under contracts, which replaced the previous notion of risks and rewards.

Note 1.26 Sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised

in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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

Asset Lives - Note 14 and 15
The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and physical asset verification exercises. The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and physical asset verification exercises.
The minimum and maximum estimated economic lives of each class of asset are disclosed in note 1.8 and 1.9, and the carrying values of property, plant and equipment and intangible assets in notes 15 and 14 respectively. The minimum and maximum estimated economic lives of each class of asset are disclosed in note 1.7.5 and 1.8.3, and the carrying values of property, plant and equipment and intangible assets in notes 15 and 14 respectively.

Land and Buildings Valuations - Notes 1.8 and 15
The revaluation of the hospital has been carried out by District Valuer (DV), who have applied the modern equivalent asset valuation. This approach assumes that these services could theoretically be provided from Croydon hospital site and providing the same services but from an optimised smaller footprint (reduced Gross Internal Area [GIA], which would occupy less land) with specialist healthcare that are currently available within this location.

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

Overall the asset values have appreciated by £9.6m (9%) as compared to the last financial year. The appreciation is simply due to the increase in building costs derived from the Building Information Cost Service (BICS) indices, which is applied in depreciated replacement cost (DRC) valuation. The indices highlight significant build cost inflation relates to a particular economic position the construction sector maybe in at one point in time, rather than just the general economy. Factors which have an major impact on building costs include material prices, the weakness of the pounds, wage inflation, immigration policies and skill shortages.

The valuation report is dated 2 April 2020, and in particular in section 21 refers to the uncertainty created by the COVID-19 Pandemic. The valuations are therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty - and a higher degree of caution - should be attached to the valuation than would normally be the case.

The valuation report does not provide a potential scale of the uncertainty and includes factors which might lead to a higher as well as lower valuation. The assessed value of the buildings is £126.5m. The impact of a 5% change would be to change the PDC dividend by £0.11m in 2019/20 based on the closing value of assets. The impact in 2020/21 would be a change in depreciation of £0.2m as well as £0.06m change in PDC dividend based on the opening value of assets.

Provision for Impairment of Receivables - Note 20.1
Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. Due to COVID-19, the Trust has prudently increased the provision for overseas visitor's debt (>60 days). The Trust follows the guidance issued in the 2019/20 Department of Health Group Accounting Manual in relation to the recommended rate for Injury Cost Recovery receivables. Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The Trust follows the guidance issued in the 2018/19 Department of Health Group Accounting Manual in relation to the recommended rate for Injury Cost Recovery receivables.

Accruals & Deferred Income (Note 22 and 23)
Accruals are measured at the Directors' best estimate of the expenditure required to settle the obligation for goods and services acquired at the Statement of Financial Position (SoFP) date. Deferred income is measured at the Directors' best estimate of the income to be recognised after the SoFP date for payments received for goods and services provided before the SoFP date.

As per the Trust's policy, in normal circumstances no annual leave can be carried forward to the next financial year. Usually, unutilised leave would be forfeited. However due to the pandemic, annual leave for staff has been cancelled in order to fully support the response. The Trust has estimated the increase in annual leave carried-forward at £918k has been accrued for this purpose.

NHS Resolution member provisions: (Note 26)
These provisions are subject to future outcome of litigation in progress. The probabilities provided by the NHS Resolution have been used to calculate the provision.

Note 2 Operating Segments

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the chief operating decision maker within the Trust. It is only at this level that revenues are reported and the overall financial and operational performance of the Trust is assessed.
The Trust's income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups (CCGs) and NHS England. This accounts for 84% of the Trust's total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4. The Trust undertakes income generation activities with an aim of achieving surplus, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Elective income	27,004	26,540
Non elective income	84,877	78,548
First outpatient income	28,813	18,660
Follow up outpatient income	25,101	20,503
A&E income	30,851	23,718
High cost drugs income from commissioners (excluding pass-through costs)	7,528	8,012
Other NHS clinical income	50,241	56,686
Community services		
Community services income from CCGs and NHS England	30,771	31,970
Income from other sources (e.g. local authorities)	5,758	10,504
All services		
Private patient income	460	329
Agenda for Change pay award central funding*		2,830
Additional pension contribution central funding**	7,737	**0**
Other clinical income	7,728	5,717
Total income from activities	**306,869**	**284,017**

* Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	30,996	21,793
Clinical commissioning groups	259,311	244,026
Department of Health and Social Care	0	2,830
Other NHS providers	2,765	3,084
Local authorities	11,539	10,504
Non-NHS: private patients	461	329
Non-NHS: overseas patients (chargeable to patient)	976	446
Injury cost recovery scheme	821	1,005
Non NHS: other	0	0
Total income from activities	**306,869**	**284,017**
Of which:		
Related to continuing operations	306,869	284,017
Related to discontinued operations	0	0

*** Additional information on revenue from contracts with customers recognised in the period.

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

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

	2019/20 £000	2018/19 £000
Income recognised this year	976	446
Cash payments received in-year	288	173
Amounts added to provision for impairment of receivables	1,268	33
Amounts written off in-year	582	145

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	501	0	**501**	619	0	**619**
Education and training	10,355	237	**10,592**	10,168	55	**10,223**
Non-patient care services to other bodies	3,262		**3,262**	3,278		**3,278**
Provider sustainability fund (PSF)	7,250		**7,250**	16,562		**16,562**
Financial recovery fund (FRF)	2,251		**2,251**			
Marginal rate emergency tariff funding (MRET)	4,272		**4,272**			
Receipt of capital grants and donations		244	**244**		449	**449**
Charitable and other contributions to expenditure		243	**243**		96	**96**
Rental revenue from operating leases		1,285	**1,285**		1,241	**1,241**
Other income*	2,238	6,400	**8,638**	2,359	0	**2,359**
Total other operating income	**30,128**	**8,409**	**38,537**	**32,986**	**1,841**	**34,827**
Of which:						
Related to continuing operations			**38,537**			**34,827**

* £6.4m relates to risk share contributions from Croydon CCG.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,042	573

Note 5.1 Transaction price allocated to remaining performance obligations

	31 March 2019/20	31 March 2018/19
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	2,332	1,042
Total revenue allocated to remaining performance obligations	**2,332**	**1,042**

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

Note 6 Operating expenses

	2019/20	2018/19
	£000	£000
Staff and executive directors costs	220,402	198,245
Remuneration of non-executive directors	107	86
Supplies and services - clinical (excluding drugs costs)	41,114	36,635
Supplies and services - general	10,691	13,265
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	17,999	18,900
Inventories written down	8	4
Consultancy costs	566	1,762
Establishment	7,598	2,106
Premises	14,249	15,182
Transport (including patient travel)	2,226	1,889
Depreciation on property, plant and equipment	8,278	8,160
Amortisation on intangible assets	214	238
Net impairments	(1,721)	34,564
Movement in credit loss allowance: contract receivables / contract assets	(35)	11
Movement in credit loss allowance: all other receivables and investments	1,094	(13)
Increase/(decrease) in other provisions	0	(250)
Audit fees payable to the external auditor		
audit services- statutory audit	73	61
other auditor remuneration (external auditor only)	0	9
Internal audit costs	187	149
Clinical negligence	13,612	15,097
Legal fees	221	470
Insurance	202	237
Education and training	980	950
Rentals under operating leases	2,176	1,543
Redundancy	0	296
Car parking & security	662	0
Hospitality	141	154
Other	245	0
Total	**341,289**	**349,750**
Of which:		
Related to continuing operations	341,289	349,750

1. 6.3% additional pension contributions of £7.7m top up by NHS England is included in the staff and executive directors costs.

2. The fee for the audit is £61,000 plus VAT at 20%.

Note 6.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus resulting from:		
Changes in market price	(1,721)	34,564
Total net impairments charged to operating surplus / deficit	**(1,721)**	**34,564**
Impairments charged to the revaluation reserve	(7,832)	44,468
Total net impairments	**(9,553)**	**79,032**

The reversal of impairments is simply due to the increase in building costs derived from the Building Information Cost Service (BICS) indices, which is applied in depreciated replacement cost (DRC) valuation. The indices highlight significant build cost inflation relates to a particular economic position the construction sector maybe in at one point in time, rather than just the general economy. Factors which have an major impact on building costs include material prices, the weakness of the pounds, wage inflation, immigration policies and skill shortages.

There has been no diminution identified in the public sector's ongoing requirement for thee operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. At the present time, BCIS have advised that it is too early for COVID-19 related issues to impact on BCIS indices published and adopted in this valuations.

Note 8 Employee benefits

	Permanently employed total	Other total	2019/20 Total	2018/19 Total
	£000	£000	£000	£000
Salaries and wages	141,140	6,298	147,438	129,242
Social security costs	15,807	289	16,096	14,715
Apprenticeship levy	724	0	724	675
Employer's contributions to NHS pensions	25,391	92	25,483	16,400
Temporary staff (including agency)	0	31,510	31,510	38,385
Total gross staff costs	**183,062**	**38,189**	**221,251**	**199,417**
Recoveries in respect of seconded staff	0	0	0	0
Total staff costs	**183,062**	**38,189**	**221,251**	**199,417**
Of which				
Costs capitalised as part of assets	**0**	849	849	876

Note 8.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £66k (£236k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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

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

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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

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

Note 10 Operating leases

Note 10.1 Croydon Health Services NHS Trust as a lessor

The Trust is the lessor of parts of its premises (front entrance) to external organisations, and for staff accommodation, for which it charges rental revenue.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,285	1,241
Total	**1,285**	**1,241**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
not later than one year	1,296	792
later than one year and not later than five years	2,266	2,734
later than five years	3,015	4,852
Total	**6,577**	**8,378**

Note 10.2 Croydon Health Services NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements for the use of accommodation to operate clinical facilities at a number of properties managed by NHS Property Services Ltd. The leases are subject to annual review and renewal.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	2,176	1,543
Total	**2,176**	**1,543**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
not later than one year	693	1,574
later than one year and not later than five years	1,486	921
later than five years	267	202
Total	**2,446**	**2,697**

Note 11 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	144	84
Total finance income	**144**	**84**

Note 12 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,842	1,855
Finance leases	3	8
Total interest expense	1,845	1,863
Unwinding of discount on provisions	(3)	1
Total finance costs	**1,842**	**1,864**

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	25	0
Amounts included within interest payable arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	25	0

Note 13 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	1,356	2,210
Total gains / (losses) on disposal of assets	**1,356**	**2,210**

During the year the sale of Purley Clinic gave rise to profit on disposal of £1.356m.

Note 14 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**5,192**	**14**	**0**	**5,206**
Additions	733	0	1,024	**1,757**
Valuation / gross cost at 31 March 2020	**5,925**	**14**	**1,024**	**6,963**
Amortisation at 1 April 2019 - brought forward	**4,705**	**14**	**0**	**4,719**
Provided during the year	214	0	0	**214**
Amortisation at 31 March 2020	**4,919**	**14**	**0**	**4,933**
Net book value at 31 March 2020	**1,006**	**0**	**1,024**	**2,030**
Net book value at 1 April 2019	**487**	**0**	**0**	**487**

Note 14.1 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**5,177**	**14**	**0**	**5,191**
Additions	15	0	0	**15**
Valuation / gross cost at 31 March 2019	**5,192**	**14**	**0**	**5,206**
Amortisation at 1 April 2018 - as previously stated	**4,467**	**14**	**0**	**4,481**
Provided during the year	238	0	0	**238**
Amortisation at 31 March 2019	**4,705**	**14**	**0**	**4,719**
Net book value at 31 March 2019	**487**	**0**	**0**	**487**
Net book value at 1 April 2018	**710**	**0**	**0**	**710**

Note 15 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**29,753**	**115,454**	**3,347**	**516**	**30,454**	**21,140**	**1,288**	**201,952**
Additions	40	1,408	0	1,686	2,396	2,445	0	**7,975**
Impairments	(40)	(148)	0	0	0	0	0	**(188)**
Reversals of impairments	0	8,020	0	0	0	0	0	**8,020**
Revaluations	6	(1,544)	11	0	0	0	0	**(1,527)**
Valuation/gross cost at 31 March 2020	**29,759**	**123,190**	**3,358**	**2,202**	**32,850**	**23,585**	**1,288**	**216,232**
Accumulated depreciation at 1 April 2019 - brought forward	**0**	**8**	**0**	**0**	**18,655**	**12,635**	**1,028**	**32,326**
Provided during the year	0	3,629	51	0	2,053	2,483	62	**8,278**
Impairments	0	411	0	0	0	0	0	**411**
Reversals of impairments	0	(2,132)	0	0	0	0	0	**(2,132)**
Revaluations	0	(1,916)	(51)	0	0	0	0	**(1,967)**
Accumulated depreciation at 31 March 2020	**0**	**0**	**0**	**0**	**20,708**	**15,118**	**1,090**	**36,916**
Net book value at 31 March 2020	**29,759**	**123,190**	**3,358**	**2,202**	**12,142**	**8,467**	**198**	**179,316**
Net book value at 1 April 2019	**29,753**	**115,446**	**3,347**	**516**	**11,799**	**8,505**	**260**	**169,626**
Breakdown of Net Book Value (NBV)	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Net book value at 31 March 2020								
Owned - purchased	29,759	120,754	3,358	1,561	11,655	8,123	124	175,334
Finance leased	0	0	0	0	19	0	0	19
Owned - government granted	0	0	0	90	47	233	0	370
Owned - donated	0	2,436	0	551	421	111	74	3,593
NBV total at 31 March 2020	**29,759**	**123,190**	**3,358**	**2,202**	**12,142**	**8,467**	**198**	**179,316**

Note 15.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - as previously stated	**49,444**	**147,504**	**4,217**	**21,026**	**29,003**	**19,336**	**1,288**	**271,818**
Prior period adjustments	0	8	0	0	0	0	0	**8**
Valuation/gross cost at 1 April 2018 - restated	**49,444**	**147,512**	**4,217**	**21,026**	**29,003**	**19,336**	**1,288**	**271,826**
Additions	0	8,357	0	2,352	1,451	1,804	0	**13,964**
Impairments	(18,353)	(28,309)	(421)	0	0	0	0	**(47,083)**
Reversals of impairments	1,622	993	0	0	0	0	0	**2,615**
Revaluations	(1,338)	(35,475)	(449)	(449)	0	0	0	**(37,711)**
Reclassifications	0	22,376	0	(22,413)	0	0	0	**(37)**
Disposals/derecognition	(1,622)	0	0	0	0	0	0	**(1,622)**
Valuation/gross cost at 31 March 2019	**29,753**	**115,454**	**3,347**	**516**	**30,454**	**21,140**	**1,288**	**201,952**
Accumulated depreciation at 1 April 2018 - as previously stated	**0**	**37**	**0**	**1**	**16,440**	**10,411**	**958**	**27,847**
Prior period adjustments	0	8	0	0	0	0	0	**8**
Accumulated depreciation at 1 April 2018 - restated	**0**	**45**	**0**	**1**	**16,440**	**10,411**	**958**	**27,855**
Provided during the year	0	3,601	50	0	2,215	2,224	70	**8,160**
Impairments	1,460	32,229	449	448	0	0	0	**34,586**
Reversals of impairments	0	(22)	0	0	0	0	0	**(22)**
Revaluations	(1,460)	(35,808)	(499)	(449)	0	0	0	**(38,216)**
Reclassifications	0	(37)	0	0	0	0	0	**(37)**
Accumulated depreciation at 31 March 2019	**0**	**8**	**0**	**0**	**18,655**	**12,635**	**1,028**	**32,326**
Net book value at 31 March 2019	**29,753**	**115,446**	**3,347**	**516**	**11,799**	**8,505**	**260**	**169,626**
Net book value at 1 April 2018	**49,444**	**147,467**	**4,217**	**21,025**	**12,563**	**8,925**	**330**	**243,971**
Breakdown of Net Book Value (NBV)	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Net book value at 31 March 2019								
Owned - purchased	29,753	113,180	3,347	82	11,110	8,095	176	**165,743**
Finance leased	0	0	0	0	38	0	0	**38**
Owned - government granted	0	0	0	0	71	311	0	**382**
Owned - donated	0	2,266	0	434	580	99	84	**3,463**
NBV total at 31 March 2019	**29,753**	**115,446**	**3,347**	**516**	**11,799**	**8,505**	**260**	**169,626**

Note 16 Donations of property, plant and equipment

Donated Assets were received from the Croydon Health Services Charitable Fund and other external organisations. Income for the purchase of donated assets is shown in the statement of comprehensive income in the year of purchase.

£0.45m in the form of donations or grants were received towards the end of the financial year, hence only £0.24m has been spent in 2019/20. The remaining spend will be carried forward to the next financial year 2020/2021. Notable projects are the Estates Technology Transformation Fund, ICN Pharmacists, Locality (IT) and laptops.

Note 17 Revaluations of property, plant and equipment

The Trust's land and buildings were valued independently by the DVS Property Specialists for the Public Sector (an executive agency of HM Revenue and Customs) as at 31st March 2020 adopting the Modern Equivalent Asset (MEA) valuation technique in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury FReM compliant DHSC Group Manual for Accounts (DHSC GAM). The valuation report was signed by Ros Johnson, MRICS an external RICS Registered Valuer who has the appropriate knowledge, skills and understanding to undertake the valuation completely, as required by the RICS Valuation - Professional Standards, 8th edition.

The valuation took into consideration the size, location and service requirements at present within the Trust. Following a review of the recently draft Estates Strategy document it is clear that if the Croydon University Hospital (CUH) buildings were replaced with a MEA (of smaller size), then the site area required would also be smaller. The Valuer has assessed the land value based on this smaller footprint, as outlined in the Estates strategy.

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

Fair values are determined as follows:

- **Land and non-specialised buildings - market value for existing use**

  There has been no diminution identified in the public sector's ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Their basis of valuation is however current value in existing use, having regard to comparable market evidence and early commentary as it exists regarding direction of travel tends to suggest and support a downward movement in value. It is too early at this stage to accurately evidence this impact and it is the DV opinion at the date of valuation on the information then available that the assessed impact falls within normal valuation tolerances.

- **Specialised buildings - depreciated replacement cost**

  There has been no diminution identified in the public sector's ongoing requirement for thee operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of COVID-19. Regarding the BCIS cost indices, BCIS have stated that they consider new construction output is likely to fall in 2020 as a result of the COVID-19 outbreak, as it affects labour availability on sites and delays or leads to cancellation of projects in the pipeline. However, at the present time, BCIS have advised that it is too early for COVID-19 related issues to impact on BCIS indices published and adopted in this valuations.

  Plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value as defined by IFRS 13.

Note 18 Inventories

	31 March 2020 £000	31 March 2019 £000
Interest expense:		
Drugs	1,175	955
Consumables	1,614	1,650
Energy	43	57
Total inventories	**2,833**	**2,662**
Of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £32,177k (2018/19: £36,594k). Write-down of inventories recognised as expenses for the year were £8k (2018/19: £4k).

Note 19 Disclosure of interests in other entities

19.1 Risk share arrangement with Croydon CCG

In 2019/20, Croydon CCG and Croydon Health Services NHS Trust entered into a novel financial risk share arrangement that pooled the financial resources of both organisations – creating a joint budget with a joint financial target ("joint control total") for the Croydon health system. This was further underpinned by joint governance arrangements and joint executive appointments.

The CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the joint budget, in accordance with the contractual agreement.

	2019/20		
	Croydon CCG	Croydon Health Services	Total
	£000	£000	£000
Source of Funds	532,856	326,390	859,246
Application of Funds	(524,356)	(345,990)	(870,346)
Surplus (Deficit) - Control Total Basis (Pre Risk Share)	**8,500**	**(19,600)**	**(11,000)**
MEMO: Revised Control Total Performance Target	2,100	(13,209)	(11,100)
MEMO: Variance from Control Total	6,400	(6,391)	9
Application of Contractual Risk Share Agreement:	(6,400)	6,400	**0**
Surplus (Deficit) Control Total Basis (Post Risk Share)	**2,100**	**(13,200)**	**(11,100)**
Items Excluded from Control Total Definition:			
2019/20 PSF/MRET/FRF	0	13,209	13,209
Other	0	436	436
2019/20 Financial Position - Surplus	**2,100**	**445**	**2,545**

19.2 London Borough of Croydon Council Pooled Budget

Croydon Health Services NHS Trust has a pooled budget arrangement with London Borough of Croydon Council (LBC) approved by Cabinet and the Croydon Clinical Commissioning Group (CCG). The agreement commenced on 1 April 2004, and is for Croydon's integrated community equipment service (CCES). The CCES agreement is hosted by the Council and only Croydon Health Services NHS Trust's proportion is recognised in the Trust's accounts.

	2019/20		
	London Borough of Croydon Council	Croydon Health Services	Total
	£000	£000	£000
Croydon's Community Equipment Service			
Funding provided to the pooled budget	(1,190)	(1,065)	(2,255)
Expenditure met from the pooled budget	1,483	1,437	2,920
Net Expenditure	293	372	665

19.3 Subsidiary

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

The provisions of IAS 27 Consolidated and Separate Financial Statements requires NHS bodies to consolidate of those Charitable Funds that fall under common control. The Trust opt out to consolidate the accounts on the basis of materiality.

The following is summarised financial activities for charitable fund, based on their financial statements prepared in accordance with FRS102.

Charity's Statement of Financial Activities

	31 March 2020 2019/20 £000	31 March 2019 2018/19 £000
Total incoming resources	431	456
Total resources expended	(344)	(168)
Net (outgoing) / incoming resources before transfers	87	288
(Losses) / gains on revaluation	(143)	43
Net movement in funds	(56)	331

The deficit of £56k has not reflected any entries in the statement of comprehensive income for 2019/20.

Charity's Balance Sheet

	31 March 2020 2019/20 £000	31 March 2019 2018/19 £000
Investments	1,141	997
Cash	61	208
Other current assets	134	153
Current liabilities	(85)	(51)
Net assets / liabilities	1,251	1,307
Restricted funds	798	717
Unrestricted funds	453	590
Total charitable funds	1,251	1,307

The Charitable Funds are administered by the Charitable Funds Committee, which is a committee of the Trust Board, and the membership of the charity committee is determined in the terms of reference of the charity.

There are four special purpose charities associated with the umbrella charity, which are:

- **Croydon Health Services NHS Trust General Fund Charity**
  Contributes to projects mainly for the benefit of Croydon Health Services NHS Trust
- **Research and Education Charity**
  Supports training and education initiatives in the Trust. It also supports clinical research projects carried out within the Trust and the dissemination
- **Croydon Health Services NHS Trust General Fund Charity**
  contributes to projects mainly for the benefit of Croydon Health Services NHS Trust
- **Research and Education Charity**
  Supports training and education initiatives in the Trust. It also supports clinical research projects carried out within the Trust and the dissemination of the useful results of those projects. All such research projects are subject to prior approval and monitoring by the Trust's Ethical Committee
- **Staff and Patients Amenities Charity**
  Contributes to the provision of extra amenities for patients at Croydon Health Services NHS Trust and to improve the working environment for staff at the Trust
- **Croydon CCG**
  Contributes to the provision of extra amenities to improve the working environment for staff at the Clinical Commissioning Group.

Note 20 Receivables

	31 March 2020	31 March 2019
	£000	£000
Current		
Contract receivables	17,644	30,778
Contract assets	1,478	1,277
Capital receivables	0	0
Allowance for impaired contract receivables/assets	(465)	(500)
Allowance for other impaired receivables	(2,322)	(1,811)
Prepayments (non-PFI)	4,019	861
PDC dividend receivable	302	1,592
VAT receivable	909	927
Other receivables	370	392
Total current receivables	**21,934**	**33,516**
Non-current		
Contract assets	892	1,008
Other receivables	659	0
Total non-current receivables	**1,541**	**1,008**
Of which receivable from NHS and DHSC group bodies:		
Current	12,087	28,048
Non-current	649	0

IFRS 15 allowed the Trust to considerate for work performed under contracts with customers are shown separately as contract receivables and contract assets.

This replaces the previous analysis into trade receivables and accrued income.

Note 20.1 Allowances for credit losses

	2019/20		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**500**	**1,811**	**0**	**2,497**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			489	(489)
New allowances arising	0	1,094	11	418
Reversals of allowances	(35)	0	0	(431)
Utilisation of allowances (write offs)	0	(583)	0	(184)
Allowances as at 31 Mar 2020	**465**	**2,322**	**500**	**1,811**

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The Trust follows the guidance issued in the 2019/20 DHSC Manual in relation to the recommended rate for Injury Cost Recovery receivables.

Note 21 Cash and cash equivalents movements

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

	2019/20	2018/19
	£000	£000
At 1 April	**5,832**	**4,433**
Net change in year	11,509	1,399
At 31 March	**17,341**	**5,832**
Broken down into:		
Cash at commercial banks and in hand	10	15
Cash with the Government Banking Service	17,331	5,832
Total cash and cash equivalents as in SoFP	**17,341**	**5,832**
Total cash and cash equivalents as in SoCF	**17,341**	**5,832**

Note 21.1 Third party assets held by the trust

Croydon Health Services NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Monies on deposit	1	3
Total third party assets	**1**	**3**

Note 22 Trade and other payables

	31 March 2020	31 March 2019
Current	£000	£000
Trade payables	12,035	13,562
Capital payables	4,144	2,596
Accruals	19,708	14,570
Social security costs	2,344	2,214
VAT payables	2,212	1,805
Other payables	3,596	4,140
Total current trade and other payables	**44,039**	**38,887**
Non-current		
Trade payables	**0**	**0**
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	7,137	7,123
Non-current	0	0

The adoption of IFRS 9, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note.

Note 22.1 Early retirements in NHS payables above

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

	31 March 2020	31 March 2020	31 March 2020	31 March 2019
	£000	Number	£000	Number
to buy out the liability for early retirements over 5 years	0		0	
number of cases involved		0		0

Note 23 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	2,332	1,042
Total other current liabilities	**2,332**	**1,042**

Note 24 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	103,560	57,004
Obligations under finance leases	22	20
Total current borrowings	**103,582**	**57,024**
Non-current		
Loans from DHSC	0	52,973
Obligations under finance leases	0	21
Total non-current borrowings	**0**	**52,994**

As per IFRS9, measuring of DHSC loans is at an amortised cost basis; means the carrying value of the loans include both principal and interest. Revenue and capital loan interests of £0.205m and £0.047m respectively have been added on the principal loans above.

1. The Trust have the following capital and revenue support loans (exclude interests) from the DHSC:

		£000	Maturity
i.	Revenue support loan	26,400	extended
ii.	Working Capital loan	21,300	extended
iii.	IUSCL (Interim Uncommitted Single Currency Loan) during FSM	2,635	extended
iv.	IUSCL (Interim Uncommitted Single Currency Loan) in 2017/18	9,959	18/09/2020
v.	IUSCL (Interim Uncommitted Single Currency Loan) in 2017/18	14,257	18/03/2021
vi.	IUSCL (Interim Uncommitted Single Currency Loan) in 2018/19	12,066	18/10/2021
vii.	Capital Loan -repayment of the principal every six months (£0.407m) until 20/08/2040	16,691	20/08/2040

The Trust projected a breakeven position for 19/20 during which time the Trust did not request for a revenue loan to support the operation. The movement of loans (repayment) were related to advance of 2018/19 Q3/Q4 PSF and repayments were made in 2019/20.

The Trust current debt of £103.56m (principle plus interest accrued as at 31 March 2020) in this financial statements have been classified as current as they will be repayable with 12 months.

Note 24.1 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2019	**109,977**	**41**	**110,018**
Cash movements:			
Financing cash flows - payments and receipts of principal	(6,370)	0	**(6,370)**
Financing cash flows - payments of interest	(1,889)	(22)	**(1,911)**
Non-cash movements:			
Application of effective interest rate	1,842	3	**1,845**
Carrying value at 31 March 2020	**103,560**	**22**	**103,582**

Note 24.2 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2018	**98,059**	**60**	**98,119**
Cash movements:			
Financing cash flows - payments and receipts of principal	11,619	0	**11,619**
Financing cash flows - payments of interest	(1,815)	(27)	**(1,842)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	259	0	**259**
Application of effective interest rate	1,855	8	**1,863**
Carrying value at 31 March 2019	**109,977**	**41**	**110,018**

Note 25 Finance leases

Note 25.1 Croydon Health Services NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**22**	**41**
of which liabilities are due:		
- not later than one year;	22	20
- later than one year and not later than five years;	0	21
Net lease liabilities	**22**	**41**
of which payable:		
- not later than one year;	22	20
- later than one year and not later than five years;	0	21
Contingent rent recognised as expense in the period	0	0

The Trust uses leasing to supplement capital investment in medical equipment where appropriate taking into account of value for money. The Trust took a finance leases with a capital value of £0.093m in 2015/16.

The Trust made repayments of principal under finance leases of £0.019m in 2019/20.

Note 26 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Clinician pension tax reimbursement	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2019	**538**	**109**	**720**	**160**	**0**	**4,474**	**6,001**
Transfers by absorption	**0**	**0**	**0**	**0**		**0**	**0**
Arising during the year	**53**	**0**	**359**	**0**	**689**	**4**	**1,105**
Utilised during the year	(83)	(11)	(500)	(160)	0	(958)	**(1,712)**
Reversed unused	**0**	**0**	**(161)**	**0**	**0**	**0**	**(161)**
Unwinding of discount	**(3)**	**0**	**0**	**0**	**0**	**0**	**(3)**
At 31 March 2020	**505**	**98**	**418**	**0**	**689**	**3,520**	**5,230**
Expected timing of cash flows:							
- not later than one year;	82	10	418	0	40	**3,520**	**4,070**
- later than one year and not later than five years;	292	41	0	0	43	**43**	**419**
- later than five years	131	47	0	0	606	**606**	**1,390**
Total	**505**	**98**	**418**	**0**	**689**	**4,169**	**5,879**

The provision for Early Departure Costs relating to pre-1995 early retirement is calculated using information provided by the NHS Pensions Agency. The Trust pays NHS Pensions an amount each quarter for these former employees, and the provision balance represents the estimated costs of the continuing liabilities. Legal claims are liabilities relating to Third Parties Scheme(LTPS) cases which are dealt with by the NHS Resolution on behalf of the Trust.

Included in "other liabilities" are amounts relating to pay provisions for withheld consultant increments; staff equal pay and capital provisions for Emergency Department.

Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31 July 2021).

NHS provider organisations will need to create a provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This will be offset by the commitment from NHS England and the Government to fund the payments to clinicians as and when they arise.

The provision calculation was provided by the Government Actuary's Department (GAD), the Business Services Authority (BSA) and the Department of Health and Social Care (DHSC).

Note 26.1 Clinical negligence liabilities

At 31 March 2020, £219,273k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Croydon Health Services NHS Trust (31 March 2019: £238,157k).

Note 27 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	0	0
Other	0	0
Net value of contingent liabilities	**0**	**0**
Net value of contingent assets	**0**	**0**

The Trust considers that the fair value of financial assets and financial liabilities are the same as book value.

Note 28 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	**0**

Note 29 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made.

	31 March 2020 £000	31 March 2019 £000
not later than 1 year	20,112	17,671
after 1 year and not later than 5 years	30,157	29,698
paid thereafter	740	2,380
Total	**51,009**	**49,749**

Note 30 Financial instruments

Note 30.1 Financial risk management

The applicable standards for financial instruments are IAS32/ IAS39/IFRS7 and IFRS9. IAS 32 defines financial instrument as a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Examples of financial assets are cash or a contractual right to receive cash.

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

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

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

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHS Improvement. The borrowings are for 1 - 40 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the DHSC (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

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

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	17,227	0	0	**17,227**
Cash and cash equivalents	17,341	0	0	**17,341**
Total at 31 March 2020	**34,568**	**0**	**0**	**34,568**

Carrying values of financial assets as at 31 March 2019

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	30,752	0	0	**30,752**
Cash and cash equivalents	5,832	0	0	**5,832**
Total at 31 March 2019	**36,584**	**0**	**0**	**36,584**

£2.4m Injury cost recovery (ICR) debtors have been reclassified between measurement category is included as financial instrument under IFRS 9.

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020

	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	103,560	0	**103,560**
Obligations under finance leases	22	0	**22**
Trade and other payables excluding non financial liabilities	38,219	0	**38,219**
Total at 31 March 2020	**141,801**	**0**	**141,801**

Carrying values of financial liabilities as at 31 March 2019

	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	109,977	0	**109,977**
Obligations under finance leases	41	0	**41**
Trade and other payables excluding non financial liabilities	31,770	0	**31,770**
Total at 31 March 2019	**141,788**	**0**	**141,788**

Note 30.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	141,801	88,794
In more than one year but not more than two years	0	37,124
In more than two years but not more than five years	0	2,454
In more than five years	0	13,416
Total	**141,801**	**141,788**

Total loans of £55.1m had expired in February 2020 and the repayment has been extended until further notice from the DHSC.

Note 31 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	12	2	0	0
Bad debts and claims abandoned	94	584	68	184
Stores losses and damage to property	12	7	12	4
Total losses	**118**	**593**	**80**	**188**
Special payments				
Compensation under court order or legally binding arbitration award	1	907	0	0
Ex-gratia payments	13	12	30	341
Total special payments	**14**	**919**	**30**	**341**
Total losses and special payments	**132**	**1,512**	**110**	**529**
Compensation payments received		0		0

Payments awarded by the Employment Tribunals to a whistleblowing and unfair dismissal claims by a Senior Specialist Cardiac Nurse on 4 of March 2020.

Further information please refer to the tribunal case number 2359206/2012.

Note 32 Gifts

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Gifts made	0	0	0	0

Note 33 Related parties

Note Related parties

Under the Requirements of IAS 24 (Related Party Disclosures), the Trust has disclosed as a related party where key management services have been provided by another entity such as personal service companies. The total transactions for these companies where key management services were provided are detailed below.

During the year none of the DHSC Ministers, or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Croydon Health Services NHS Trust except four of the Executive Directors as disclosure below.

The DHSC, as the parent of Croydon Health Services NHS Trust, is regarded as a related party. During the year the Trust has had a significant number of material transactions with the other entities listed below for which the DHSC is regarded as the parent. Also included are local government bodies where material transactions have taken place.

* Only for transactions with a threshold of £250k and above is disclosed below.

	2019/20		2018/19	
	Income	Expenditure	Income	Expenditure
NHS Body	**£000**	**£000**	**£000**	**£000**
Croydon CCG	237,378	0	217,153	23
Bromley CCG	6,308	0	5,268	0
East Surrey CCG	2,565	0	3,641	0
Lambeth CCG	5,549	0	5,162	0
Merton CCG	3,461	0	3,257	0
Sutton CCG	3,320	0	2,597	0
Surrey Downs CCG	406	0	342	165
NHS Wandsworth CCG	2,344	0	2,009	21
NHS Southwark CCG	575	0	659	0
NHS Lewisham CCG	630	0	800	0
Health Education England	10,061	0	9,663	10
NHS Resolution (formerly NHS Litigation Authority)	0	13,796	0	15,307
NHS England	37,479	0	38,842	0
St Georges Healthcare NHS Foundation Trust	670	16,308	518	13,535
Moorfields Eye Hospital NHS Foundation Trust	3,405	74	3,512	41
Epsom and St Helier NHS Trust	701	75	415	45
Guy's & St Thomas' NHS Foundation Trust	458	139	636	108
The Royal Marsden NHS Foundation Trust	865	442	423	498
NHS Property Services	0	1,461	0	1,466
Department of Health and Social Care	0	0	2,830	0

The following Executive Directors became joint Directors of both Croydon CCG and Croydon Health Services NHS Trust during 2019-20 (refer to joint arrangements Note 1.3 and 19).

	2019/20		2018/19	
	Income	Expenditure	Income	Expenditure
	£000	£000	£000	£000
Matthew Kershaw, Chief Executive and Place Based Leader for Health **Mike Sexton,** Joint Chief Finance Officer **Josh Potter,** Joint Director of Strategy and Transformation **Elaine Clancy,** Joint Chief Nurse	237,378	0	217,153	23

In addition, the Trust has a number of balances at year end with NHS bodies (outside DH group), other government departments, other central and local government bodies and external bodies. Most of these transactions have been with HM Revenue & Customs in respect of PAYE, NI contributions and VAT refunds.

	2019/20		2018/19	
	Income	Expenditure	Income	Expenditure
Body (Other government and external)	£000	£000	£000	£000
HM Revenue & Customs	0	16,820	0	15,390
National Health Service Pension Scheme	0	25,483	0	16,400
Croydon London Borough Council	10,999	0	10,374	1,468
NHS Blood and Transplant	0	769	0	714

* Only for outstanding with a threshold of £100k and above is disclosed below.

	2019/20		2018/19	
	Receivable	Payable	Receivable	Payable
NHS Body	£000	£000	£000	£000
Croydon CCG	741	24	2,074	361
Bromley CCG	175	0	936	0
East Surrey CCG	225	0	1,093	0
Lambeth CCG	90	0	879	0
Merton CCG	831	0	955	0
Sutton CCG	1,187	0	904	0
Surrey Downs CCG	127	0	165	0
NHS Wandsworth CCG	0	511	929	39
NHS Southwark CCG	32	3	165	1
NHS Lewisham CCG	26	0	211	0
Health Education England	18	0	337	0
NHS England	4,047	0	11,002	0
St Georges Healthcare NHS Foundation Trust	1,177	2,886	1,146	2,875
Moorfields Eye Hospital NHS Foundation Trust	878	168	1,338	81
Epsom and St Helier NHS Trust	379	167	247	247
Guy's & St Thomas' NHS Foundation Trust	134	91	176	192
The Royal Marsden NHS Foundation Trust	247	722	826	802
King's College Hospital NHS Foundation Trust	300	315	48	244
Hounslow and Richmond Community Healthcare NHS Trust	0	368	0	207
NHS Property Services	13	1,238	13	984

	2019/20		2018/19	
	Receivable	Payable	Receivable	Payable
Body (Other government and external)	£000	£000	£000	£000
HM Revenue & Customs	0	4,556	0	4,019
National Health Service Pension Scheme	0	2,579	0	2,361
Croydon London Borough Council	289	5	1,622	1,675
NHS Blood and Transplant	0	69	0	72

The Trust Board is the Corporate Trustee of the Croydon Health Services Charitable Fund (Registered Charity No. 1054824), and some of the members of the Trust Board are also members of the Charitable Funds Committee. The total value of the charitable contributions to the Trust was £243k in 2019/20 (£96k in 2018/19).

Note 34 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	48,072	169,490	50,411	163,689
Total non-NHS trade invoices paid within target	34,684	120,157	20,998	80,021
Percentage of non-NHS trade invoices paid within target	72.2%	70.9%	41.7%	48.9%
NHS Payables				
Total NHS trade invoices paid in the year	1,880	35,086	2,150	33,001
Total NHS trade invoices paid within target	812	26,261	486	17,280
Percentage of NHS trade invoices paid within target	43.2%	74.8%	22.6%	52.4%

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

Note 35 External financing limit

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

	2019/20 £000	2018/19 £000
Cash flow financing	(16,150)	14,746
Other capital receipts		
External financing requirement	**(16,150)**	**14,746**
External financing limit (EFL)	1,624	15,831
Under / (over) spend against EFL	**17,774**	**1,085**

Note 36 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	9,732	13,979
Less: Disposals	0	(1,622)
Less: Donated and granted capital additions	(244)	(449)
Charge against Capital Resource Limit	**9,488**	**11,908**
Capital Resource Limit	9,488	11,952
Under / (over) spend against CRL	**0**	**44**

Note 37 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	445
Add back income for impact of 2018/19 post-accounts PSF reallocation	564
Breakeven duty financial performance surplus	**1,009**

Note 38 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The Trust current debt of £103.56m (principal plus interest accrued as at 31 March 2020) in this financial statements have been classified as current as they will be repayable with 12 months.

The UK Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. For the period April 2020 to June 2020 the Trust is receiving income via block contract lump sums.

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,106	4,913	3,967	199	(19,683)
Breakeven duty cumulative position	1,403	2,509	7,422	11,389	11,588	(8,095)
Operating income		198,499	241,804	236,941	243,551	244,595
Cumulative breakeven position as a percentage of operating income		1.3%	3.1%	4.8%	4.8%	(3.3%)

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(27,532)	(34,490)	(23,787)	(22,151)	1,507	1,009
Breakeven duty cumulative position	(35,627)	(70,117)	(93,904)	(116,055)	(114,548)	(113,539)
Operating income	246,279	255,354	274,671	293,116	318,844	345,406
Cumulative breakeven position as a percentage of operating income	(14.5%)	(27.5%)	(34.2%)	(39.6%)	(35.9%)	(32.9%)

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

The amounts in the above tables in respect of financial years 1997/98 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

Statutory breakeven duty, overall and recurrent financial position: The Trust delivered a £12.8m deficit (pre PSF) and £0.4m surplus (post PSF) for the financial year 2019-20, taking account of £0.1m post technical item adjustments for donated assets and £1.7m of reversal impairments.

The Trust has been in technical breach of the statutory breakeven duty (NHS Act 2006) for some time, and it will be many years before that duty is met. The Trust has been in regular contact with NHS Improvement to implement financial recovery plan hence the auditor issuing a Section 30 referral specifically relating to a breach of the breakeven duty would not itself cause a material concern for NHS Improvement.

GLOSSARY

LIST OF NATIONAL HEALTH SERVICE (NHS) ACRONYMS

A

A&E Accident & Emergency.

Acute Trust A trust is an NHS organisation responsible for providing a group of healthcare services. An acute trust provides hospital services (but not mental health hospital services, which are provided by a mental health trust).

ADN Associate Director of Nursing.

Adult social care Adult social care Social care includes all forms of personal care and other practical assistance provided for people.

AHP Allied Health Professional.

AKI Acute Kidney Injury.

Audit Commission The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trusts, primary care trusts and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for money studies.
Visit: **www.audit-commission.gov.uk**

AMU Assessment Medical Unit.

AsiT Association Of Surgeons In Training.

B

BAF Board Assurance Framework.

BAME Black, Asian and Minority Ethnic.

BNF British National Formulary.

Board (of the trust) The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community.

C

CAI Infection Community Acquired Infection.

CAS Central Alerting System.

CAUTI Catheter Associated Urinary Tract Infection.

CAMHS Children and Mental Health Services.

CCCG Croydon Clinical Commissioning Group.

CCG Clinical Commissioning Group.

CCU Coronary Care Unit.

Cerner millennium system (CRS) Cerner millennium is the newly introduced IT system at CHS. This is an electronic system that captures patient data.

CHAH Children's Hospital at Home Team.

CHD Coronary Heart Disease.

CHS Croydon Health Services NHS Trust.

CIP Cost Improvement Plan.

Clinical Audit Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clinical Coding Clinical Coding Officers are responsible for assigning 'codes' to all inpatient and day case episodes, They use special classifications which are assigned to and reflect the full range of diagnosis (diagnostic coding) and procedures (procedural coding) carried out by providers and enter these codes onto the Patient Administration System.

The coding process enables patient information to be easily sorted for

	statistical analysis. When complete, codes represent an accurate translation of the statements or terminology used by the clinician and provides a complete picture of the patient's care.
Clinical Directorate	Clinical Directorates: ***Integrated Adult Care (IAC)*** ***Integrated Women and Children's and Sexual Health (IWCSH)*** **Integrated Surgery, Cancer and Clinical Support Services (ISCCSS).**
Clostridium difficile/ C. Difficile/C Dif	Clostridium difficile also known as C.difficile or C.dif, is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or persons gut are wiped out by antibiotics. C. difficile infection can range in severity from asymptomatic to severe and life-threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. difficile infection in the community and outpatient setting is increasing.
CNST	Clinical Negligence Scheme for Trusts.
COO	Chief Operating Officer.
COPD	Chronic Obstructive Pulmonary Disease.
Commissioners	Commissioners are the organisations that commission NHS services.
CQC	The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: **www.cqc.org.uk**
CQI	Croydon Quality Improvement.
CQRG	Clinical Quality Review Group.
CQUIN	Commissioning for Quality and Innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.
CRR	Corporate Risk Register.
CRES	Cost Releasing Efficiency Savings.
CRL	Capital Resource Limit.
CRT-D	Cardiac resynchronisation therapy - defibrillators.
CST	Core Skills Training.
CSU	Clinical Support Unit.
CTG	Cardiotocograph.
CUH	Croydon University Hospital. The largest of the Trust's hospitals.
Culture	Culture Learned attitudes, beliefs and values that define a group or groups of people.
CUP	Cancer of Unknown Primary.
CUSUM	Cumulative Sum.

D

DASV	Domestic abuse and sexual violence.
Datix	This is the name of the incident reporting system at Croydon Health Services.
Dignity	Dignity is concerned with how people feel, think and behave in relation to the worth or value that they place on themselves and others. To treat someone with dignity is to treat them as being of worth and respect them as a valued person, taking account of their individual views and beliefs.
DiPC	Director of Infection Prevention and Control.
Discharge	The point at which a patient leaves hospital to return home or be transferred to another service, or the formal conclusion of a service provided to a person who uses services.
DKA	Diabetic Keto Acidosis.
DNA	Did Not Attend.
DNAR	Do not attempt resuscitation.
DoF	Director of Finance.
DoH	Department of Health and Social Care is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

DOLs	Deprivation Of Liberty.
DS&PT	Data Security and Protection Toolkit.
DTOC	Delayed Transfer of Care.
DTA	Discharge to Assess.

E

EBME	The electrical and biomedical engineering.
ECIP	Emergency Care Improvement Programme.
ED	Emergency Department.
EIA	Equality Impact Assessment.
ELoS	Estimated Length of Stay.
EMB	Executive Management Board.
EMIS	Electronic Medical Information System.
ENT	Ear Nose & Throat.
ESR	Electronic Staff Record.
EWS	Early Warning System is based on vital signs such as blood pressure, heart and breathing rates.

F

FFT	Friend & Family Test. Introduced in 2013 it is an opportunity for family and friends to give feedback to hospitals regarding their care and experience.
FITC	Finance, Investment & Transformation Committee.
FGM	Female Genital Mutilation.
FNOF	Fractured Neck of Femur.
FOI	Freedom of Information.
FRP	Financial Recovery Plan.
FT	Foundation Trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS foundation trusts provide and develop healthcare according to core NHS principles - free care, based on need and not on ability to pay. NHS foundation trusts have members drawn from patients, the public and staff, and are governed by a board of governors comprising people elected from and by the membership base.
FTSU	Freedom to Speak Up.
FY1 & FY2	A **Foundation doctor** (**FY1 or FY2** also known as a **house officer**) is a grade of medical practitioner in the United Kingdom undertaking the Foundation programme - a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/ general practice training. The grade of Foundation Doctor has replaced the traditional grades of pre-registration doctors and senior house officers.

G

GDPR	General Data Protection Formulary.
GIRFT	Getting it right first time. Is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care.
GMC	General Medical Council.
GP	General Practitioner.
GRE	Glycopeptide-resistant Enterococci.
GREATiX	A system for reporting clinical excellence.
GTT Audit	Global Trigger Tool Audit. The Global Trigger Tool is a recognised and validated audit tool developed by the Institute for Healthcare Improvement (IHI) In Boston USA. It can be used as part of an organisation's safety improvement programme to identify and so learn about harm and safety incidents which occur as part of the patient's treatment. Twenty records are reviewed each month using the GTT and the findings plotted over time on a run chart to establish a harm rate. Barts and The London NHS Trust has been undertaking GTT auditing since 2008.
GUM	Sexual Health Clinic (genitourinary medicine).

H

HAI	Hospital Acquired Infections.
HCAI	Healthcare Associated Infection. An avoidable infection that occurs as a result of the healthcare that a person receives.
HCA	Health Care Assistants.
HEE	Health Education England.
Hep B&C	Hepatitis B&C.
HES	Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.
HESL	Health Education South London.
HGD	High-grade dysplasia.
HIV	Human Immunodeficiency Virus.
HWE	Health Watch England.
Hospital Episode Statistics	Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.
HRA	Health Research Authority.
HR&OD	Human Resources and Organisational Development.
HSMR	Hospital standardised mortality ratio.
HV	Health Visitor.

I

IAC	Integrated Adult Care.
IBD	Inflammatory Bowel Disorder.
ICO	Information Commissioner's Office.
IDA	Iron deficiency anaemia.
IG	Information Governance. The structures, policies and practice to ensure the confidentiality and security of health and social care service records, especially clinical records which enable the ethical use for the benefit of the individual to whom they relate and for the public good.
IHI	Institute for Healthcare Improvement.
IMCA	Independent Mental Capacity Advocate.
IQI	The Indicators for Quality Improvement (IQI) are a resource for local clinical teams providing a set of robust indicators which could be used for local quality improvement and as a source of indicators for local benchmarking. The IQI can be found on the NHS Information Centre website at: **www.ic.nhs.uk/services/measuring-for-quality improvement**
IP	Inpatient.
ISC&CS/ISCCS	Integrated surgery, Cancer and Clinical Support.
IWCSH	Integrated Women's Children and Sexual Health.
ITU/HDU	Intensive Treatment Unit/ High Dependency Unit.

J

JAG	The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) was established in 1994 and set standards for individual endoscopists set standards for training in endoscopy quality assure endoscopy units quality assure endoscopy training courses.
JSCC	Joint Staff Consultative Committee.

K

K2 CTG	Learning Package which all Midwives have been enrolled on.
KHWD	Knowing how we're doing.
KLOE	Key Lines of Enquiry.
KPI	Key Performance Indicator.

L

LAS	London Ambulance Service.
LA	Local Authority.
LD	Learning Disabled.
LFB	London Fire Brigade.

LIFE	Living Independently for Everyone. Created by the One Croydon Alliance in 2017, LIFE brings together teams from health and social care as well as the voluntary sector. It provides coordinated short-term support to people and enable them to retain or regain their independence and continue living in their own home.
LiA	Listening into Action (LiA) LiA is about re-engaging with employees and unlocking their potential so they can get on and contribute to the success of your organisation, in a way that makes them feel proud.
LHW	Local Health Watch.
LMWH	Low Molecular Weight Heparin.
LHB	Local Health Board.
LOS	Length Of Stay.
LTC	Long Term Condition.
LTFM	Long-Term Fiscal Model.

M

MAU	Medical Assessment Unit.
MAPPA	Multi-agency Public Protection Arrangements.
MARAC	Multi-agency Risk Assessment Conference.
MASH	Multi agency safeguarding hub.
MCA	Mental Capacity Act.
MDT	Multi-Disciplinary Team.
MHRA	Medicines & Healthcare Products Regulatory Agency.
MECC	Make Every Contact Count.
MINAP	Acute Coronary syndrome or Acute Myocardial Infarction.
MMC	Medicine Management Committee.
MOPAC	Mayor's Office for Policing And Crime.
MR	Medical Revalidation.
MRG	Mortality Review Group.
MRI	Magnetic Resonance imaging.
MRSA	Methicillin-Resistant Staphylococcus Aureus. Methicillin-Resistant Staphylococcus Aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. MRSA is, by definition, any strain of Staphylococcus aureus bacteria that has developed resistance to antibiotics including the penicillin's and the cephalosporins. MRSA is especially troublesome in hospitals, where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.
MSSA	Methicillin-Sensitive Staphylococcus Aureus.
MUST	Malnutrition Universal Screening Tool. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

N

NAOGC	Oesopha-gastric Cancer.
NAO	National Audit Office.
NBV	New Birth Visit.
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death.
NEWS	National early Warning System.
NETA	Non Elective Threshold Adjustment.
NFF	No Fault Found.
NHS	National Health Service.
NHSE	National Health Service England.
NHSI	National Health Service Improvement.
NHS Number	National unique patient identifier that makes it possible to share patient information across the whole of the NHS safely, efficiently and accurately.
NHSR	NHS Resolution.
NICE	The National Institute for Health and Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: **www.nice.org.uk**

NJR	National Joint Registry.
NLCA	National Lung Cancer Audit.
NMB	Nursing & Midwifery Board.
NNAP	Neonatal Intensive and Special Care.
NPDA	National Paediatric Diabetes Audit.
NPSA	The National Patient Safety Agency is an arms-length body of the Department of Health and Social Care, responsible or promoting patient safety wherever the NHS provides care. Visit: **www.npsa.nhs.uk**
NRLS	National Reporting and Learning System.
NRPF	No Recourse Public Funds.
NSPCC	National Society for the Prevention of Cruelty to Children.
nSTEMI	Non-ST-segment-elevation myocardial infraction.

O

OBC	Outcomes based Commissioning.
OBD	Occupied Bed Days.
OCA	One Croydon Alliance.
OGD	Oesophago - Gastro-duodenoscopy.
OPD	Out Patient Department.
OPTIMAL	Research project improvement.
OP	Outpatient.
OT	Occupational Therapy.
OSC	Overview and Scrutiny Committee. Since January 2003, every local authority with responsibilities for social services has had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS - not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

P

PALS	Patient Advice Liaison Service.
Patient	A person who receives services provided in the carrying on of a regulated activity. This is the definition of "service user" provided in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
PAU	Paediatric Assessment Unit.
PACS	Primary and Acute Care Systems.
PCI	Percutaneous Coronary Interventions.
PDR	Personal Development Review.
PE	Pulmonary Embolism.
PEWS	Paediatric Early Warning Score.
PGMC	Post Graduate Medical Centre.
PHE	Public Health England.
PHSO	Parliamentary and Health Service Ombudsman.
Picker Institute UK	Picker research and gather patient's views of healthcare using surveys, focus groups and other methods as for example by supporting the national survey programme in the NHS for the Care Quality Commission.
PLACE	Patient Led Assessments of the Care Environment. PLACE assessments provide a framework to review how the healthcare environment supports patient privacy and dignity, quality of food provided, cleanliness and general building maintenance. The inspectors are a mix of Trust members, external inspectors and patient representatives.
PM	Post Mortem.
PMO	Project Management Office.
PPI	Patient and Public Involvement now called Patient and Public Voice.
PPV	Patient and Public Voice. This used to be called Patient and Public Involvement (PPI) but has been renamed. It highlights ways in which the public and patients are involved in a trusts patient care.
P&D	Privacy and Dignity.
PROMs	Patient Reported Outcome Measure.

Providers	Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.
PTL	Patient Tracking List.
PS&MC	Patient Safety & Mortality Committee.
PWMH	Purley War Memorial Hospital.

Q

QESP	Quality, Experience, Safety Programme.
QC	Quality Committee.
QIP	Quality Improvement Programme.
QIPP	Quality, Innovation, Productivity and Prevention. A programme to ensure that each pound spent is used to bring maximum benefit and quality of care to patients.

R

RAG	Red Amber Green - Grading.
RAPG	Risk Assurance and Policy Group.
RCA	Root Cause Analysis.
RCEM	Asthma Paediatric and adult care in Emergency Department.
RCN	Royal College of Nursing.
RCPCH	Royal College of Paediatrics and Child Health.
Registration	From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).
Research	Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.
R&D	Research & Development - The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another.
RAMU	RAPID Assessment Medical Unit.
RFID	Radio Frequency Identification.
RTT	Referral To Treatment.

S

Safeguarding	Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded.
SARs	Subject Access Requests.
SALT	Speech & Language Therapy.
SAU	Surgical Assessment Unit.
SCBU	Special Care Baby Unit.
SCR	Serious Case Reviews.
SI	Serious Incident.
SIRG	Serious Incident Review Group.
SHMI	Summary Hospital - Level Mortality Indicator.
SLAM	South London and Maudsley NHS Foundation Trust.
SOP	Standard Operating procedure.
SRO	Senior Responsible Officer.
SSNAP	Sentinel Stroke National Audit Programme.
STF	Sustainable and Transformation Fund.
SUS	Secondary Uses Service. A single repository of person and care event level data relating to the NHS care of patients, which is used for management and clinical purposes other than direct patient care. These secondary uses include healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance. Visit: **www.ic.nhs.uk/services/the-secondary-uses-service-sus/using-this-service/data-quality-dashboards**
Superspells	Spells ending in transfer to another NHS hospital are linked together.

T

TB	Tuberculosis.
TIA	Transient Ischaemic Attack.
T&O	Trauma & Orthopaedics.
ToR	Terms of reference.
TTA (medication)	To Take Away (medication).

U

UKAS	United Kingdom Accreditation Service.
UKBHC	UK Board of Healthcare Chaplaincy.
UNIFY	Data Collection System.
UCC	Urgent Care Centre.

V

VFM	Value for Money.
ViEWS	VitalPAC Early Warning System is a tool for bedside evaluation incorporated into VitalPAC. It is based on seven physiological parameters: pulse; temperature; systolic blood pressure; respiratory rate; AVPU (the level to which the patient responds), oxygen saturation, plus the patient's inspired oxygen requirements.
VitalPAC	An electronic track and trigger system that provides a recording mechanism for patient's vital signs and essential screening tools.
VTE	Venous Thrombo Embolism.

W

WHO	World Health Organisation.
WTE	Whole time Equivalent.
WRES	Workforce Race Equality Standard.
WDES	Workforce Disability Equality Standard.

Y

YTD	Year To Date.

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