Barking, Havering and Redbridge University Hospitals NHS Trust

PRIDE

ANNUAL REPORT AND ACCOUNTS 2017-18

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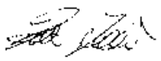
A MESSAGE FROM OUR CHAIR

Joe Fielder,
Chair



Welcome to our annual report for 2017/18. My first as Chair of Barking, Havering and Redbridge University Hospitals NHS Trust.

Since joining the Trust towards the end of 2017, I have been hugely impressed by the commitment, passion and dedication of all the staff to deliver high quality care to our patients, which has been unwavering, despite the huge pressure which has undoubtedly been felt, particularly across the winter months.

I am absolutely committed towards continuing our journey to achieving our vision of delivering outstanding care to our community, and I know all my colleagues in the Trust feel similarly and there is a huge commitment to keep improving our quality of care and our standards in every field.

It has not been a year without its challenges. It is well known that the past few months have seen systemic financial problems come to light and we are now tackling some significant issues. While these are described elsewhere, I should say that from a Board perspective, we take responsibility for the lack of governance and failure in financial performance of the Trust, and we are sorry.

It is clear that things were not as they should have been for some while. However, I think we responded appropriately, seeking external support, gathering the right intelligence and gaining improved insight to ensure that we were able to diagnose the underlying issues. I believe that we end the year stronger and wiser for the experience, and with important lessons having been learned.

The Board itself has seen a period of significant change, with both executives and non-executives, including myself, having joined the Trust. These periods can always throw up challenges as organisations reorder themselves and that has been the case here. I look forward to helping to create a more stable and sustainable leadership into 2018 and beyond.

Ultimately, being placed into financial special measures by NHS Improvement at the very end of the financial year was a disappointing outcome, but we understood the reasons and rationale for the decision. The more important thing will be how we respond to the challenge in 2018/19. I am calling for everyone's full commitment to safely meeting this challenge.

As I write this, some weeks on from the close of the year, the signs are very positive that we can work constructively and productively to reduce our deficit, but without compromising the quality and scope of patient care which must and will continue to be our priority.

We cannot do what we do in isolation, so we continue to work hard on how we engage with partners – be it our Patient Partners – who have become an increasingly invaluable asset to our Trust, or our partners in the local and national health economy – NELFT, our Clinical Commissioning Groups, GPs, NHS England and NHS Improvement to name a few, or internationally, the Virginia Mason Institute, which continues to shape our approach to driving improvements in our hospitals.

We continue to engage closely with our local Sustainability and Transformation Plan (STP) for North East London – this is a long-term, strategic view that we must keep in our minds to ensure we are making collaborative and sustainable decisions for now, and long into the future.

We will be holding more frequent Board meetings and improving the mix of representation so that more of you are heard.

I must pay tribute to the continued work of the King George and Queen's Hospitals Charity, which has funded many projects this year which will continue to make a real difference to our patients, visitors and staff. I'd like to thank everyone in the team and all who support our charity.

I would like to thank the Board, the leadership and the staff for their continued commitment and hard work and I look forward to the year ahead.

A MESSAGE FROM THE CHIEF EXECUTIVE

Matthew Hopkins,
Chief Executive

I would like to give huge thanks to every one of our staff, volunteers and partners for their tremendous support, effort and hard work in what has been a year of both highs and lows.

The year started on a huge high of course, after the announcement at the end of March that we were the first trust in London to leave special measures for quality reasons, which we'd entered three years previously. Staff rightly felt proud of their huge efforts being acknowledged by the Care Quality Commission (CQC) and NHS Improvement.

Our performances against the constitutional standards – particularly in cancer, Referral To Treatment (RTT) and the Four Hour Emergency Access Target – show there have been both significant successes, and some stubborn challenges.

Our waiting lists for elective care have shrunk dramatically thanks to a huge collective effort across the local health community. From where we were just 18 months ago, this represents a fantastic transformation, and to hit the National Standard as we did, ahead of the planned trajectory, was a great result.

While we were not quite able to sustain hitting the 92% target, to be hovering so close, given the context locally and nationally, is a huge tribute to the efforts of our staff. The difficulty will be how we sustain this and meet the need, given the ever increasing levels of demand we are seeing, and the challenges facing the local health economy particularly.

Similarly, over the past year, we have seen a transformation in the care we are providing to patients with cancer – something the whole Trust can feel pride about.

This is both in terms of the speed with which we are moving patients through the pathway – we hit the NHS constitutional standard for ensuring that 85% of patients begin treatment within 62 days of referral in eight months of the year.

It's also about the quality of care. The unveiling of the UK's first Halcyon radiotherapy machine at the end of 2017 is one example of the cutting edge treatment we are now offering. Over the course of 2018/19 we will continue to invest in our facilities and improve our hospitals, with at least one further new treatment machine on the way.

However, our performance, particularly over the extremely challenging winter months, against the four-hour emergency access target, has been less positive. Our patients are sicker, with multiple concurrent illnesses, meaning we have higher admissions, longer lengths of stay, and one of our most challenging winters ever.

As Joe has already mentioned in his introduction, being placed into financial special measures as a result of significant financial challenges which we have faced, was very disappointing.

I believe that we were up front and honest about the problem when it became fully apparent and we took swift action to address the immediate issues and develop a plan to move forward.

Now the underpinning issues have been identified, it has been an opportunity to reflect and learn that things were not as they should have been, in terms of our approach, our processes, our reporting or our culture.

I have been hugely impressed with the commitment, resilience, passion and dedication of our staff to tackle this challenge – just as they have tackled other challenges before. Every day I find new reasons to be proud of them.

It should also be acknowledged that the picture across the whole of North East London is extremely challenging. Our local Clinical Commissioning Groups are under similar levels of financial strain, so this year will be hugely significant in terms of recognising and dealing with the broader health challenges which face our population, and finding ways to balance the supply and demand for our services, while using our resources wisely.

I am very clear, as are the Board, that while we need to regain tighter control of our finances, we absolutely will not compromise on patient safety or the quality of patient care.

Now, more than ever, we will press on with embedding The PRIDE Way – our improvement methodology forged through our partnership with the Virginia Mason Institute. It will give us the tools to make sustained, embedded change, improving our efficiency and reducing costs.

This will build on our having launched the Leaders' Agreement last year, which set out our clear expectations of leaders in the Trust to support and develop their teams, to make our Trust a great place to work.

I would like to thank our staff, volunteers and patient partners, our stakeholders and partners, but most importantly, our patients.

OUR YEAR IN PICTURES

APRIL

Our apprentice, Samantha Misselbrook was named the best apprentice for the north, central and east London region in the National NHS Apprenticeship Celebration Awards.

Samantha works in our Education department as a training and development assistant and is passionate about helping young people plan their future, after being unsure of what she wanted to do on leaving school.

MAY

A miracle mum was about to celebrate the first birthday of the daughter she didn't think possible. Beatrice Way and husband Alexander celebrated the first birthday of baby Rosemary, and thanked our surgeon, Hu Liang Low, who saved Beatrice's life with a pioneering operation following a stroke.

JUNE

We made it possible for a devoted couple to marry in our hospital after Robert Davies, 52, received the news that his cancer was terminal.

Robert married long-term partner Julie on Ocean B ward at Queen's Hospital watched over by family and friends including their two daughters, Megan and Cerys.

JULY

Grateful patient Kate Baker (who later became a patient partner) brought yummy cakes to staff on Sahara B ward at Queen's Hospital to thank them for looking after her so well when she was treated following the removal of a benign brain tumour just before Christmas.

AUGUST

We improved care for our cancer patients, thanks to a machine designed by our own Divisional Manager for Cancer and Clinical Support, Paula Tinniswood.

The 'Airglove' provides a more comfortable way to find a vein when administering chemotherapy.

SEPTEMBER

Some of our colleagues shared their own stories as we marked Organ Donation Week, and saw the highest ever number of people signing up to the register at our hospitals during the national event. Among them was Ernesto Antonio, one of our team, who had a heart transplant almost two decades ago.

OCTOBER

A caring seven-year-old visited our NICU to donate premature baby clothes and money he'd raised to help our tiniest patients. Henry O'Keefe had been inspired by a Pampers TV ad.

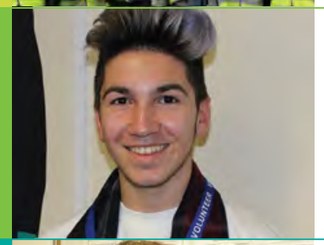
NOVEMBER

We held our annual Long Service and PRIDE Awards, to give thanks and recognition to our dedicated staff and volunteers.

DECEMBER

We held special tree lighting ceremonies at both our hospitals in the run-up to the festive season to launch our Treasured Memories appeal. The Avanti School choir brightened the day of visitors to King George Hospital with some festive tunes before a lucky pupil got to switch on the Christmas tree lights.

JANUARY



Our youngest patient partner, Alex Burulea, 17, was interviewed in our local press to encourage other young people to get involved with their local hospital.

FEBRUARY

We held a celebration event to mark the achievements of our trainee nurse associates, a year after we became one of the first trusts to launch the programme. Among those celebrating was Alina Stevens, who discovered a love of helping dementia patients when she spent a summer holidays working in a dementia unit with her stepmother.

MARCH

We swept the board at the Patient Experience Network National Awards with three awards; for our short film for cancer patients; our bereavement support, including opening the Daisy Centre; and our patient partner Sara Turle won the best networker award. We were also runner-up for our innovative partnership work with critical care patients at the end of their lives.

SECTION ONE:

PERFORMANCE REPORT

This section of the Annual Report details our operational performance over the 2017/18 financial year.

It is structured into five sections, which align with our five core objectives, as set out in our Operational Plan for 2017-2019.

These core objectives, and those which sit beneath them, were led by our staff and volunteers, working in partnership with key local stakeholders and patient representatives.

OUR 2017-18 OBJECTIVES

DELIVERING HIGH QUALITY CARE

- Embed quality and safety systems to respond to quality concerns and reduce harm
- Ensure the highest standards of infection control
- Embed The PRIDE Way, our quality improvement methodology

RUNNING OUR HOSPITALS EFFICIENTLY

- Develop our divisional teams to ensure we are well-led
- Continue to improve delivery of our constitutional standards
- Improve back office productivity, including procurement, IT and clinical support services, and refresh our estates strategy

BECOMING AN EMPLOYER OF CHOICE

- Implement the Leaders' Agreement to enable our staff to achieve excellence
- Establish new roles and implement our academic and education strategies to develop our staff
- Increase and retain our substantive workforce

WORKING IN PARTNERSHIP

- Work with our partners to deliver the Sustainability and Transformation Plan
- Improve engagement and community development with our partners, patients and public
- Work with our partners to develop services to align with our Clinical Services Strategy

MANAGING OUR FINANCES

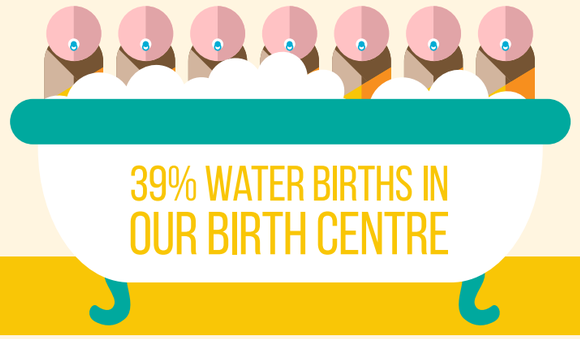
- Embed service line reporting and management to improve decision-making and budgetary control
- Make sure we get paid for all the work we do
- Achieve financial balance with the inclusion of transformation funding

OUR HOSPITALS IN 2017/18:

136,000 GP REFERRALS

MATERNITY

99% POSITIVE RECOMMENDATIONS



8,299 BABIES DELIVERED THIS YEAR

PAEDIATRICS

6,202 PAEDIATRIC INPATIENTS (ADMISSIONS)

12,290 PAEDIATRIC OUTPATIENTS

EMERGENCY

239,136 ATTENDANCES (ALL TYPES)

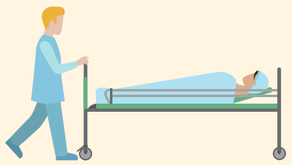
73,088 EMERGENCY ADMISSIONS

67,711 AMBULANCE ARRIVALS

PLANNED CARE

50,517 DAY CASE PROCEDURES

739,842 OUTPATIENT APPOINTMENTS 2,027 A DAY



23,938 THEATRE OPERATIONS

DELIVERING HIGH QUALITY CARE

- Embed quality and safety systems to respond to quality concerns and reduce harm
- Ensure the highest standards of infection control
- Embed The PRIDE Way, our quality improvement methodology

PROVIDING EXCELLENT QUALITY CARE, OUTCOMES AND SAFETY

Our patients are at the heart of everything that we do, and delivering first-class care is our top priority.

We believe we have had a positive year, with a strong focus on improving the quality of care, embedding and sustaining improvements in this area.

When the Care Quality Commission (CQC) published its report just before the start of the financial year, in March 2017, inspectors rated us 'Good' in the Safe domain in five out of six of the areas they reviewed. More detail on our performance this year is found in our Quality Account.

We welcomed the CQC back to the Trust at the start of 2018 to undertake further reviews, including one of the 'Well Led' domain. At the time of writing this report, we await the CQC's written report, but we were encouraged by their informal feedback.

IMPROVING SAFETY

We have made significant changes to the way we deliver care to our patients alongside understanding how safe that care is. We draw on information from clinical incidents, patient feedback, complaints and litigation to tell us where we need to focus our efforts. Where appropriate we have worked hard to learn lessons.

PATIENT SAFETY SUMMITS

We continue to hold weekly, multi-disciplinary Patient Safety Summits, with representation from across the organisation, as well as patient representatives, to review recent serious incidents, and share learning.

These gatherings, which are for all the clinical divisions, continue to be extremely valuable opportunities for learning and reflection, and it was encouraging to hear positively from the Secretary of State for Health and Social Care, Jeremy Hunt MP about his enthusiasm for them when he visited us.

VITALPAC

The rollout of VitalPac this year has been another huge step forward. This software system allows us to record patient observations on iPod touch devices at the bedside which means we will no longer have to write down patient observations.

This new technology is helping our staff and patients by recording information in real time and will therefore be always up-to-date, and it boasts an early warning system to help identify high risk patients, or those who may be deteriorating.

QUALITY AND SAFETY

We are continuing to feel the benefit of the addition of an expert quality and safety team to help our frontline staff to deliver high quality, safe care. We continue to focus on four main objectives:

- Increase incident reporting, whilst reducing harm from incidents
- Reduce the number of falls
- Reduce hospital-acquired pressure ulcers
- Reduce healthcare-acquired infections

AT THE END OF THE YEAR WE ARE NOW IN THE TOP 20% OF TRUSTS FOR REPORTING INCIDENTS - A HUGE IMPROVEMENT

INCIDENT REPORTING

Reporting events or actions that pose a risk or actual harm to our patients is critical to improving levels of safety. Research, both nationally and locally, shows that there is a correlation between the numbers of incidents which are reported, and the reduction in harm to patients.

This is because often, any near misses which are spotted by staff first, before any patient is harmed, can result in pre-emptive action to mitigate the future risk. More reporting demonstrates a more vibrant safety culture.

We have previously acknowledged that we have not done well enough historically at reporting clinical incidents. Last year we reported a real step forward, with significant increases in the numbers of incidents reported. Naturally, it is not possible to keep increasing numbers indefinitely, so this year has been about consolidating this position, embedding these practices, and improving how we learn from incidents.

At the end of this year, we are now in the top 20% of Trusts nationally. From having been in the bottom 20 in 2015, this marks a huge improvement.

We held three Rapid Process Improvement Workshops (RPIWs) across the year, using our improvement methodology from The PRIDE Way (see p22/23) to focus on improving how we report, progress and report back on incidents. We look forward to the year ahead as a further opportunity to progress.

PRESSURE ULCERS

A pressure ulcer is damage to the skin and the deeper layer of tissue under the skin. This happens when pressure is applied to the same area of skin for a period of time. Periods of immobility and ill health are significant risk factors. Key to preventing this damage is understanding each patient's risk and responding appropriately.

In 2017/18 we said we would:

- Reduce hospital acquired pressure ulcers by 5% for the 2017/18 period
- Continue pressure ulcer prevention and management training for nursing staff via clinical training sessions, induction and mandatory programmes; with the aim of training 3,096 nursing staff over a three-year period
- Continue to investigate hospital acquired incidents for grade 2, 3 and 4 pressure ulcers and where required ensure action plans are in place to address issues through the pressure ulcer review panels.

We are very pleased that we actually reduced the number of patients with hospital acquired pressure ulcers by 38.9% from 2016/17 – a total of 140 patients at an incident rate of 0.40%.

We also hit our training aspiration ahead of the original target date of November 2018, which was extremely encouraging.

NATIONAL COLLABORATIVE

The Trust has also been one of 25 trusts across the country taking part in a 'National Collaborative' aimed at the reduction of pressure ulcers, led by NHS Improvement.

This work has been a huge success.

Two wards were involved in this project for the six month duration. Ward 1 was aiming to reduce its incidence of avoidable hospital acquired pressure ulcers by 20% and Ward 2 was demonstrating healing of inherited pressure ulcers; with the aim of demonstrating improvement or healing of wounds by 50% from the baseline audit.

Ward 1 had no avoidable pressure ulcers by the end of the project on 31 March 2018 and had achieved 166 days without an avoidable pressure ulcer by the end of the project.

Ward 2 exceeded their target by demonstrating healing of 25% of wounds and 75% of wounds showed improvement; all patients with pressure ulcers and moisture damage on the ward were monitored as part of this project.

In the year ahead we will continue to take forward our learning, and we have appointed a tissue viability nurse for a short period to work with staff on the elderly care wards to improve further.

INFECTION PREVENTION AND CONTROL

We've seen improvements this year in our performance in infection prevention and control which are encouraging, but it remains a target area for us and we will ensure continued vigilance, emphasis and messaging to staff.

We made a big improvement this year in our performance against C. difficile infection. We achieved the national stretch target for C. difficile infection with 15 cases this year, against a target of <30. This compares with 29 cases last year, but we missed our target for MRSA infections (five cases against a target of zero).

We will continue to do what we can to improve our hand hygiene and to ensure that staff are fully trained in specialist "non-touch" techniques that protect against the spread of infection.

FALLS

Falls are a serious problem among older people. A major cause of disability and mortality, falls also have a significant psychological impact on confidence and independence.

We've run a comprehensive training programme which has reduced falls

We are now midway through our three-year Falls Strategy for 2016-2019 with an annual action plan which was introduced across our hospitals.

We have run a comprehensive training programme throughout the year, comprising sessions in our simulation suites and online, with supporting information made available for both staff and patients.

Our target for 2017/18 was to seek a 3% reduction in the number of falls overall per 1,000 bed days, and we were able to achieve this.

We also pay close attention to falls which result in moderate, or more serious, harm. There were a total of 19 incidents in the year, compared with 25 the year before, so we achieved a 25% reduction in the number of falls with harm.

IMPROVING THE PATIENT EXPERIENCE

OUR PATIENT ENVIRONMENTS

We know that the environment in our hospitals can have a significant impact on patients.

As across the NHS, we continue to utilise Patient-Led Assessments of the Care Environment (PLACE) inspections to drive action plans for the year ahead. These involve both staff and patients/volunteers.

We have a rolling programme of improvement works to keep our facilities as up-to-date and welcoming as possible.

As the year opened, we were ready to open our new, improved facilities in phlebotomy and pre-assessment, both at King George Hospital in April. The moves for both these services represent a significant improvement for patients and staff, with more space, better waiting areas, and purpose-built cubicles.

Further detail on specific projects, including the reconfiguration and improvement of our Emergency Department/Enhanced Urgent Care Centre (EUCC) at Queen's, and the work undertaken to install the UK's first Halcyon radiotherapy machine, is elsewhere in this report.

PATIENT EXPERIENCE

The opinions of our patients are vital as we strive to make improvements that will make a real difference to their experience. We want to ensure that every patient has the best possible care, and that we listen to every patient so we can understand what we are doing well and where we can improve.

We gather patient feedback in a variety of ways, including through the Friends and Family Test, our Mystery Shopper scheme, and via comment and feedback cards.

FRIENDS AND FAMILY TEST

We continue to work with external partner "I Want Great Care" to help us gather and analyse data relating to our Friends and Family Test (FFT) scores. We received more than 135,000 this year – a significant evidence base from which we can further refine and improve in coming years.

Many of our clinicians have embraced the programme and we were delighted to be able to award a large number with certificates to acknowledge the volume of outstanding feedback they have received from patients.

We use the FFT scores to identify and reward our Team of the Week, motivating our staff to continue encouraging patients to participate, but we also changed the criteria for Team of the Week this year, acknowledging that not every team has the opportunity to earn this feedback. It has been nice to get the chance to recognise the efforts of even more of our colleagues.

Many of the comments and suggestions we have received have already led to changes and improvements to our services.

PATIENT EXPERIENCE COLLABORATIVE

This year we were one of 12 trusts across the country that formed a Patient Experience Collaborative. The aim of the collaborative is to work together to share good practice and learning.

A key component of the work relates to how we talk to our patients about their experience. We identified eight wards where we have piloted a patient experience questionnaire which asked patients detailed questions about their care and treatment.

We were the only trust to also include a staff experience element to this work as we recognise the clear link between good staff experience and good patient experience. Putting patients at the heart of everything we do, we also ensured that a Patient Partner was part of our collaborative team – the only trust in the programme to have done this.

#HELLOMYNAMEIS

We continue to build on the national #HelloMyNameIs campaign to develop our own approach to greeting patients. The initiative, started by Dr Kate Granger before she passed away, is to ensure all patients get a more positive first impression when in hospitals, and so they know who is looking after them.

We want to encourage our staff to create a great impression by smiling, introducing themselves, explaining their role and either offering to help, or explaining what they are here to do. It's really simple, but it has a big impact. We were delighted to welcome Kate Granger's husband, Chris Pointon, to Queen's Hospital as part of a tour this year, to raise awareness, and we were delighted so many staff took the time to attend his sessions.

ROYAL ASSOCIATION FOR DEAF PEOPLE QUALITY MARK – BECOMING THE FIRST DEAF-AWARE HOSPITAL

We were delighted to become the first NHS trust to achieve the Deaf Aware Quality Mark from the Royal Association for Deaf People for Queen's Hospital. We have worked really hard on improving communication, information and accessibility for patients who are deaf and hard of hearing, so it was fantastic to get this recognition.

The regular training sessions for staff continue to be really popular and well-attended. For 2018/19 we will be working on getting the same accreditation for King George Hospital.

KING GEORGE AND QUEEN'S HOSPITALS CHARITY

Our charity continues to provide invaluable support, raising funds so that we can make both of our hospitals even better for patients.

The restructured charity team is thriving and over the course of the last year has raised around £580,000, an increase of over 36% on the previous year.

The charity organises several public charity events throughout the year; the most popular and successful of these remains the annual Christmas Ball – tickets from the 2017 Motown-themed event sold out several weeks in advance and raised over £59,000.

Funding also comes in by means of generous donations from individuals; through legacies and in memorium donations; from the JustGiving pages of our supporters and from the traders selling goods in the hospitals.

At the time of writing this report, we have just strengthened the team by bringing in a new team member with event experience, who will be instrumental in 2018/19 in delivering more high quality events.

All the money the charity receives is reinvested in our hospitals, via the Charitable Funds Committee, which meets regularly to discuss applications.

CASE STUDY

CLAIRE'S NEST AND MINIBOOS

The charity has worked closely with the specialist team in Queen's to find ways to make life even more comfortable for our tiniest patients. Parents with a baby needing to be in an incubator often lose out on those precious cuddles that support the important parent/baby bonding. Charity funds provided soft and comforting fabric nests called Claire's Nests to help the baby feel secure and cossetted while in their incubator.

Miniboos are little star shaped characters made from soft bamboo rayon that come in packs of two. Parents get to keep one on their person, as well as leaving one alongside the baby, swapping back and forth so they can smell baby, while their smell becomes familiar to the baby too. They can also aid with breastfeeding.

CASE STUDY

REMINISCENCE INTERACTIVE THERAPY ACTIVITIES

With a growing and aging population, caring for our elderly and those with complex cognitive illness is a priority. The charity has raised funds with the help of The League of Friends from King George Hospital to purchase touch screen PCs and iPads for patients in wards at King George Hospital.

These systems have been specifically designed to engage patients who are living with all types of cognitive illness such as dementia, Alzheimer's, Delirium or Parkinson's. Becoming engaged and enjoying the day helps our patients to find better eating and sleeping patterns, resulting in a reduction in trips and falls caused by wandering at night.

Patients use them to watch films; listen to music, be entertained with their favourite TV sketches from the past as well as taking part in games, competitions and even armchair exercises. Staff say the wards seem more calm and relaxed and they have seen many positive outcomes. The charity is now raising funds to buy the same equipment for patients in Queen's Hospital very soon.

LEARNING FROM PATIENT FEEDBACK

Despite our best intentions, we don't always get things right. Last year we took steps to improve our complaints processes to make them more responsive, and this year has seen a positive continuation of the improvement.

The grading system we designed last year continues to work effectively, so that we can ensure that complaints have the right amount of time to sufficiently investigate to greater depth. These can then be escalated depending on the risk grading.

We believe we are offering a more responsive, comprehensive and thorough complaints process than ever before.

During the year we also successfully launched the Patient Advice and Liaison Service (PALS) Twitter account and Facebook page. We did this to offer another route for our patients to engage with us, recognising that increasing numbers use social media to ask questions or provide feedback or opinions. This has been well received and a helpful addition.

However, our increased accessibility may have something to do with the increased numbers of complaints overall. Although we hoped to achieve an overall reduction, we actually saw the number increase – to a total of 919, compared with 843 last year.

We also introduced a follow up process to all complainants via telephone, which appears to have had a positive impact on reducing the numbers of reactivated complaints.

The focus for the year ahead will be on further thematic analysis to identify any problem areas and also general workshops and training to try and deal with patient concerns before they escalate.

WE BELIEVE WE ARE OFFERING A MORE RESPONSIVE, COMPREHENSIVE AND THOROUGH COMPLAINTS PROCESS THAN EVER BEFORE.

A PATIENT'S STORY – JENNIFER SYKES

My GP said that because of my symptoms I needed to have a colonoscopy. To be honest, I was dreading it because I had had a dreadful experience at Queen's Hospital about 10 years ago.

This time, the whole experience was amazing. It made me appreciate that we expect the clinical care to be good and, as long as it is, then what matters to the patient is how they are made to feel.

It all started with the wonderful Raj phoning me a few days after I saw my GP and together we arranged an appointment date and time. It was so good not to just be sent an appointment and then have the difficulty of trying to change it. He explained what would happen during the procedure and more than once asked me if I had any questions. He left me feeling so much better.

The medication to prepare for the procedure arrived as Raj had said through the post – how easy! And the instructions were easy to understand. However I really struggled to take it. It was awful but it worked.

On the day of my appointment my husband dropped me off and I was pointed to the department by the receptionist. I couldn't find it straight away although it is clearly marked. A lovely member of staff asked me if I wanted help as I looked lost and showed me to the door.

I was actually almost there but being nervous I missed the signs. The lady didn't work in the department but had bothered to stop – that meant such a lot. Then I saw the receptionist of the department and a nurse, they were both brilliant and really put me at my ease. Then I met Raj who showed me to a bed and explained in detail how to prepare and I was given disposable pants and a gown and a dressing gown.

I saw a doctor in a private room who checked my history and again asked if I had any questions. They then took me into the treatment room. Everyone was kind and professional and my dignity was totally respected. I had a sedative and during the procedure was told what they were seeing on the screen and that they had found nothing unusual. I was congratulated on my preparation! Then it was back to the bed area for a cup of tea and a biscuit.

The cleaner asked me if I was warm enough and did I want a blanket, I had already been asked, but it was so kind of her. I told her that the place was spotless and how great she was at her job, she said she loved her job and all the team were very helpful.

I was given an evaluation form by Raj and loved that it asked if I had had "great" care – not "good enough" but "great". I love the aspiration. Of course I did have "great" care. In fact it was such a good experience that I took the time to email the Chief Executive.

I met a neighbour a few weeks ago and she said she had a colonoscopy at Queen's and was surprised at how good the experience it was. We exchanged notes and both agreed that Queen's has improved so much.

So, thank you for all the wonderful improvements and the opportunity to share my experience.

THE PRIDE WAY – EMBEDDING IMPROVEMENTS

We are one of the five trusts chosen to benefit from the experience of Virginia Mason – a leading American hospital.

We continue to do our best to ensure our relationship with the Virginia Mason Institute (VMI) offers our trust an opportunity to implement an evidence-based quality improvement culture and methodology to the benefit of our patients, visitors and staff.

We refer to this as The PRIDE Way. The PRIDE Way is a fundamental change in the way we work. It's about our staff having the power to make continuous improvements to the care we give to our patients and influence change in our Trust.

We have had a very positive year in 2017/18 as we continue to move towards embedding the principles of The PRIDE Way across our organisation, particularly through the launch of the Pride Way for Leaders training, which will gather even more momentum through 2018/19.

We are increasingly moving the 'theory' of The PRIDE Way, into 'action', with the focus on four key areas (referred to as value streams) where we are making real progress on improving our processes, improving efficiency, standardising work and eliminating waste.

There are four key value streams:

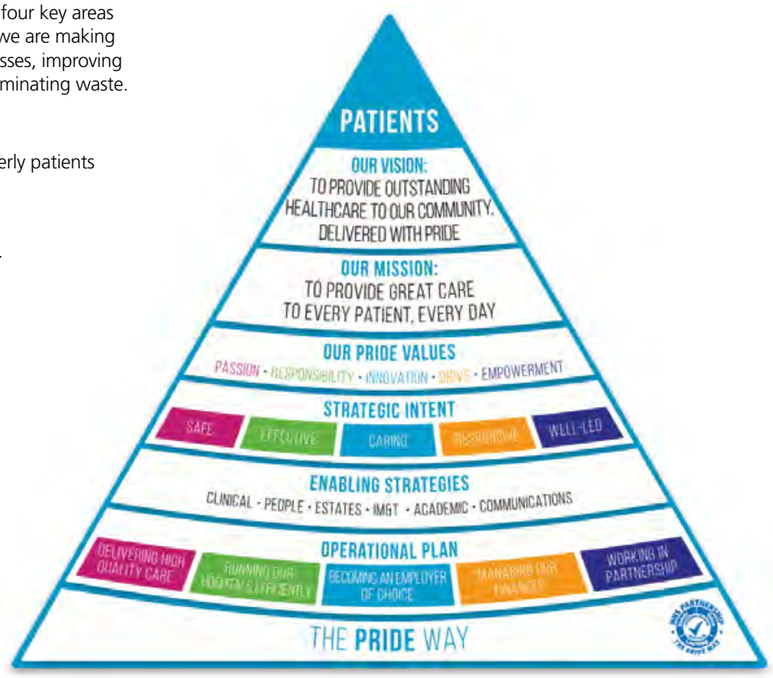
- The first 24 Hours for frail and elderly patients
- Diagnostic processes
- Discharge processes, and
- Managing patient safety incidents.

We chose these value streams because we believe that to improve them, across our hospitals, would have a dramatic positive impact on the quality of care we provide.

One of the main tools we use to make these improvements are comprehensive five-day workshops, called Rapid Process Improvement Workshops (RPIW), involving representatives of all the staff who have any role in the identified process. Critically, every one of these workshops includes one of our patient partners, to provide the patients' perspective.

The case studies below highlight how we have made real improvements, and we will continue to work to embed these in the teams and the organisation.

For 2018/19, we will be continuing to embed the methodology across the organisation, primarily through our Leaders' Agreement, and the roll out of a major staff training programme – The Pride Way for Leaders.



CASE STUDY

DEALING WITH SERIOUS INCIDENTS

Two RPIWs took place in December 2017 and March 2018 to improve the process of raising and closing patient safety incidents for our staff. It's really important that in order to keep encouraging staff to report incidents, the process is as simple and straightforward as possible.

The teams streamlined both the incident form and the closing manager's form, as well as reducing the number of recipients of the initial incident report and the number of incidents that require manual closure by a closing manager (by creating an automatic closure function) as a number of incidents are raised for data collection purposes.

As a result, the teams significantly reduced the time taken to complete an incident form (from over nine minutes to around four minutes). Furthermore, as a result of the changes, 100% of staff felt positive when closing an incident or receiving the closure feedback on an incident that they had raised.

Both of these RPIW outputs are awaiting formal 'go-live' dates.

CASE STUDY

GETTING MEDICATION TO PATIENTS AND DISPENSING

We held two RPIWs to focus on pharmacy and medication as we recognised that patients were waiting for long periods of time after they had been told they could be discharged from the wards.

Some of the reasons for the 'wait' were due to delays in Electronic Discharge Summary (EDS) sign off, screening, dispensing and transportation of the medications to the wards. These RPIWs looked at both processes to eliminate waste to ensure the patient has a better inpatient experience

As a result of the dispensing workshop (which is currently still being measured) we can say that patients being discharged from all wards are getting their 'To Take Away' (TTA) medication dispensed within 40 minutes which is a 50% improvement from before the workshop. As a result of the medications to patient workshop we can say that patients are now getting their medication within 32 minutes of being dispensed which is a 68% improvement from before the workshop.

Together both RPIWs are ensuring that once an EDS is screened by a pharmacist, it will now take a median of 1 hour 12 minutes for patient TTA medications to be dispensed and delivered to all 40 wards in Queen's Hospital. This is an improvement of 60% from the baseline which originally took three hours.

RUNNING OUR HOSPITALS EFFICIENTLY

- Develop our divisional teams to ensure we are well-led
- Continue to improve delivery of our constitutional standards
- Improve back office productivity, including procurement, IT and clinical support services, and refresh our estates strategy

Over the last year, our teams have worked hard to improve our services against national and locally-agreed quality and performance measures. You can find out more detail about the quality of our services and the care we provided in our Quality Account, available on our website.

EXTERNAL ASSESSMENT – CQC

All health organisations which provide regulated activities must be registered by the Care Quality Commission (CQC) and show that they are meeting standards of safety and quality.

When the CQC visits, it asks five key questions:

- Are we well-led?
- Are we safe?
- Are we responsive?
- Are we effective?
- Are we caring?

The CQC inspected the Trust in February 2018, focusing on:

- Urgent and emergency services
- Maternity
- Surgery
- Medical care (including older people's care)

There was also an inspection of the Trust against the 'Well Led' domain, which took place in March 2018.

While at the year end we were still awaiting the CQC's final reports, we were encouraged by the informal feedback from the inspection team regarding the quality of care and the commitment of our staff.

When we receive the report, which will identify any Must Do actions, we will ensure that these are prioritised for attention through the remainder of 2018/19.

CONSTITUTIONAL STANDARDS PERFORMANCE

FOUR HOUR TARGET AND ED PERFORMANCE

This has represented a challenge for the trust this year. With a regional and national context of ever-increasing pressure on emergency services, it is unquestionably the case that this has been one of the most difficult areas of our performance.

It was an exceptionally busy winter particularly, with very high attendances throughout and continuing to the end of March. At times we were seeing around 900 attendees a day at our Emergency Departments.

We continued to see very high numbers of patients transferred via ambulance – once more Queen's Hospital saw more ambulances than almost any other hospital in London.

We also continue to notice an increase in acuity. Patients are sicker, and are staying longer.

Staffing, particularly in our Emergency Departments, also continues to be a significant issue. We are routinely in a position where we have to turn to agency staff to fill rota gaps. We know that this impacts upon our ability to see and treat patients efficiently.

As a result, we have not hit the constitutional standard of treating, admitting, or discharging 95% of patients within four hours this year. We received regular visits from the CQC, NHS England and NHS Improvement, particularly over the busy winter period, and the consistent feedback was that we continue to provide good quality care, which was pleasing.

However, we accept that we are not providing the level of service that we should. With the pressure seemingly set to continue, this will be one of the top operational priorities for the year ahead, across our Trust.

CAPITAL INVESTMENT – ENHANCED URGENT CARE CENTRE (EUCC)

The Department of Health invited applications from trusts to bid for capital funding to invest in key changes to facilitate new ways of working to assess and stream patients.

We prepared a bid which set out the key changes we would seek to make to the layout and configuration of the Emergency Departments at Queen's and King George hospitals.

We were delighted to complete our EUCC project at Queen's Hospital on schedule, opening in January 2018.

The project entailed the reconfiguration of much of the wider space in and around the reception and waiting area, and moving the entrance to our Emergency Department. It required the movement of several teams to other areas of the hospital and was no minor undertaking, but we are pleased with the new environment and the improved accessibility to key services to help our patients more quickly.

Barking, Havering and Redbridge University Hospitals NHS Trust

We now have a new reception, with better private areas for initial assessments; more private consultation rooms – with walls and doors, not just curtains to separate them; and a number of services, such as blood tests and x-rays, are available in one place so patients aren't sent from department to department, having to find different areas across the hospital.

While there were some challenges in implementing some of the care pathways since the EUCC opened, we have now worked through them to ensure all patients receive the most appropriate treatment effectively.

We are now preparing to undertake improvements at King George which will be completed in 2018/19.

OUTPATIENTS

There were nearly 740,000 outpatient appointments last year. Across both hospitals that's more than 2,000 a day. We also handle around 6,000 telephone calls to our appointments centre each week.

We have made some positive changes to our Outpatients team which have had impacts for our staff and our patients. We introduced a new senior team structure to improve the management of our Outpatients service, and to ensure that patient experience, quality of care and staff engagement are top priorities.

SERVICE IMPROVEMENTS – TEXT MESSAGING, BOOKINGS AND OUTCOME FORMS

In November 2017 we introduced the Envoy text messaging system to improve our contact with patients and to reduce the numbers of patients not attending appointments. The service is a two-way system that sends a reminder a week before an appointment reminding them of the date, time, site and team.

Another reminder is sent 48 hours before. The patient can confirm, rebook or cancel via text, so this flags the team in the booking centre who can attempt to rebook and fill any gaps.

This has had a positive impact on reducing the numbers of patients who Did Not Attend, along with our appointment of Hybrid Mail – a third party which is ensuring more of our letters reach our patients, guaranteeing they receive them.

We continue to feel the benefit of the booking system brought in last financial year, which helps ensure the right information is populated on the system and the right rooms are booked for clinics, reducing delays and confusion.

We have also made good progress on improving how we complete and distribute outcome forms from our outpatient clinics. These forms detail the necessary follow up actions for patients and any further referrals.

It's really important that we process them quickly and accurately, and we've made good changes to our processes on that front this year to ensure we are also getting accurate information to our Clinical Commissioning Groups (CCGs) about our numbers of patients, thereby ensuring we are giving an accurate picture of our levels of activity.

REFERRAL TO TREATMENT (RTT)

We announced in 2014 that we had identified several issues with our Referral to Treatment reporting, dating back several years. RTT is part of the NHS Constitution which states that 92% of patients should receive hospital treatment within 18 weeks of having been referred by their GP.

Once the issues came to light, a thorough investigation showed that thousands of people had been waiting too long to be seen. A long-standing mismatch of capacity and demand, coupled with issues with reporting our performance, meant that a significant backlog had built up.

Thanks to a huge programme of work with our system-wide partners, including our Clinical Commissioning Groups and GPs, we were delighted to be able to report in July 2017 that we had returned to hit the RTT national standard – ahead of the agreed trajectory.

This was a significant achievement for the whole Trust.

While we have not quite been able to sustain the national standard for all the subsequent months, we are still ensuring that nine in 10 patients are being seen within the 18-week timeline. This is a significant improvement on where we were, and placing us comfortably in the top half of all trusts.

We ensured that nearly every elective (planned) appointment over the winter was fulfilled – we felt it was important to continue to ensure that patients were able to have operations or treatment many had been waiting for.

The comprehensive and robust recovery plan we have implemented has included a number of key workstreams, including:

- Validation of waiting list data
- Outsourcing of patients to independent providers
- Improving our theatre productivity
- Enhancing our resources to treat patients
- Carrying our detailed demand and capacity work
- Implementing processes to manage the demand from GP referrals.

Our clinical harm review of patients continues to show that no serious harm has been found in patients who have been kept waiting too long.

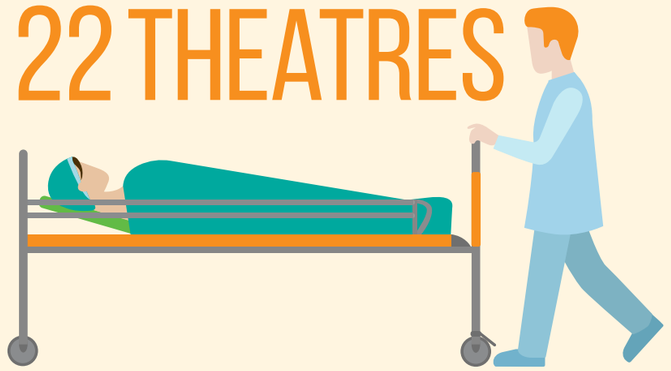
We are confident that the new processes, data, management and scrutiny we have collectively put in place will ensure that we do not see a repeat of where we were, so this is a positive outcome. However, the year ahead will undoubtedly prove challenging as we continue to strike the appropriate balance of activity with our commissioners.

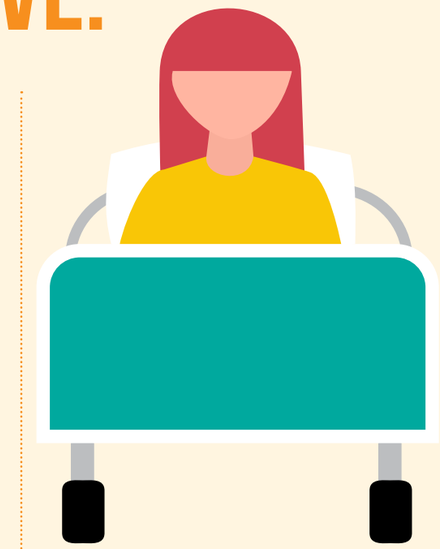
THANKS TO A HUGE PROGRAMME OF WORK WITH OUR SYSTEM-WIDE PARTNERS, INCLUDING OUR CLINICAL COMMISSIONING GROUPS AND GPS, WE WERE DELIGHTED TO BE ABLE TO REPORT IN JULY 2017 THAT WE HAD RETURNED TO HIT THE RTT NATIONAL STANDARD – AHEAD OF THE AGREED TRAJECTORY.

OUR HOSPITALS HAVE:

52 CRITICAL CARE BEDS

22 THEATRES





911 INPATIENT BEDS

62 MATERNITY BEDS

CANCER SERVICES

Our cancer performance is undoubtedly one of the highlights of the year. This year has seen a step-change in our cancer performance across the Trust.

For 2017/18, our objective was to meet all the national standards for cancer pathways (these are detailed in the Performance Analysis section); whether a two-week wait, the 31 day standard, or the 62 day target; which stipulates that 85% of patients should have received treatment within 62 days of urgent referral.

We were delighted that we were able to achieve this objective for the year.

Since July 2017 we have achieved the national 62-day standard – which states that 85% of patients should start cancer treatment within 62 days of being urgently referred by their GP, putting us in the top 25% of acute Trusts nationally. This is the most challenging of all the cancer standards so it is a significant achievement to have met this and all the others during such busy periods in our hospitals.

It has been pleasing to be increasingly recognised regionally and nationally for our progress, work and innovation.

This success has been built on a solid foundation of work delivered last year and this, particularly in the form of implementing a comprehensive and robust recovery trajectory and cancer action plan, developed with support from the CCGs and NHS Improvement (Intensive Support Team).

This action plan includes:

- Improving clinical engagement and communication with our GPs colleagues
- Improving pathway management across all the tumour groups enabling patients to be treated in a timely manner – this includes improvements in the booking processes in addition to reporting turnaround times for histopathology and imaging
- Offering patients an appointment within seven days across all tumour groups so that patients are seen much quicker in their pathway, allowing more time for diagnostics, first treatments and referral to other providers for surgery
- Implementing Straight To Test (STT) across specific tumour groups
- The recruitment of consultants to create more capacity, and coordinators and trackers to improve tracking of patients through to their treatment.

MULTI DIAGNOSTIC CENTRE PILOT CASE STUDY

We have had a positive experience as one of 10 pilot trusts trialling the Multi Diagnostic Centre approach within the gastroenterology specialty. This is where patients with suspected cancer are given a priority referral and we make a full suite of appropriate diagnostic tests available on one day, so patients come in, are taken care of by a specialist cancer nurse, and then can undertake any further diagnostic tests, for example a CT scan.

We have had one of the highest detection rates of the trusts in this pilot – around 17% of the patients referred to us are diagnosed with cancer. This highlights both the high prevalence of cancer in our community, and the value of such an approach

HALCYON AND EDGE RADIOTHERAPY MACHINES

In October we were delighted to become the first trust in Britain to install a cutting edge new radiotherapy machine – the Varian Halcyon. The Halcyon offers more precise, more comfortable treatment at twice the speed of more traditional machines, ensuring that we can offer better treatment to our patients than ever before.

As the year ended we were in the middle of the installation of a second machine – the Edge – as part of our planned replacement cycle. Most of the funding came from the Department of Health for this project, but we added additional features by investing to upgrade it.

We refurbished the rooms too, including redecorating and installing sky panels to help provide the most welcoming and calming environment possible.

SURGICAL ASSESSMENT UNIT

We made some changes to improve our surgical capacity for the benefit of our patients and colleagues.

We found we were experiencing challenges presented by a lack of surgical assessment space, which means that emergency patients who are waiting for surgical assessment can't always be seen promptly. This leaves them waiting longer than we'd like, and affects our flow of patients through the Emergency Department.

So, we reconfigured our surgical services to generate additional Surgical Assessment Unit (SAU) space, and introduced a new Surgical Stepdown Unit (SSU) for those patients recovering from surgical procedures who are more acutely unwell and therefore require more specialist care.

We recruited new nurses to help staff the improved facilities. Overall, the new layout and setup is enabling us to offer senior clinical evaluation more quickly and efficiently, reducing patients' waiting times, and with greater continuity of care.

BECOMING AN EMPLOYER OF CHOICE

- Implement the Leaders' Agreement to enable our staff to achieve excellence
- Establish new roles and implement our academic and education strategies to develop our staff
- Increase and retain our substantive workforce

LEADERSHIP DEVELOPMENT – THE LEADERS' AGREEMENT

At the centre of the change in culture required to deliver continuous improvement in our organisation is the development of our Leaders' Agreement.

The Leaders' Agreement sets out a series of expected behaviours of staff in leadership roles as well as articulating what the organisation will do to support leaders to create this new, dynamic change culture.

We worked to engage over 1,000 staff, patients and visitors to develop the content of our agreement, involving dozens of interactive engagement events, to which managers across the organisation were invited to discuss the Agreement, and give their own views on how we need to shape the leadership of our Trust in the future.

OUR WORKFORCE

We know that having a dedicated, engaged and motivated workforce is crucial to deliver improvements and to provide great care to every patient, every day.

Around 80% of our staff are in direct clinical care roles, and over the last 12 months we have increased the number of permanent staff we have working in our hospitals to ensure that our patients receive the highest and most consistent levels of care possible.

Recruiting and retaining high quality staff is a key priority. One of our biggest challenges continues to be the recruitment of permanent staff, particularly in specialist areas such as our Emergency Departments. However, this is a challenge facing the whole NHS.

At the end of March our vacancy rate stood at 13.3%. This is still higher than we would like, however we have increased the number of staff we employ.

We are still spending too much money on agency staff however – during the year, our total spend on agency staff was 9% of our entire pay bill. We continue to consider ways that we can reduce this level. One planned development which should make a difference will be introducing weekly pay runs, so that staff on Trust Temps (our bank) can get a similar experience to those working for agencies.

We set a challenging target for sickness absence in April 2017 at 2.8%, and although during certain months during the year we have achieved that figure, our average absence rate was 3.4%.

RECRUITMENT AND RETENTION

Over the past year we recruited 907 new staff members, including a record number of nursing staff. However, during the same period, we lost nearly as many – the majority from clinical posts; nurses, allied health professionals and doctors.

Recruitment takes time and resources, and a constant turnover of staff impacts on the delivery of patient care, staff morale and the ability to build teams.

By the end of the year, we were beginning to see some positive results. At the start of the year, we were losing 26% of staff within their first year. By the end, this was down to 20%. We had also got our staff turnover to under 16%, but it's still above the NHS average of 10%.

Towards the end of the year we conducted a significant review of all our data, including the staff survey, outcomes from exit interviews, and specific focus groups and discussion groups. These highlighted a number of issues, including:

- Some unhappiness due to lack of flexible working opportunities and consideration for work/life balance.
- Issues around bullying and harassment and the respect they are given whilst at work.
- An absence of support from their immediate line manager
- Lack of education investment and 'release time' to support career development and skills.

TACKLING THE CHALLENGE

To tackle these issues, all Divisions have developed retention and engagement plans, with a specific focus undertaken on nurse retention first.

We will be encouraging managers to support flexible working and flexible retirement; working to support improvements in E-rostering so that our staff can have a better work/life balance.

We have also made good progress with our People Strategy 2018-2020. This will be launched at the beginning of the 2018 financial year and will set out our plan to take forward our workforce as we move towards 2020.

We are continually looking at new ways of working to support our workforce challenges and improve both career development and retention. This year we have supported the Trainee Nurse Associate Programme, with just under 50 going through a training programme shared with North East London Foundation Trust (NELFT).

In addition we have supported the introduction of both the Advanced Care Practitioner role (13 posts) and Extended Care Practitioners roles (16 posts) within our Emergency Department. These extended nursing roles will help bridge the gap between our medical and nursing groups.

INTERN MENTORING PROGRAMME

We launched an exciting new scheme, in which our more experienced nurses work to support less experienced nurses, or those new to our Trust, providing them with practical and emotional support and advice, and helping them settle into their career.

We started with one mentor and appointed two more who started in January 2018. Ordinarily we would typically recruit around 150 Band 5 (newly qualified) nurses every year.

From this group, we would typically expect one in four, so about 35-40, would leave within their first year. From when we introduced this support in September, to the end of the financial year, just three Band 5 nurses have left our Trust.

NURSING TRANSFER SCHEME

We have introduced this year an internal transfer scheme so that nurses can transfer very easily within the Trust, without going through the full application process, to move between wards and specialty areas. This is not offered universally across the NHS, but we have already found it to be a very positive move to help career development and motivation.

STAFF SURVEY

Nearly 2,900 staff returned a completed questionnaire this year, giving an improved response rate of 47%. This makes us now slightly above the average response rate for acute trusts (44%) which is pleasing given our history – we were in the bottom 20% in 2014.

Our overall engagement score remained in line with the national average – this is an indicator of staff motivation, advocacy and involvement in the organisation.

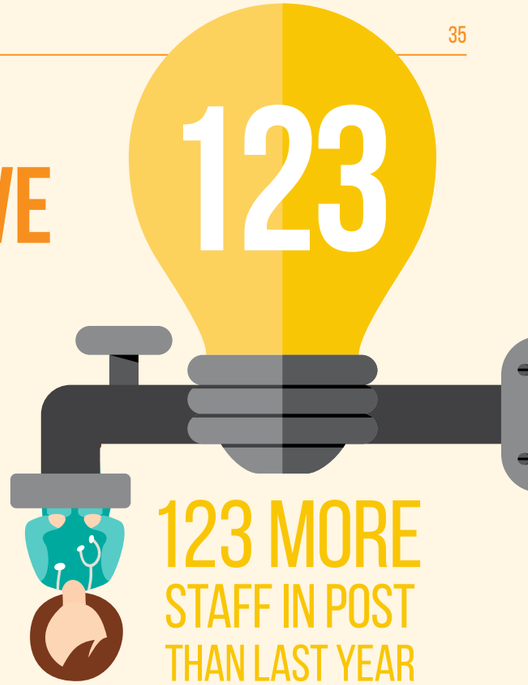
Our staff remain among the most motivated in the acute sector and have a high level of satisfaction with the quality of work and care they deliver. We are also among the top 20% of acute trusts for staff agreeing their role makes a difference (92% of staff).

The areas where staff experience is poorest relate not to the practicalities of doing the job but what can be classed as cultural and relationship factors. Therefore focused and continued action is needed to improve against these key findings.

OUR HOSPITALS HAVE

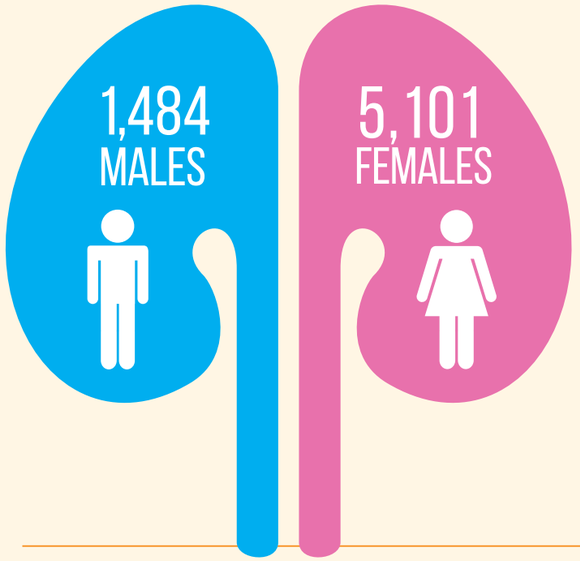
OVER 500
VOLUNTEERS
WHO BETWEEN
THEM HAVE GIVEN MORE THAN
30,000
HOURS OF SUPPORT

PROVIDED OVER
300
WORK EXPERIENCE AND
APPRENTICE PLACEMENTS



123
123 MORE
STAFF IN POST
THAN LAST YEAR

6,585
STAFF OF WHOM 80%
ARE IN DIRECT CLINICAL CARE ROLES



In particular, we have not seen any improvements in key findings related to equality, diversity and inclusion. We remain in the bottom 20% of trusts for staff believing we provide equal opportunities for career progression and promotion; staff experiencing discrimination, harassment, bullying and abuse at work; and satisfaction with flexible working.

INSPIRE BME PROGRAMME

Our staff survey findings and our Workforce Race Equality Standard (WRES) data both highlight ongoing differences in the experiences and treatment of BME staff in our Trust compared to white staff, particularly with career progression and experience.

So we were delighted as the year drew to a close to announce that 21 BME colleagues were accepted onto the INSPIRE BME talent management and mentoring programme, which will support and help drive the development and progression of our BME colleagues.

OUR VOLUNTEERS

We have taken some big steps forward this year. At the start of the year, we set ourselves the challenge of increasing the numbers of volunteers in our hospitals to 500 – by 31 March we were delighted to have 506 volunteers engaged, delivering in excess of 30,000 hours of volunteering over the year.

This year we introduced the start of our new Students in Volunteering programme. This is a formal agreement with us and local colleges/ schools. Havering Sixth Form College were our first cohort of students this year. We have taken on six of their students, for a six month period, during which they received a four-week induction period.

We hope the programme will pave the way to allow young people the opportunity to volunteer in a more formal arrangement which both supports our local community and offers exposure into the life of a hospital and has obvious benefits for their future employment prospects.

We also introduced a way of supporting new volunteers. It's not always easy to start working with a ward. Volunteer champions are our way to help, by pairing an experienced volunteer with a new one – they work together for the recruit's first few sessions. It's proved really successful.

We also designed new Ward Befriender packs – an innovative little set of credit card-sized cards which attach to the volunteer's lanyard, and which contain useful information on who to contact in an emergency, information about protected mealtimes and other tips and guidance.

Our volunteers are a massive support to our hospital's and patients. Every day they give their time and expertise to help others. They help us on our journey to outstanding and together we are improving patient and staff experiences.

We're proud of our trainees

NURSING ASSOCIATES PROGRAMME

We are very proud of our efforts to create accessible pathways into nursing, midwifery and other professions, and our ground-breaking work with Nursing Associates is a good example.

The Nursing Associate role is designed to bridge the gap between existing health care assistants; who have completed a care certificate; and registered nurses. We have one of the largest cohorts of Nursing Associate trainees in the country and we are really proud of them.

The trainees are currently in the middle of spending two years in an apprentice-style working and learning environment, with one day a week spent at London South Bank University (our local education partner).

They have been spending time in acute and community hospitals to give them a broader understanding of various partners and their respective roles, improving the connections between agencies and improving the patient pathway and care.

CELEBRATING OUR PEOPLE

We have dedicated and hardworking people serving our communities, and it is important that we recognise and thank them for the work that they do, and also achievements and accomplishments away from work.

We have a range of ways to do this, including awarding "Terrific Tickets", which are given at any time to thank people for going above and beyond and for displaying our PRIDE values.

We continue to do our best to search out and celebrate the achievements of colleagues wherever we can, particularly via our internal communications channels – the intranet and The Link – and via social media.

Staff are encouraged to nominate colleagues for a Star of the Month award, and patients can also get involved – putting forward the name of a particular member of staff who has stood out for them, as well as Team of the Week (see p18).

Our annual PRIDE Awards celebrate achievements and dedication across a range of categories including Hospital Hero, Working Together and Pursuing Excellence. On the night of the ceremony, held in November, we also gave out our Long Service Awards, thanking our people who have given 20, 30 or even 40 years' service to the NHS.

WORKING IN PARTNERSHIP

- Work with our partners to deliver the Sustainability and Transformation Plan
- Improve engagement and community development with our partners, patients and public
- Work with our partners to develop services to align with our Clinical Services Strategy

OUR SUPPORT FOR THE INTEGRATED CARE SYSTEM

It is worth noting that the strategic landscape continues to evolve at a fairly rapid rate.

The Integrated Care System (ICS) is a new way of structuring health and social care services. The intention is that by simplifying pathways and becoming more centred on the person and where they live, we can ensure seamless health and social care, be more focused on preventing ill health and unnecessary hospital admissions, and make local services sustainable for the future.

We are committed to collaborative working with our provider partners in the Barking and Dagenham, Havering and Redbridge health system.

We have formed a 'provider alliance' which includes us, our community and mental health partners: North East London Health Foundation Trust, Barking and Dagenham, Havering and Redbridge GP Federation Chairs and HealthWatch representatives from each of the boroughs and the local authorities. We are all in agreement that we need to focus on pathways in order to improve patient care and to drive efficiencies.

ENGAGING PATIENTS

Our Patient Partnership Council (PPC) (and its members) continues to go from strength to strength, and has become an increasingly vital part of our Trust's operation.

The PPC brings our patient partners and our staff together to help improve the quality and safety of the care we provide.

The council is our patient forum, helping us to oversee patient and public involvement and providing our organisation with independent and objective recommendations for the way we care for our patients.

It comprises 11 lay members (including chair/vice chair); clinical staff (including doctors, nurses and a Deputy Chief Nurse); and non-clinical staff.

The council's work touches on all aspects of the care we provide, services and pathways.

Each of the services below has a dedicated patient partner 'lead':

Anaesthetics
Care of the Elderly
Cancer and Clinical Support
Children and Young People
Emergency Care
Learning Disabilities
Maternity and Women's Health
Outpatients
Specialist Medicine
Surgery

Our patient partners work closely with our Patient Experience team, ensuring that we are listening and acting appropriately. In addition to this group, we have a wide range of patient partners who are involved in other work in the hospital, at every level. Patient partners are a key part of everything we do and we have recruited many this year to support us in improving our services.

Our Patient Engagement and Experience Assurance Group continues to scrutinise the work that we do. Made up of patients and carers, this group provides us with important insight and contribute to the development of our services, putting patients at the centre of the decisions that we make.

WE WILL CONTINUE TO EVOLVE OUR APPROACH, SO THAT WE ARE PROVIDING MORE OPPORTUNITY FOR PARTNERS TO ACTUALLY SEE AND EXPERIENCE WHAT LIFE IS LIKE IN OUR HOSPITALS AND HOW WE ARE CARING FOR PATIENTS.

STAKEHOLDER ENGAGEMENT

We have continued to build and maintain key relationships with partners and stakeholders this year.

We relaunched our Local Representatives' Panel, which will meet regularly, giving the opportunity for dialogue and engagement with members including Healthwatch and local councillors, and try and bring our hospitals and work to life for them.

We have held regular meetings with our MPs to keep them fully informed, and to ensure openness and transparency.

We will continue to evolve our approach, so that we are providing more opportunity for partners to actually see and experience what life is like in our hospitals and how we are caring for patients.

Our stakeholder e-newsletter continues to be a valuable channel of information.

Senior executives have represented us at all council scrutiny sessions, Oversight Groups, and Health and Wellbeing Boards across Barking & Dagenham; Havering and Redbridge, and we continue to value these sessions as a good opportunity to explore key issues in depth with elected representatives.

We have routinely facilitated access to our hospitals via structured visits, so that local and national stakeholders, from both a health and policy perspective, can get a better idea of how we operate. We continue to support the Department of Health's Connect programme – we are very happy to provide the opportunity for civil servants to understand the operational realities of a busy acute hospital to ensure informed policy.

Amongst others, we have welcomed Jeremy Hunt MP, Mike Gapes MP, Wes Streeting MP, Andrew Rosindell MP and Simon Stevens, Chief Executive of NHS England.

Our relationships with the media have improved, and we have built new relationships with key journalists, correspondents and producers. We have taken good opportunities to achieve national exposure for our work and our people, for example our Senior Intern nursing mentors, and a feature with one of our bed and site managers, both on the BBC.

We aim to provide a fast and effective press office, responding to queries and questions promptly. The year has had its share of both positive and negative coverage – mainly due to the circumstances in the Trust which are described elsewhere, but the reporting has been mainly balanced, accurate and fair, and where less so, we have challenged as we should.

WORKING WITH GPS

2017/18 has seen good progress in engagement with our local community of GPs, despite some personnel changes within the team and a period of being short-handed. The GP helpdesk operated by our GP Liaison Manager received nearly 200 issues or questions, of which more than 90% were resolved at the year end.

GP Liaison is also typically the route for Quality Alerts which are raised by GPs to the CCGs to be actioned and resolved.

We now routinely attend all Local Medical Councils, which is a good opportunity to engage. Of the 138 GP practices across our patch, we have categorised 103 as 'engaged' – either through face-to-face meetings, or regular telephone/email contact.

We continue to circulate the dedicated GP e-newsletter – GP Connect (launched last year) to compile and summarise key information – which is well-regarded. We have run a series of education events throughout the year on key topics for the local GP community, which have been extremely well-supported. In 2018/19 we hope to do more of this activity, and increase the amount of informal networking too.

GP Liaison helped drive through the requirements for hospitals in the 2017/18 NHS Standard Contract, to play our part in alleviating the pressure where we can on GP colleagues.

One of the strongest themes that continues to emerge from both national research and our own reporting, is the workload created by the lack of clear systems and processes for practices and their local hospitals to communicate with each other and their shared patients.

Over the year we have been preparing for the 'paper switch off' in 2018 and increasingly ensuring that GPs (as well as our own teams) are aware

of what needs to happen in order to make that transition smooth.

Thanks to the efforts of colleagues in pathology, it was particularly gratifying to resolve the technical issues around the access to the Cyberlab testing and results system. This was one of the top problems being reported by GPs, so it was pleasing to make significant progress.

NEW COMMUNICATIONS AND ENGAGEMENT STRATEGY

At the beginning of 2018 we launched our new Communications and Engagement Strategy for the Trust, replacing our previous strategy which was introduced in 2015.

The strategy sets out our aspirations for delivering the very best communication and engagement with all our key audiences – our patients and public; our staff and volunteers; key stakeholders and partners; and the media.

It identifies the specific strategies, tactics and actions that we will employ to drive this forward.

ENGAGING WITH THE PUBLIC

We continue to see much higher traffic to our website since the redesign and relaunch at the beginning of the last financial year. Its accessibility and 'responsiveness' – where the content resizes if being looked at on a tablet or mobile – continue to be valuable features.

Social media is an increasingly important channel for us to engage with the public, to share news about us and to try and improve people's understanding of the work we do, and of how and where to get the right care more broadly. We are particularly active on Twitter and Facebook, and these will be important for future development.

The new strategy identifies the importance of offering interesting and vibrant content – particularly images, graphics and video – as this is much more engaging for our audiences, and stands a greater chance of making an impact. We have collaborated with various partners over the course of the year to realise opportunities when they have arisen and we will continue to do so.

One of the key longer term issues we will continue to work on, along with colleagues in the CCGs and elsewhere, is trying to improve the general awareness and signposting to other NHS services – whether pharmacy, NHS 111, GPs or GP hubs.

OUR ROLE IN DELIVERING THE EAST LONDON HEALTH & CARE PARTNERSHIP (ELHCP) PLAN

We are committed to collaborative working with our partners in the East London Health Care Partnership (previously known as the North East London Sustainability and Transformation Plan).

A joint vision has been developed across the north east London footprint:

- To measurably improve health and wellbeing outcomes for the people of north east London and ensure health and social care services, built around the needs of local people
- To develop new models of care to achieve better outcomes for all, focused on out of hospital care
- To work in partnership to commission, contract and deliver services efficiently and safely.

Within our plan we will support this vision in a number of ways:

We have developed our Clinical Services Strategy to align with the overarching East London Health Care Partnership strategy, which sets the roadmap for our operational plan.

Ultimately, we are proposing for King George Hospital to become our centre of excellence for elective care, long-term conditions and care of the elderly and Queen's Hospital to become our centre of excellence for emergency, maternity and paediatric care. In particular, we will work with our GPs and community services to improve out of hospital care.

We are intending to invest in several key areas, over the next two years, to support this overall vision and deliver the ambition of providing care that is safe, effective and efficient every time.

Our proposed service development areas for 2018/19 are being finalised but include increasing our neonatal intensive care unit capacity, and continuing the replacement of our Linear Accelerators (for cancer treatment) and pathology equipment. We are seeking external investment to support key strategic developments.

MANAGING OUR FINANCES

- Embed service line reporting and management to improve decision-making and budgetary control
- Make sure we get paid for all the work we do
- Achieve financial balance with the inclusion of transformation funding

This year has undoubtedly been a very challenging one in terms of our financial position.

As the year unfolded, it became apparent that our financial situation was not as we had previously stated. An account of what occurred is set out below, including some commentary which extends beyond the 2017/18 financial year, in the interests of completeness and for contextual purposes.

In summary, for 2017/18 our agreed financial target was to achieve a surplus of £1.7m. Our reported position for the year end was a loss of £49m.

Our overall financial picture was significantly impacted by the failure to secure a significant sum (£12.6m) from the Sustainability and Transformation Fund. This loss resulted from issues with delivering against our cost improvement programme (£16.2m), changes to some accounting policies and judgement (£13.0m) and outstanding expert determination issues with our main commissioner (assessed at £7.2m).

It is unfortunate that we once more needed to go through formal contract resolution and ultimately expert determination to agree with our commissioners about work we have undertaken, and to seek the appropriate level of income. While we know this is reflective of a broader financial challenge locally, it still has a significant impact on our Trust.

HOW THE SITUATION DEVELOPED

In the autumn of 2017 we discovered a serious cash shortfall. The issue had caused us to delay payments to many suppliers, with some knock on operational impacts, but at that time we were not fully aware of the extent of the issue or the underlying causes.

We approached NHSI for the necessary loans to enable us to resolve the situation in the short term and we asked the accountancy firm, Grant Thornton, to carry out a thorough independent investigation.

As these investigations developed, it became evident that there were a number of broad problems across the Trust with our approach, in terms of day-to-day management and culture, escalation, reporting and overall financial governance.

FINANCIAL SPECIAL MEASURES

As a result of the above, and the significant in-year financial deterioration, which meant we were well adrift of our agreed plan, on Friday 9 February, NHS Improvement announced that they were placing us into special measures for finance to ensure we could be provided with additional support and so as to be in a better position to provide oversight and scrutiny.

NHSI required that we bring on board additional consultancy support to help us refine and improve our approach to cost improvement planning and delivery.

We undertook a procurement exercise to appoint a company to provide this support, and we appointed PwC – an accountant and consultancy firm – to work with our teams and to help us bring forward our Financial Improvement Plan.

GRANT THORNTON REPORT KEY FINDINGS

The Grant Thornton report was circulated to all staff, key stakeholders and placed on our website on 18 April 2018, having been reviewed and approved by our Board, and by the co-commissioner of the report, NHS Improvement.

The report makes clear that a number of factors came together to create a broader problem. It identifies that over a prolonged period of time, we developed a flawed approach of not paying our suppliers on time.

Some other factors include: higher demand and delivery of services above the levels agreed with our clinical commissioners; some optimistic assumptions about 2017/18; overspending; weak financial control; and a lack of forward analysis of our cash requirements.

Grant Thornton found that repeated instances of delayed payments to suppliers were being reported by clinical and operational teams. However, the overall cash-flow risk was not high enough on the Board's agenda and the manner in which the cash problem progressively developed, and ultimately unfolded, represented a significant breakdown in financial governance at our Trust.

There were also points raised about the robustness of our approach to delivering our Quality and Cost Improvement Programme (QCIP). It's evident that we weren't focusing enough on cost reduction.

We felt that the report was a fair and thorough reflection of the issues, and that many of the recommendations made by the Grant Thornton team were sensible and necessary – in many areas we had in fact already started making changes through the latter half of the year.

To accompany the report we produced a response document which set out our progress and timelines for progress against all the key recommendations made by Grant Thornton.

We will be making significant changes to the ways that we manage our finances, our financial governance, processes of escalation and oversight, and the way that we report to ensure the appropriate scrutiny.

We would like to thank our suppliers for their patience over this time and we are pleased that cashflow issues are much more transparent and we are now able to pay suppliers within a much shorter time frame.

As we have not yet achieved a break even position our auditors KPMG have raised a Section 30 Referral to the Secretary of State for Health. We are addressing this in our longer term plans.

CAPITAL INVESTMENT

This year, we invested more than £21.4m in capital items (including PFI items), delivering our improvement plans, our IT strategy, replacing and expanding our medical equipment and improving our estate and procurement. This included a major programme of work at Queen's Hospital improving our Enhanced Urgent Care Centre.

This is where the money was spent:

Medical Equipment	£2.7m
Managed Equipment Replacement	£5.4m
IT Equipment	£4.6m
Estates	£4.1m
Procurement	£0.6m

FINANCIAL OUTLOOK

The Annual Plan for 2018/19 was submitted to NHSI at the end of April 2018. The proposed planned income and expenditure deficit, based on current assumptions, for 2018/19 is £34.8m.

There remain a number of material uncertainties in setting this plan, including:

- Agreement of income principles with the expert determinant in the resolution of 17/18 outturn
- Finalisation of the individual cost improvement schemes that total the efficiency ask
- Understanding of the proposed risk sharing agreement with the CCG for 2018/19
- Understanding of how the 2018/19 nationally agreed pay award will be afforded outside of tariff
- Cash and payment by CCGs during the year is a risk.

To deliver the proposed planned deficit a 7.1% QCIP (£39.0m) is required and needs to be cash releasing. There has been considerable progress on identification of the QCIP. PwC has been commissioned to support the identification and assist delivery of the QCIP over the first quarter of 2018/19.

The Trust has submitted realistic activity growth forecasts, which are higher than the Commissioner's plans. If our figures are delivered as it's believed, then this will be unaffordable for the local CCGs.

With no expected capital external funding the Trust's internal resources available is £4.9m. Of this amount there are already £5.9m approved projects being deferred to start next year which will take priority over the available funding, taking the Trust into a capital cash deficit.

The Trust will need cash support for 2018/19 to the value of £104m. This includes the request for a loan support for £28.1m to repay the existing principle loan due for repayment in December 2018; the Trust request for a revenue deficit loan support for £34.8m, excluding STF; the Trust request for a capital programme loan support for £10.0m; and the Trust request for a working capital loan of £31.1m.

These loans attract an interest payment of up to 6% - a full year cost pressure in excess of £3m dependant on timing of the loans.

Risks have been identified and where possible have mitigations to reduce the impact or occurrence of the relevant risk.

The financial challenges are substantial, and therefore action in particular to make efficiency savings and productivity gains is imperative as early as possible to prepare the Trust for the coming years.

2018/19 would see the beginning of a three year plan that returns us to a financially sustainable position and to establish a platform on which to re-finance the balance sheet.

PERFORMANCE ANALYSIS

OUR PERFORMANCE REPORT

We produce regular reports setting out the detail of our performance against our plans. They are available on our website at www.bhrhospitals.nhs.uk, along with further information compiled in our annual Quality Account.

I am particularly pleased by our performance in cancer this year. In last year's performance report, we highlighted our commitment to tackling cancer pathways, and that we were already looking at how we could improve them.

It is very pleasing to be in a position today where this hard work has shown a clear positive impact for our patients.

We also mentioned one-stop clinics last year – again, these have proven to be very successful and effective. The cancer diagnosis rate from these clinics is higher than the traditional two-week pathway, and this approach could even shape the future of cancer referrals and diagnosis across the NHS.

Our recovery performance for those people waiting for elective treatment (RTT) has been another positive this year. We were delighted to finally return to the national standard of 92% of patients being seen within an 18-week timescale. While we haven't been able to quite sustain that standard, there has still been a dramatic improvement overall.

This has only been possible by working in close partnership with our local health economy, particularly the CCG and local GPs and we thank them all for their input and support.

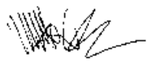
Our maternity care continues to go from strength to strength, with fantastic feedback from women using the service, and we are continuing to provide one-to-one care in labour.

This year has been a difficult year in terms of delivery against the emergency access target. We still have considerably more work to do with our partners to improve the situation so that patients are seen and treated as quickly as we would like.

But the biggest area for attention for 2018/19 will undoubtedly be bringing our finances back under control as a result of the situation which unfolded in 2017/18.

As is explored elsewhere in this report, our loss of control was not good. While I am relieved that no patients came to any harm as a result of our financial difficulties according to our investigation, we will need to spend considerable time and effort now getting back on track.

Finally, we identified here last year that we wanted to reduce the number of healthcare acquired infections we recorded. I'm pleased to report that we showed improvements in numbers of both MRSA and Clostridium difficile (C.diff) – in the case of the latter, we halved the number of cases.



Matthew Hopkins
Chief Executive

OUR PERFORMANCE

The below performance measures have been identified as our key indicators.

We monitor our performance closely, with all of the information captured on our electronic systems.

Performance packs are sent out to all of our clinical divisions monthly. Performance meetings are then held with the Executive team scrutinising the performance, interrogating the data and holding the divisional teams to account.

Daily and weekly operational reports are circulated around the organisation. Emergency access performance is shared daily, with cancer and diagnostic measures circulated weekly.

We have the following assurance measures for our performance reports:

- We produce a series of monthly data quality reports against our performance data and test data completeness and timeliness
- We have developed a series of validation rules to test the validity of data that has been completed
- We have a data assurance team within data quality who undertake regular sampling of data to confirm its accuracy
- We have an annual risk assessment of data returns to identify what risks may exist against a new risk framework
- We ensure that all mandatory returns are produced from source data, by a trained professional from the information department
- We ensure that a set proportion of validations undertaken by services are tested to ensure the validation is appropriate.

We have key targets for data quality for major datasets across all the facets of data quality, and benchmark our performance where data exists nationally. Data is uploaded monthly onto Unify, where it is accessible to NHS England and NHS Improvement. These are set out below:

PERFORMANCE	THE STANDARD	OUR RESULTS
Emergency access	95% of all patients attending our Emergency Departments to be treated, admitted or discharged within a maximum of four hours	Not achieved: 81.8%
Access to treatment	92% of patients referred to us to have treatment started within 18 weeks	Not achieved: 90.8%
Cancer: urgent referrals	93% of our patients to be seen in two weeks following an urgent referral from their GP	Achieved: 96.8%
Cancer: 31 days	96% of our patients to have a diagnosis and first treatment within 31 days of the decision to treat	Achieved: 98.5%
Cancer: 62 days	Target of 85% of patients receiving first treatment from the date of GP referral	Achieved: 86.2%
Infection control: C diff	No more than 30 cases	Achieved: 15
Infection control: MRSA	Zero cases of MRSA bacteraemia	Not achieved: 6

PERFORMANCE TRENDS

The below table shows the targets set nationally that we work towards. As well as measuring performance weekly and monthly, we also monitor trends over time.

Standard to achieve		Target 2017/18	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
Infection control	Number of Clostridium difficile cases	30	15	29	36	33	N/A	N/A
	Number of MRSA blood stream infection cases	0	6	7	5	6	N/A	N/A
Access to cancer services diagnosis to first definitive treatment	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96.00%	98.52%	98.67%	96.10%	98.00%	96.10%	99.40%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98.00%	100.00%	99.80%	99.70%	99.60%	100.00%	100.00%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94.00%	99.56%	99.15%	96.10%	98.30%	87.80%	100.00%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	94.00%	99.89%	99.47%	98.70%	98.70%	95.30%	93.20%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment	85.00%	86.21%	74.22%	74.00%	81.20%	84.20%	83.00%
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	90.00%	96.78%	95.16%	93.70%	94.00%	96.20%	100.00%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to date first seen	93.00%	96.79%	95.20%	94.50%	91.30%	90.50%	98.40%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	97.89%	93.47%	93.20%	80.10%	80.40%	96.90%
Access to A&E	18 weeks referral to treatment - total incomplete	92.00%	90.80%	88.20%	Not reported			92.10%
Access to treatment	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95.00%	81.84%	85.65%	87.90%	85.30%	88.60%	88.40%
Cancelled operations	Number of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	0	651	974	524	494	378	400
Cancelled operations not performed within 28 days	Number of patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days	0	77	42	38	39	14	11

As one of the largest trusts in the country, providing acute healthcare services to a diverse population of in excess of 750,000 people, we work hard to provide the best possible care to our communities.

RISKS

A growing and aging population means that demands on our services will be increasing over the coming years, and we are already seeing the impact of that.

If we do not match our capacity and capability to the increasing number of referrals and emergency attendances then we risk not meeting national performance targets. More importantly, we will not be providing the outstanding care that we aspire to. We are working as a whole health economy to deal with these issues.

There is a risk that financial pressures will impact on performance, although we have Quality and Cost Improvement Programmes in place which are helping to mitigate that risk.

We have received assurance from NHS Improvement that it expects us to continue as a going concern and that it will make sufficient financing available to the organisation in line with our operational plans.

While we have seen some improvements in recruitment and retention, we face on-going challenges in attracting and retaining permanent staff, which means that we are still using more bank and agency staff than we would like, which can impact performance.

SUSTAINABILITY

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supercede this target by reducing our carbon emissions 28% by 2019/20 using 2012/13 as the baseline year. To date, performance is 19.8%.

POLICIES

We ensure that sustainability is considered in key policy areas, including travel, business cases, procurement (environmental and social aspects), and suppliers' impact.

In order to fulfil our responsibilities for the role we play, we have a sustainability mission statement within our Sustainable Development Management Plan (SDMP) to "continually sustain, retain and enhance the savings and culture change to meet our sustainability commitments."

An update to our SDMP is required because it has not been approved by the Board in the last 12 months. However, a review and update is provided through our Annual Performance Reports, to be considered in the Trust's Annual Financial Reports.

Our organisation evaluates by using the tools such as SDAT and also used other measures such as the environmental and socio-economic opportunities during our procurement process.

We understand the social and economic impact of the trust and our staff through measures such as: the number of staff doing mandatory sustainability training, the total number of staff cycling, Carbon and energy savings, and waste reduction and recycling rates. Sustainability and waste management is included in our corporate staff induction.

ADAPTATION, GREEN SPACE AND BIODIVERSITY

Climate change brings new challenges both in direct effects, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Board-approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events.

We achieve this by delivering a health and wellbeing strategy in conjunction with our sustainable travel plan. Initiatives include preserving green spaces, hosting an on-site fruit and veg stalls, and a healthy hike around the site for walking and relaxing spaces.

PERFORMANCE

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

Context info	2014/15	2015/16	2016/17	2017/18
Floor Space (m^2)	154,022	154,022	154,022	154,022
Number of Staff	5,557	5,732	5,905	6,039

ENERGY

We have spent £2,991,090 on energy in 2017/18, which is a 8.7% decrease on energy spend from last year. We managed to retain the UK CRC Tax exemption status by meeting the EU ETS Emissions target helping to achieve approximately £250,000 in tax savings. We generate approximately 16% of our own electricity saving approximately £200,000.

Carbon Emissions - Energy Use

PERFORMANCE/KEY ACHIEVEMENTS

Despite increasing activity, the Trust has managed to retain and make further savings year-on-year.

100% of our electricity use comes from renewable sources in 2017/18. Up to 16% of our total electrical demand is generated on-site through a Combined Heat and Power plant. This represents savings of 2,452 tonnes CO2e and approximately £200,000 savings a year.

Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	37,609,622	27,635,521	32,487,315	40,222,345
	tCO_2e	7,891	5,784	6,789	8,528
Oil	Use (kWh)	255,600	174,000	317,256	209,832
	tCO_2e	82	56	101	69
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	0	10,237,196	0	0
	tCO_2e	0	5,886	0	0
Green Electricity	Use (kWh)	26,461,270	17,972,839	27,539,864	24,192,330
	tCO_2e	0	0	0	0
Total Energy CO_2e7,972		11,725	6,890	8,596	
Total Energy Spend		£4,063,202	£3,753,584	£3,276,071	£2,991,090

TRAVEL

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public who use our services.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport. Around 5% of travel and transport in England is due to NHS services so we have quantified the impacts on health. In 2017/18 travel and transport related to our services reduced the local population health by 0.0 Quality Adjusted Life Years (QALYs). As an organisation we aim to minimise our impact.

Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient and visitor own travel	miles	0	673,831	650,048	TBC
	tCO_2e	0.00	243.68	234.93	TBC
Staff commute	miles	5,337,718	5,506,260	5,674,705	5,801,582
	tCO_2e	1,961.23	1,991.26	2,050.90	2,067.25
Business travel and fleet	miles	0	1,160	522	5,746
	tCO_2e	0.00	0.48	0.51	2.04
Active & public transport	miles	0	20	279	195
	tCO_2e	0.00	0.00	0.00	0.00
Owned Electric and PHEV mileage	miles	0	0	0	0
	tCO_2e	0.00	0.00	0.00	0.00
Total cost of business travel	£	0.00	0.00	0.00	0.00

PERFORMANCE/KEY ACHIEVEMENTS

- Introduced Go by Bike – a staff pool bike scheme
- Implemented a 125% increase in the cycle parking facility across the Estates
- Up to 2% increase in the number of staff cycling to work since 2014/15
- Successfully conducted Travel Surveys, and revised our Sustainable Travel Plan
- Introduced the FAXI car share scheme to reduce single occupancy car use
- Bus route 5 is now rerouted to Queen's Hospital following last year's partnership work with the Transport for London (TfL) and Havering Council.

We introduced Go By Bike - a staff pool bike scheme

WASTE

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	1334.43	1269.95	1403.78	1409.87
	tCO_2e	28.02	25.40	29.48	30.68
Other recovery	(tonnes)	1611.62	1666.83	1602.23	1635.92
	tCO_2e	33.84	33.34	33.65	35.60
High Temp disposal	(tonnes)	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00
Landfill	(tonnes)	2.15	3.30	21.78	53.35
	tCO_2e	0.53	0.81	6.75	18.38
Total Waste	(tonnes)	2948.19	2940.08	3027.78	3099.14
% Recycled or Re-used		45%	43%	46%	45%
Total Waste tCO_2e		62.39	59.54	69.88	84.65

Waste Breakdown

PERFORMANCE/KEY ACHIEVEMENTS

- 23% less, high cost incineration clinical waste against 2012/13
- 6% increase in recycling rate against 2012/13
- Doubled the offensive waste, a low environmental impact waste rationalisation
- We launched an online "Healthcare Waste Management course" which mandatory for all clinical staff with RCN and CIWM accreditation
- The implementation of Green Machine, a Reverse Vending machine to reward for recycling
- Introducing cardboard waste containers instead of plastic containers in pharmacy for waste drugs

FINITE RESOURCE USE – WATER

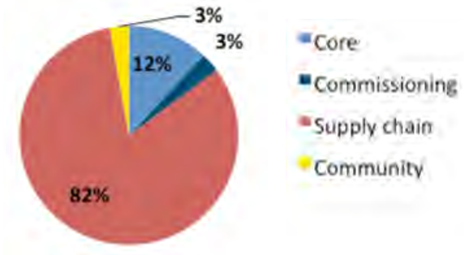
We are now consuming 14% less water in comparison with 2012/13, and noted another successful year in 2017/18, dropping below 190,000m3 for the first time since 2012/13.

Water		2014/15	2015/16	2016/17	2017/18
Mains Water	m^3	239,202	200,143	207,174	189,466
	tCO_2e	218	182	189	172
Water & Sewage Spend		£476,551	£408,482	£397,388	£348,997

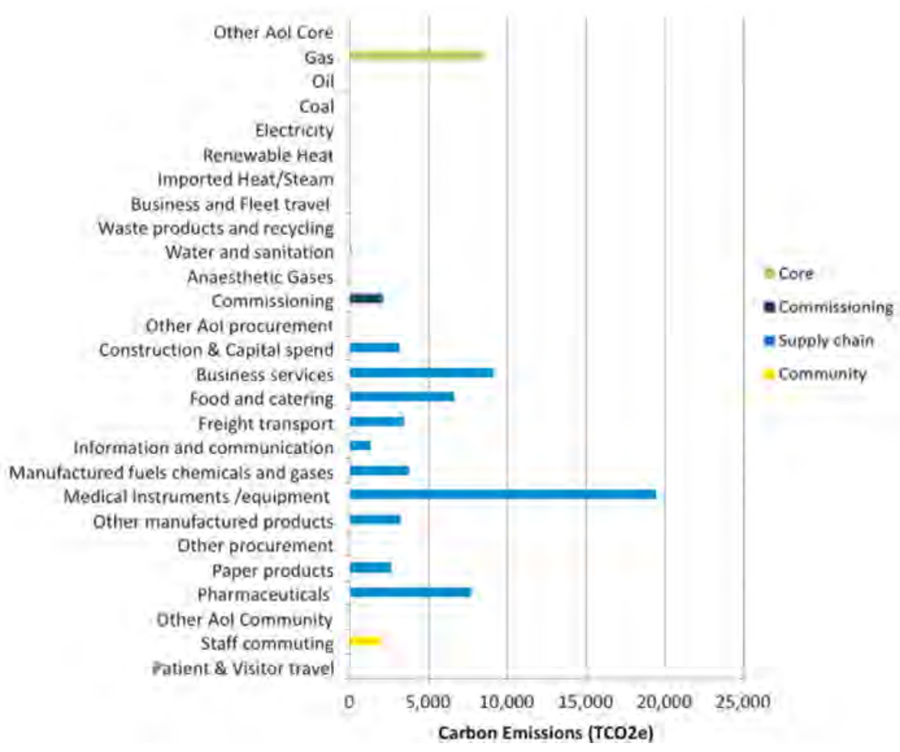
MODELLED CARBON FOOTPRINT

Resulting in an estimated total carbon footprint of 73,779 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 124 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.

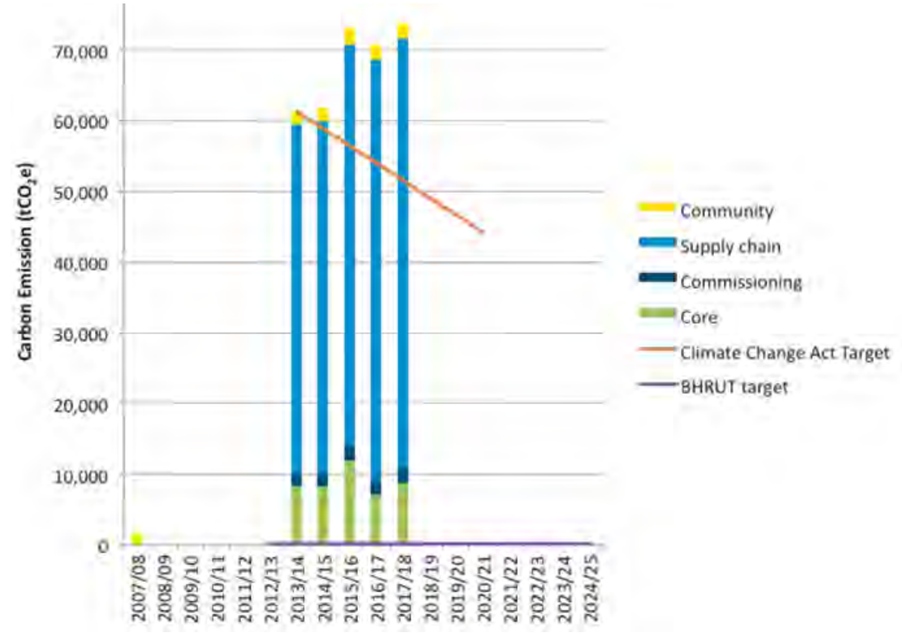
Proportions of Carbon Footprint



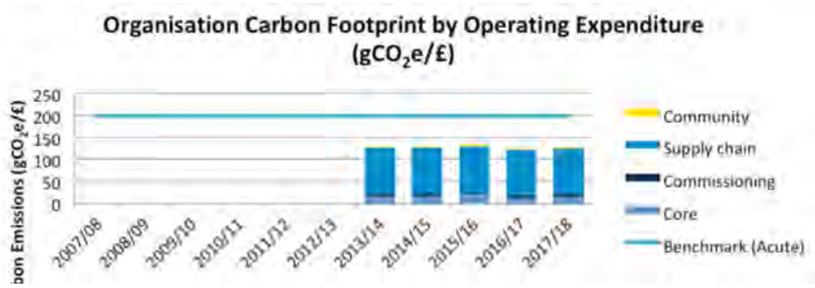
Breakdown of 2017/18 emissions ($tC0_2e$)



Climate Change Act Target



Benchmarking



Many of our plans and ambitions are delivered with key partners, such as Sodexo (our facility management partner) the NHS Sustainable Development Unit, local councils (London Boroughs of Havering, Redbridge and Barking and Dagenham), and Transport for London. The collaboration and support offered by all continues to be a very positive story.

SECTION TWO:

OUR ACCOUNTABILITY REPORT

This section of the Annual Report focuses on our governance, providing information about the legal status of our Trust, the processes and structures by which we maintain our commitment to good governance.

DIRECTORS' REPORT

OUR TRUST

Barking, Havering and Redbridge University Hospitals NHS Trust provides core hospital and specialist services from two large acute sites: Queen's Hospital in Romford and King George Hospital in Ilford. We also provide services in the communities of Barking and Dagenham, Havering, Redbridge and Brentwood. It is a statutory body which came into existence on 5 June 2000 under the Barking, Havering and Redbridge Hospitals National Health Service Trust (Establishment) Order 2000 (SI 2000/1413).

As an NHS Trust, it is governed by the NHSA 2006, the HSCA 2012 and by secondary legislation made under these Acts. The statutory functions of the Trust are set out in the NHS Act 2006, (Chapter 3 and Schedule 4) and in the Establishment Order as amended by Amendment Order 2009 No 43.

Our hospitals are run by our Board which is collectively responsible for the quality of healthcare delivery and financial performance. It is held to account for stewardship of public money and delivery of services by the Trust Development Authority working as NHS Improvement (NHSI), and for quality of services by the Care Quality Commission (CQC).

Our Trust can hold contracts in its own name and act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

LEADERSHIP

The Chair is responsible for the leadership of our Board. He is responsible for ensuring the Board's effectiveness and setting its agenda. The Chair facilitates the effective contribution and performance of all Board members who collectively are responsible for our long-term success and sustainability. He also ensures that there is sufficient and effective communication with stakeholders to understand their issues and concerns.

THE ROLE OF THE TRUST BOARD

The Trust Board has key functions for which it is held accountable by NHSI. Within the context of the Broad, overall strategy for the NHS, the Trust Board sets the strategic direction of the organisation and functions as a corporate decision-making body. The Trust Board considers the key strategic issues facing the Trust in carrying out its statutory duties.

The Trust Board is required to comply with applicable legislation, meet the standards in the NHS Constitution and those set by the quality and safety regulator, the Care Quality Commission, ensure progress towards delivering against the NHS Outcomes Framework and exercise the functions of the Trust effectively, efficiently and economically, operating as a going concern. In doing so, the Trust Board must ensure high standards of corporate governance and personal behaviour are maintained across the whole organisation.

The Trust Board is responsible for promoting effective dialogue between the organisation and the local community on its plans and performance, ensuring that the plans are responsive to the community's needs.

The Chief Executive is responsible for executing the strategy agreed by the Board and developing the Trust's objectives through leadership of the executive team. He recommends to the Board any investment or new business opportunities which meet this strategy. He also ensures that the Trust's risks are adequately addressed and appropriate internal controls are in place.

APPOINTMENTS

It is the role of NHSI to appoint or re-appoint the Chair and Non-Executive Directors (NEDs). A new Chair, Mr Joe Fielder, was appointed on 1 November 2017. The previous chairman, Dr Maureen Dalziel's, final term ended on 29 September 2017.

In the interim period, Mr Eric Sorensen was acting Chair. In addition to the new Chairman, one new independent non-executive director, Ms Jackie Westaway, was appointed to the post on 21 August 2017. She replaced Mr Dusty Amroliwala who left our Trust on 30 June 2017.

At the end of the year, five non-executive directors were considered independent in character and judgement using the criteria for independence listed within the UK Corporate Governance Code.

The Chair was considered to be independent on his appointment in November 2017.

There was one substantive executive director appointed during 2017/18: Mr Ian O'Connor on a fixed-term contract as Director of Finance and Investment from 3 January 2018.

During the year, there were extended periods of absence for the Chief Eexecutive (from 13 March 2017 to 1 September 2017), Medical Director (26 December 2016 to 12 September 2017) and Director of People and Organisational Development (from 13 February 2017 to 12 September 2017).

In order to maintain strong leadership during this period the following appointments were made or were in effect:

- Mr Jeff Buggle as Acting Chief Executive from 13 March to 21 July 2017, and then Mr Chris Bown 24 July to 12 September 2018.
- Mr Stephen Collins as Acting Director of Finance from 13 March until 20 December 2017).
- Ms Sarah Tedford, Chief Operating Officer, left the Trust on 1 September 2017, and Mr Jon Scott joined as interim Chief Operating Officer from September 2017 to 20 December 2017, and then Ms Shelagh Smith as Acting Chief Operating Officer from 3 January 2018.
- Ms Anne Robson as Interim Director of People and Organisational Development from 13 February 2017 until 12 September 2017.
- From 26 December 2016 to 12 September 2017, Dr Magda Smith became Acting Medical Director.

As with all staff, new directors receive a full and tailored induction on joining the Board.

The Board ensures that directors, especially NEDs, have access to funded, independent professional advice. This is facilitated through the Trust Secretary. The availability of independent external sources of advice is made clear at the time of appointment. A full-time Trust Secretary has been in place since September 2017.

In addition to the Board of Directors, the Board has six non-executive director advisers who provide additional support and capacity to the Chairman and Chief Executive by chairing consultant interview Panels, and HR hearings and appeals. They are paid the same as the Board non-executive directors, and since 2016/17, they have been members of some Board Committee, as follows:

Ms Sandra Malone – People and Culture Committee

Mr Jonathan Steinert – Quality Assurance Committee, Audit Committee

Mr Mehboob Khan - Quality Assurance Committee, Audit Committee, People and Culture Committee

Mr George Wood is the Chair of the Charitable Funds Committee

Ms Sue Levy and Ms Caroline Roberts were not members of any Board Committees in 2017/18.

ENSURING THE BOARD MAINTAINS HIGH STANDARDS OF GOVERNANCE

Our Board recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance and has adopted, where applicable, the NHS Foundation Trust Code of Governance which sets out best practice principles and processes to help NHS Foundation Trust boards of directors to:

- Maintain good quality corporate governance
- Contribute to better organisational performance
- Provide safe, effective services for patients

The Trust has maintained its significant efforts during 2017/18 to improve its corporate governance framework through:

- Continuing to drive improvement actions following the strategic governance review in 2015 supported by the Good Governance Institute, embedding a system of governance and risk management meetings at both departmental and divisional levels across core services
- Continuing the development of the Improvement Portfolio to sustain the improvements already made, and to provide a framework for the way we monitor improvements, and to ensure we keep a dedicated focus on quality of care
- Implementing clearer leadership and investing resources into improving clinical governance structures and risk management
- Redevelopment of the Board Assurance Framework (BAF) to manage risks and deliver objectives in conjunction with ongoing board development
- Development of the Trust's Operating Plan for 2016/17 and 2017/18 with reference to priorities identified by NHSI in the shared planning guidance for NHS trusts
- Establishing a Board level task and finish group to implement related recommendations from its commissioned review of the financial governance at the Trust
- Reviewing the procurement function of the Trust (with the Audit Committee overseeing the implementing of recommendations).

During the year, the Trust experienced significant cash flow challenges and after adjusting its forecast year-end outturn to a significant deficit from a planned small surplus, the Trust was placed into financial special measures.

COMMITTEES OF THE TRUST BOARD

The Trust Board can delegate and make arrangements to exercise any of its functions through a committee, sub-committee or other group, such as a task and finish group. During 2017/18, the Trust further embedded its new management structure and refined its committee structure.

HOW WE CONDUCT TRUST BOARD MEETINGS

The Trust has maintained its support of the Principles of Public Life and makes the majority of its decisions at Board meetings held in public. During the year, the Trust held 10 Board meetings.

The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Decision details what types of decisions can be delegated to board committees, management groups and staff.

ATTENDANCE

Membership and attendance at Trust Board and committee meetings is summarised in the table below:

Directors' attendance at meetings: 2017/18

	Trust Board	Audit	Finance and Investment (FIC)	Quality Assurance	People and Culture
Non-Executive Directors					
Dr Maureen Dalziel	6/6		4/6		
Joe Fielder	4/4		3/4		
Dusty Amroliwala	1/3	1/1		2/3	
Mark Lam	7/10	5/5	6/11		4/4
Joan Saddler	7/10			6/11	3/4
Eric Sorensen	10/10	5/5	11/11		
Prof Anthony Warrens	6/10			6 /11	
Tom Phillips	6/10	5/5			
Jackie Westaway	3/4		2/4	3/5	
Executive Directors					
Matthew Hopkins	4/4		4/6	5/7	2/2
Jeff Buggle	5/5		2/5	2/4	1/1
Kathryn Halford	9/10		7/11	10/11	3/4
Dr Nadeem Moghal	4/4		3/6	4/7	1/2
Jason Seez	9/10		7/11		
Deborah Tarrant	4/4		4/6	0/7	2/2
Sarah Tedford	4/5		3/5	3/4	1/2
Anne Robson	4/6		3/5	0/4	2/2
Steve Collins	7/7		8/8	7/8	3/3
Ian O'Connor	1/1		2/2	0/3	
Jon Scott	3/3		4/4	2/4	1/1
Shelagh Smith	2/2		1/2	3/3	1/1
Magda Smith	5/5			11/11	2/2
Peter Hunt	2/3			3/4	

The values shown are the number of attendances against the number of meetings held during the year that the director was eligible to attend. The shaded areas indicate that the director was not a member of that committee.

Membership and attendance at Trust Board and committee meetings and the functions of the Board's committees are summarised in the Governance Statement. Further specific detail on the work of the Audit Committee is provided below.

AUDIT COMMITTEE

The Board has a well-established Audit Committee comprising independent NEDs. The Audit Committee supports the Board by critically reviewing governance, internal controls and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by a Board Assurance Framework.

The detail of the Committee's work predominantly focused upon the monitoring and provision of assurance to the Trust Board on the adequacy and effective operation of the Trust's overall system of risk management and internal control.

Key activities for 2017/18 included:

- Review and approval of the internal audit plan, and more detailed programme of work, ensuring that this was consistent with the audit needs of the Trust
- Consideration of the major findings of internal audit work, the appropriateness of management responses, and the timeliness of completion of agreed actions
- Review of all external audit reports and the annual audit letter
- Review of the Trust's Annual Report and Financial Statements including the Annual Governance Statement and changes in, and compliance with, accounting policies and practices
- Review of the Trust's Quality Account
- Review of all work related to security, fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect
- From October, regularly review the structure and process of the Board Assurance Framework
- From October reviewing divisional and corporate risk registers.

The Audit Committee also received regular or specific reports on:

- Losses and compensation payments
- Waiver of tendering process and competitive quotations
- Write off of debts
- Any allegation of suspected fraud notified to the Trust.

The Audit Committee routinely met with auditors without officers present as part of established good practice.

Members of the Audit Committee in 2017/18 were Mr Tom Phillips (Chair), Mr Eric Sorenson, Mr Mark Lam, and Mr Dusty Amroliwala.

PROFILES OF OUR BOARD

Mr Joe Fielder
Chairman
Member: FIC, Remuneration Committee

Joe is chairman in common, being also the chairman of the North East London Foundation Trust since April 2016. Prior to his NHS roles, Joe gained a number of years' experience at Board level within BT, having served on both south west and south east regional boards. He was previously Sales & Marketing Director of BT Fleet Ltd, a wholly owned subsidiary of BT Plc.

Joe has a track record in delivering transformational change programmes for cost improvement and in driving business growth in a variety of senior sales, marketing and operational roles.

Eric Sorensen
Independent Non-Executive Director, Vice Chairman / Senior Independent Director, Chair Finance and Investment Committee
Member: Audit Committee, Remuneration Committee

Eric Sorensen was appointed in July 2014. Following his earlier civil service career, Eric has worked for many years to promote regeneration and development, particularly in east London. He is Chair of a local community regeneration trust in Tower Hamlets, of a grant-giving trust in Newham, and of an Islington primary school.

Eric is an experienced NHS non-executive director having held posts at Homerton Hospital and at South East London Healthcare Trust.

Mark Lam
Independent Non-Executive Director, Chair, People and Culture Committee
Member: Audit Committee, Finance and Investment Committee, Remuneration Committee

Mark Lam was appointed in September 2014. A senior corporate executive, Mark has extensive global experience in telecommunications and information technology. He is an executive and Chief Information Officer at Openreach, a BT Group business, and has previously held management positions at Siemens and The Carphone Warehouse. His experience of global business spans Europe, the USA and Asia, where he has led major contracts and operations.

Joan Saddler OBE
Independent Non-Executive Director
Member: Quality Assurance Committee, People and Culture Committee, Remuneration Committee

Joan Saddler OBE was appointed in September 2014 for a four year term of office. Joan spent five years as the National Director of Patient and Public Affairs at the Department of Health and is now responsible for national policy and practice in public and patient engagement at the NHS Confederation. She previously served as the Chair of Waltham Forest Primary Care Trust.

Professor Anthony Warrens
Non-Executive Director
Member: Quality Assurance Committee, Remuneration Committee

Anthony joined the Trust in July 2011. A qualified doctor with a clinical practice in renal medicine and based principally at Barts Health NHS Trust, Anthony has a particular interest in transplantation medicine.

He is a former President of the British Transplantation Society.

Since 2010 he has been Dean for Education at Barts and The London School of Medicine and Dentistry, where he has re-organised educational structures within the School and improved basic science teaching.

Tom Phillips
Independent Non-Executive Director, Chair Audit Committee
Member: Remuneration Committee

Tom was appointed to the Board in April 2017. He has previously held senior Board roles as Chief Executive, Chief Operating Officer and Group Finance Director in commercial multi-site retail operations within the pharmacy, transportation and leisure sectors.

Most notably Tom spent 15 years as an executive board member of the Tote and served on the tripartite working group comprising HM Treasury, Home Office and the Tote looking at future options for the Tote.

Tom is a Non-Executive Director for three other companies including at an international language school charity and at Kent & Medway NHS and Social Care Partnership Trust where he is also currently its Audit Chair.

Jackie Westaway
Independent Non-Executive Director
Member: Quality Assurance Committee, Finance and Investment Committee from November 2017 to April 2018), Remuneration Committee

Jackie has experience of delivering commercial success within the tightly regulated environment of the Pharmaceutical Industry. She is highly experienced in change management and UK and global marketing leadership. She has a strong customer focus with a track record of effectively working alongside the NHS.

Jackie led the compliance function for the European pharmaceutical business of her company and has worked alongside audit teams to implement changes. Jackie is a Non-Executive Director of the British School of Osteopathy, a director of HealthWatch Bucks and a Trustee of an Academy.

Matthew Hopkins
Chief Executive
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

Matthew Hopkins was appointed as Chief Executive in April 2014. Prior to joining our Trust, Matthew was Chief Executive of Epsom and St Helier University Hospitals NHS Trust for three years. He has also worked at a number of other London teaching hospitals including Guy's and St Thomas', Imperial, and Barts and The London. Starting his NHS career as a nurse, Matthew trained at Addenbrooke's Hospital in Cambridge before spending five years as a Macmillan nurse.

PROFILES OF OUR BOARD

Dr Nadeem Moghal
Medical Director, Caldicott Guardian
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

Dr Nadeem Moghal joined the Trust in January 2015. He is responsible for leading and directing our medical workforce, clinical standards, patient safety, and clinical governance.
Prior to joining our Trust, Nadeem was the Director of Strategy and Knowledge Management at George Eliot Hospital in North Warwickshire, where he led the implementation of a transformative and unique paediatric service model and worked with the senior leaders and teams to lead the organisation out of special measures.

He has authored and co-authored over twenty peer-reviewed papers in medicine and social science and was co-editor of The Oxford Handbook of Renal Transplant.

Kathryn Halford
Chief Nurse
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

Kathryn joined our Trust in January 2016 from Walsall Healthcare where she was the Director of Nursing. She qualified as a registered nurse in 1984 and then as a registered sick children's nurse in 1987. Since that time she has held a number of senior nursing roles within secondary and tertiary care settings and has led a number of national programmes including a focus on new roles and an independent review into children's palliative care whilst working at the Department of Health.

Ian O'Connor
Director of Finance and Investment
Member: Finance and Investment Committee, People and Culture Committee, Quality Assurance Committee

Ian's experience covers a number of settings including commissioning, acute, mental health, and community services, so is well placed to support our journey into the world of integrated care organisations and more collaborative working.

Ian has won HFMA awards for innovative practice in the development and implementation of cost improvement programmes.

As well as promoting the need for financial rigour he actively promotes the need to look beyond the numbers and apply commercial skills to the delivery of clinical and non-clinical services, working with multidisciplinary teams to deliver real change for the benefit of patients.

Deborah Tarrant
Director of People and Organisational Development
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

Deborah joined us in May 2014 having previously worked at the Royal Marsden NHS Foundation Trust, where she was Director of Workforce and Corporate Affairs.

Prior to that, she spent four and a half years at Queen Mary's Hospital, Sidcup, as Director of Human Resources and Organisational Development.

Deborah is President of the Healthcare People Management Association.

Shelagh Smith
Interim Chief Operating Officer
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

Shelagh joined our Trust as Divisional Manager for Clinical Support Services in 2007.

She then worked as Divisional Manager for Emergency Care and Medicine, and the Women and Child health divisions. More recently she was Director of Operations for King George Hospital, then the Deputy Chief Operating Officer for Emergency Care until her appointment as Interim Chief Operating Officer.

Prior to working at our Trust, Shelagh worked at the Royal Marsden as General Manager which followed on from a 20 year career as a diagnostic radiographer, seven of those years were at Harold Wood and Oldchurch Hospitals.

Jason Seez
Director of Strategy and Planning
Member: Finance and Investment Committee

Jason Seez joined our Trust as the Director of Planning and Governance in December 2014 and became Director of Strategy and Planning in 2016.

With a strong background in strategic development, Jason joined us from Medway NHS Foundation Trust where he was Executive Director of Strategy and Infrastructure.

Prior to that, he worked for Barts Health NHS Trust.

Peter Hunt
Director of Communications and Engagement
Member: Quality Assurance Committee, People and Culture Committee

Peter joined us in November 2017 after a career as a BBC correspondent and presenter where he was at the forefront of the organisation's news coverage. As one of the BBC's most senior journalists, he covered international and national events, politics and the royal family.

DECLARATION OF INTERESTS

Our Standing Orders require all Board members to declare any outside interests which are relevant and material to their position.

A register of all such declarations is maintained and updated on an on-going basis and confirmed at the end of each financial year by the Trust Secretary. Interests of Board members are published with the Board agenda and the register is also available upon request from the Trust Secretary at **Trust.Secretary@bhrhospitals.nhs.uk**

ADDITIONAL DISCLOSURES

This section includes items of information which we are required to include in our annual report.

ACCOUNTING POLICIES

The Accounting Policies for the Trust are shown as Note 1 to the Accounts and include policies on pensions and other retirement benefits. Details of senior employees' remuneration are set out in the Remuneration Report. The Trust's external auditors' remuneration and fees are shown in operating expenses in the Accounts.

EXTERNAL AUDITORS

The external auditors appointed to audit the accounts for the year ended 31 March 2018 were KPMG LLP. KPMG LLP has not carried out any non-audit work for the Trust during the year.

COST ALLOCATION AND CHARGES FOR INFORMATION

We have complied with HM Treasury's guidance on setting charges for information required.

BETTER PAYMENT FOR SUPPLIERS

The Trust supported The Better Payment Practice Code that was established in 1998 by business and government together, to help improve the payment culture amongst organisations trading in the UK. The Code is supported by public as well as private sector organisations. Collectively they represent about 20% of the UK's gross domestic product.

This simple code sets out the following obligations of a business to its suppliers:

- Agree payment terms at the outset of a deal and stick to them
- Explain your payment procedures to suppliers
- Pay bills in accordance with any contract agreed with the supplier or as required by law
- Tell suppliers without delay when an invoice is contested, and settle disputes quickly.

The Better Payment Practice Code was replaced by The Prompt Payment Code in 2009. It applies the following principles to payment practices:

- Pay suppliers on time
- Give clear guidance to suppliers
- Encourage good practice.

The Trust's performance is summarised in the notes to the Annual Accounts.

MODERN SLAVERY ACT 2015

Barking, Havering and Redbridge University Hospitals NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015 and we expect our staff and suppliers to comply with the legislation. We have updated a number of relevant policies and ensured that training about slavery and human trafficking is available to staff through the safeguarding team. Future actions include scoping our procurement flows and developing a clear action plan to ensure Modern Slavery is not taking place in any part of business or any of our supply chains.

POLITICAL AND CHARITABLE DONATIONS

As an NHS trust, we make no political or charitable donations. The Trust continues to benefit from charitable donations received and is grateful for the efforts of fundraising organisations and members of the public for their continued support.

EXIT PACKAGES AND SEVERANCE PAYMENTS

Exit Packages and severance payments are detailed in the Financial Statements and Notes.

OFF PAYROLL ENGAGEMENTS

The Trust's off-payroll engagement disclosures are in accordance with HMRC requirements and are shown in the Remuneration and Staff report section of this document.

INFORMATION GOVERNANCE

During the year, the Trust had five personal data incidents reported to the ICO, covering:

- Health records management breach – which related to ED cards taken offsite against Trust policy. The patient records were held securely and there was no report of unauthorised access. Duty of Candour applied and patients were informed and invited to raise concerns. The investigation was closed with an improvement plan
- The national cyber-attack - on 12 May 2017, we were one of 48 NHS trusts in England that came under an unprecedented global cyber-attack, which also affected many organisations in 99 countries. The virus spread very quickly through our trust's computing network and significantly affected access to trust information and the provision of services. The investigation closed with a national improvement plan
- Adoption data breach – personal information of birth parent sent to adopter. The birth mother was an overseas patient who was required to pay for maternity services and owed the Trust for this. Eventually the birth mother's contact details were passed on to the Trust's debt collection agency, along with a change of address, however this information was incorrect. Further investigation confirmed that it was another NHS Trust had changed the address and was responsible for the breach. The investigation closed with improvement plan
- Staff data loss –a Health and Safety Executive (HSE) Approved third party contractor responsible for managing and storing radiation doses of Trust staff was a victim of a data security attack. Unauthorised access was detected and malware was installed by unknown person(s) on contractor's UK server. This led to the breach of person identifiable data of 674 Trust staff. Hundreds of other NHS Trusts were also affected. Investigation closed with national improvement plan
- PACS – during the PACS migration project, access to the Trust's CPW PACS database was lost during, and following, the WannaCry cyber-attack in May 2017. Clinicians were unable to access mismatched records for a period of time however workarounds were in place. Reports remained available but there was potential for some delayed reporting. Investigation closed with improvement plan.

DIRECTORS' STATEMENT TO THE AUDITOR

The directors know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and have taken all the steps that he or she ought to have taken to make himself/herself aware of any such information, and to establish that the auditors are aware of it.

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

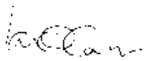
- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- Assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use 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.[1]

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 such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Chief Executive
Date: 24 May 2018



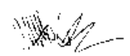
Director of Finance and Investment
Date: 24 May 2018

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Development Authority, has designated that the chief executive should be the accountable officer to the trust. The relevant responsibilities of accountable officers are set out in the Accountable Officer's Memorandum issued by the Department of Health. 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
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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



Matthew Hopkins, Chief Executive
Date: 24 May 2018

ANNUAL GOVERNANCE STATEMENT 2017/18

SCOPE OF RESPONSIBILITY

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

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Barking, Havering and Redbridge University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them effectively, efficiently, and economically. The system of internal control has been in place in Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISKS

The Trust faced risk management challenges throughout the year, as well as uncovering some weaknesses in its controls, and during the course of that time has worked to improve its related processes. By year end, the Trust had ensured that its risk management system received the appropriate leadership and management. The Trust has ensured that its risk management system received the appropriate leadership and management. We have a Risk Management Policy and Strategy which applies to all our staff. At the strategic level, our board assurance framework (BAF) enables us to assess and evaluate the principal risks to achieving our strategic objectives.

During the year, the BAF was developed with the help of the Good Governance Institute (GGI) and reviewed at a Board development seminar in October 2017, before regularly being presented to the Board and Audit Committee. It provides a current view around the risks to our meeting strategic objectives, and the appropriate controls, assurances, gaps in controls and planned actions. Risks are assigned to executive directors. Risk appetite is determined by the Board in accordance with the Trust Risk Management Strategy and Policy.

Operational risks are subject to a risk management process that we are continually strengthening and refining. Whilst the management of risk is everyone's responsibility, the Chief Executive and executive directors are accountable for managing risks within the scope of their management responsibilities as defined in the table below:

ROLE	RISK RESPONSIBILITY
Chief Executive	Designated Accountable Officer and overall accountability for our risk management
Medical Director	Caldicott Guardian and joint lead on the management of quality and patient safety
Chief Nurse	Joint lead on the management of quality and patient safety Responsible for the Risk & Compliance Team
Director of Finance and Performance	Financial control and investment risks. Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks from 01 August 2016 to 01 November 2017
Chief Operating Officer	Risk relating to the delivery of clinical services
Director of People and Organisational Development	Workforce and organisational development risks
Director of Strategy and Infrastructure	Risks relating to the development of strategy and estates
Director of IM&T	From 1 November 2017: Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks

Assurance around operational risks is provided to our Board through both the management route, and from additional scrutiny from the committee structure. The Risk and Compliance Group reviews the Trust risk register monthly. From October 2017, the Audit Committee began the inviting of a divisional director and corporate director to attend meetings to present their risk registers and from January 2018, the Trust Executive Committee commenced the quarterly review of the Trust corporate risk register. The chief nurse is the governance and risk lead.

The Risk and Compliance Group reports to the Trust Executive Committee through the Quality Governance Steering Group. The Risk and Compliance Group scrutinises key risk management instruments such as the risk register and the operation of the risk escalation process through the direct engagement of senior operational staff. The risk register is a live instrument that is increasingly connected to other risk and safety systems such as incident reporting, serious incident (SI) investigation and patient feedback.

A training and development programme is in place to enable staff at all levels to fulfill their responsibilities and work with those systems to minimise and mitigate risk to staff, patients, visitors and contractors. This programme also improves understanding on how the risk management policy and strategy operates, as well as on incident management and compliance with the statutory Duty of Candour.

Many partners support and help us to manage risk. These include our PFI partners; the Local Counter Fraud and Local Security Management Specialists patient representatives; the work of the local Overview and Scrutiny Committees and Health and Wellbeing boards; our Local Representatives' Panel and the National Patient Survey Programme and the results of real time feedback on wards and departments, and via complaints, compliments and social media.

Our Local Counter Fraud service ensures that the annual counter fraud plan work programme minimises the risk of fraud within our Trust and is compliant with NHS Protect Counter Fraud Standards for providers. Preventative measures include reviewing our policies to ensure they are, as far as possible, fraud-proof, using intelligence, best practice and guidance from NHS Protect. Detection exercises are undertaken where a known area is at high risk of fraud and the National Fraud Initiative (NFI) data-matching exercise is conducted bi-annually. Staff are encouraged to report suspicions of fraud through communications, presentations and fraud awareness literature across our sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented regularly to the Audit Committee.

The Audit Committee scrutinises risk management on behalf of the Trust Board. In 2017/18, the committee met five times, and retains the capacity to meet more often, if necessary, and scrutinises the integrity of the Trust's risk management processes and the board assurance framework (BAF). The Quality Assurance Committee meets monthly as the high-level committee which scrutinises quality assurance and specific risks on behalf of the board. The Finance and Investment Committee meets monthly to scrutinise, and assure the Board, of matters related to finance, and the People and Culture Committee meets bimonthly to oversee, for Board assurance, all workforce and culture related issues in the Trust. The Trust also has a Trust Executive Committee, chaired by the chief executive, which provides a forum and mechanism for executive decisions and management.

During the year, the Board committee chairs reported to the Board and escalated issues, as appropriate. Individual committee reports are a standing Board agenda item. The practice of having a standing item, on committee agendas and Board reports, on escalation has helped ensure systematic consideration by all committees about emerging key risks the Board needs to consider.

My review on the effectiveness of internal control has been informed by:

- Executives, directors and managers within the organisation who have responsibility for the development and maintenance of the system of risk management and internal control
- Performance against national and local standards
- The work of Internal Audit (RSM) through the year
- The results of External Audit's (KPMG) work on our annual accounts and local tailored performance management reviews
- Patient and staff surveys and feedback, NHS Litigation Authority (now NHS Resolution) and Care Quality Commission assessments, Ombudsman and other sources of external scrutiny and accreditation

THE RISK AND CONTROL FRAMEWORK

The Risk Management Strategy is reviewed by the Trust Executive Committee, approved by the Board and is available to all staff through the Trust's intranet. The Risk Management Strategy describes the Trust's overall risk management approach, corporate and divisional responsibilities for risk, the risk management process, and the Trust's risk identification, assessment and control system, as well as the Trust's risk appetite. It includes guidance on the risk assessment matrix used to evaluate risks for inclusion on the Trust's risk registers.

By the end of the financial year, risk management was embedded in the activities of the organisation in the following ways:

- Corporate and divisional objectives are risk assessed as part of the annual business planning and performance management process
- Structured processes are used for the completion of local risk assessments to populate the Trust's risk register
- The Risk and Compliance Group monitors risk registers
- There are structured processes in place for incident reporting, the investigation of Serious Incidents (SIs), complaints and litigation cases
- The Audit Committee reviews divisional and corporate risk register at its meetings, and the Trust Executive Committee reviews the corporate risk register
- All executive directors regularly review the BAF to ensure that appropriate action is being taken against key risks to the Trust strategic objectives and the Board formally reviews the BAF at its meetings in public.

The Trust continues to carry out on-going exercises to capture both clinical and non-clinical risk data at divisional and departmental levels through local risk assessments. Best practice is highlighted and shared across divisions through divisional leads, the quality subcommittees at the Trust and patient safety summits. The Trust is committed to continuous improvement and learning; from incidents and complaints, outcomes from audits and the experiences of patients, clients and staff. The quality of performance information is assessed through data quality reports to divisions and regular audit. The major risks to the Trust over the last year and into the current year include:

- A failure to recruit and retain appropriate numbers of permanent, capable staff to deliver the operational plan
- The failure to deliver the Constitutional Standards and other key operational targets will have detrimental consequences, such as impact on patients, reputational loss and contractual fining
- Not being able to embed an appropriate high-performing culture throughout the whole Trust
- Failure to deliver the control total
- Commissioner inability to fund activity within the payment by results (PBR) contract
- Failure to identify solutions to the cash flow deficit.

The Trust is one of five trusts in the UK working in ground-breaking partnership with the Virginia Mason Institute to introduce a standardised approach to quality improvement using lean methodology throughout the organisation. Through this process our staff that deliver the service, improve the service, by using rapid process improvement workshops to address quality defects and reduce waste in our systems and processes. One of the successful improvements has been in incident reporting processes which will contribute to even better incident reporting rates, monitored through the integrated quality report.

The Trust achieved the national benchmark for harm free care in all four quarters. The Trust did not achieve the A&E 4-hour wait target during the year, and did not maintain RTT standard performance at all times during the year. It did achieve the cancer standards throughout the year, with the exception of the 62-day cancer standard, which was achieved in quarters 2 and 3. There were 143 SIs reported during the year and 5 never events. These and other year-end key performance indicators are referenced in the performance report section of the annual report and within the quality account. The Trust achieved the targets for safe staffing in all four quarters.

The Trust has received multiple quality based visits and inspections to its Emergency Departments, all of which provided assurance that quality and safety were at a high level. The Trust has also developed its Urgent Treatment Centre (UTC), which is the focus of targeted improvement activity, through a task and finish group.

The Trust implemented a mortality review process during the year as well as developing a strong Mortality Faculty, and establishing a mortality assurance group. The Trust also agreed a learning from deaths policy and reviewed all deaths and escalated any, where there were concerns, to a structured subject review using the Royal College of Physicians approved methodology. The Trust's measures of mortality (MRSA and SHMI) reduced over the year, and are within 'expected limits'. Performance around this is regularly scrutinised by the Quality Assurance Committee and presented to the Board. Risks in relation to data security are placed on the risk register.

We have redesigned our data quality strategy to become an information rich organisation. During the year, internal audit reviewed data quality, for RTT and cancer waiting times, which received reasonable assurance. The Trust has in place a comprehensive validation and data quality strategy which has been overseen by our chief operating officer. Reports are presented at our weekly Access Board chaired by our deputy chief operating officer detailing the volumes of patients and waiting times data that have been checked each week. We have audit trails and a robust recording system for all of our validation. Our elective access policy has been reviewed by a third party – the Intensive Support Team from NHS Improvement.

The Trust had a surplus financial plan agreed with NHS Improvement at the start of the year, which included recognised risks. During the year, however, it became apparent that the Trust had some significant cash flow and financial challenges, and after review, it realised a revised deficit forecast. The cash flow pressures had caused us to further delay payment to suppliers. At year-end, the Trust recorded a £49m deficit. In response to this, the Trust commissioned Grant Thornton to conduct a financial analysis and financial governance review. The report had a number of recommendations, which the Trust is working to complete, overseen by the Financial Governance Steering Group, established by, and reporting to, the Finance and Investment Committee. The Trust was placed in special measures for finances by NHSI in February.

The Board reviews and monitors monthly performance reports to meet the requirements of NHS Improvement's (NHSI) Accountability Framework building those requirements into its annual operational plan, and ensuring that they are addressed as part of our integrated planning process.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The work of the Quality Assurance Committee, and quality subcommittees, monitors compliance with CQC registration requirements.

The CQC visited the Trust between 13 January and 21 February 2018 to carry out unannounced inspections of our emergency and urgent care, medical care (including older people care) and surgery at both Queens Hospital and King George Hospital. They returned from 13 to 15 March 2018 to complete a well-led review. The completed report is not expected before June 2018. The Improvement Plan, set from the previous CQC inspection, last year, has largely been completed, and was developed into a trust-owned Improvement Portfolio which has become part of our 'business as usual'. This was integrated our quality improvement strategy flowing from our partnership with the Virginia Mason Institute. We have complied with the relevant guidance on Corporate Governance. The Trust continued to implement its Board development programme throughout the year, using months where it did not hold a Board meeting in public. This has provided opportunities for the Board to reflect on priorities, behaviours and working assumptions around key strategic issues. During the year, it focused on the development of the BAF, how well-led it was, discussed strategic topics such the development of an ACS, and dedicated time to the Trust's financial challenges, which were uncovered during the year.

With reference to the requirements of our Standing Orders, the director of finance and investment assessed the arrangements for the discharge of statutory functions. No irregularities or gaps in legal compliance have been identified other than those identified within this statement. The Trust, after review, made some changes to the SFI to provide additional discipline to the adherence of budgets throughout the Trust, which were ratified at the May 2018 Board meeting.

Overall responsibility for quality governance rests jointly with the chief nurse and medical director. The medical director is executive lead for clinical standards, patient safety and clinical governance, and is the Trust's Caldicott Guardian. The chief nurse is our executive lead for improving patient experience. A new patient experience strategy was approved in the first quarter of 2017/18. The Good Governance Institute continued to support the Trust in developing the quality governance arrangements and in particular, reviewing the quality groups that reported to the Quality Governance Steering Group.

Quality key performance indicators (KPIs), including the number of never events, serious incidents and explanations of follow-up actions, are monitored by our Board. We have further developed and embedded our divisional structure, strengthening the divisions' governance and leadership capability, and in particular their ownership of our clinical strategy.

Our governance framework and system of internal control helps us to manage risk to a reasonable level; it does not eliminate all risk, and it therefore provides reasonable and not absolute assurance of effectiveness. Our system of internal control aims to identify and prioritise risks to compliance with policies, and the achievement of our aims and objectives, and evaluate the impact and likelihood of risks being realised and to manage them efficiently, effectively and economically.

PENSIONS

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

CARBON REDUCTION

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

EQUALITY, DIVERSITY, AND HUMAN RIGHTS

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has an established process to ensure that equality and diversity and human rights is embedded in its policy development process. All new, and reviewed, policies have an equality impact assessment completed, which is considered by the approving group and the Trust's Policy Ratification Group. Board papers require an assessment of equality and diversity issues.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

Monthly finance and performance reports are provided for the Board. Internal Audit also has an important role to challenge how resources are used. The Trust has an internal performance management review process which provides evidence of performance at divisional level and the actions being taken to ensure resources are being used effectively and efficiently. In addition the annual business planning process, including the requirement to identify productivity and efficiency opportunities, provides another mechanism to achieve this aim.

INFORMATION GOVERNANCE

Our Information Governance (IG) Assessment Report for the period 2017/18 was 79%, and was rated as satisfactory.

The Trust declared that it has complied with information governance guidelines and the Data Protection Act 1998.

I can confirm that there has been five level two Information Governance incidents reported to the ICO during 2017/18. To date the ICO has taken no action against the Trust.

The Trust has been preparing for GDPR, and the Board reviewed risks to implementation of the requirements by 25 May 2018.

ANNUAL QUALITY ACCOUNT

Our Quality Account is the annual report to the public from providers of NHS healthcare about the quality of services delivered. The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.. Our 2017/18 Quality Account will:

- Aim to improve organisational accountability to the public and engage our board in the quality improvement agenda for the organisation
- Enable us to review our services, decide and show where we are doing well, but also where improvement is required
- Enable us to demonstrate what improvements we have made against our 2017/18 priorities
- Provide information on the quality of our services to patients and the public
- Demonstrate how we involve and respond to feedback from patients and the public, as well as other stakeholders.

We will also include a review of mortality, as we are expected by NHS England to report our progress in using learning from deaths to inform our quality improvement plans for the 2017/18 Quality Account. This will build on the work of the Royal College of Physicians in developing a methodology to support our process.

An editorial group led by our Medical Director and Chief Nurse, has been established to review and to quality assure the account. The timeline for publication is on track including stakeholder meetings to obtain feedback on progress and planned objectives.

REVIEW OF EFFECTIVENESS

As Accounting 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 foundation trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality 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 risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance and on the controls reviewed as part of the work that Internal Audit has undertaken. Internal Audit has issued the following opinion: "There are weaknesses in the framework of governance, risk management and control such that it could become, inadequate and ineffective."

All internal audit reports are presented to Audit Committee and the Trust implements management actions to address weaknesses, which is overseen by Audit Committee. The Trust has made reasonable progress during the year at implementing agreed actions. Over the year, six completed internal audit reports provided only partial assurance, and five other reports were in draft; six provided reasonable assurance and one substantial assurance. No audits returned a conclusion of 'no assurance'.

The following finalised audits returned partial assurance:

- Risk Management
- Delivery of Agency Cap
- Financial Planning and QCIP
- Benefits Utilisation from the Use of Consultants
- Succession Planning
- Management of Capital Expenditure

Weaknesses in relation to financial governance were identified, in year. These related to financial planning and quality cost improvement plans (including cash flow management and reporting), procurement, and management of capital expenditure. The Trust is committed to implementing the management actions from these audits, and in addition has recruited senior finance staff, accepted the recommendations of a review of financial governance by Grant Thornton, and established the Financial Governance Steering Group to ensure improvements in this area are made.

CONCLUSION

The internal control issues that I have outlined in this statement have resulted in measures being put in place, which at year-end, have given rise to improvements to our system of internal control. The Trust has further work to undertake to improve its internal controls, which we are committed to achieving.

The Chief Executive authorises both the Annual Governance Statement and Accountability Report.

Matthew Hopkins

Date: 24 May 2018

Chief Executive and Accountable Officer

Barking, Havering and Redbridge University Hospitals NHS Trust

REMUNERATION AND STAFF REPORT

REMUNERATION REPORT

Our remuneration policy states that Agenda for Change applies to all directly employed staff except very senior managers and those covered by the Doctors' and Dentists' Pay Review Body. A personal performance review process incorporating development plans is in place to enable performance and talent management of our people.

The remuneration package and conditions of service for executive directors is agreed by the Remuneration Committee. The remuneration for executive directors does not include any performance related bonuses and none of the executives receive personal pension contributions other than their entitlement under the NHS pension scheme.

Each year the Remuneration Committee considers the contribution of each director against the responsibilities of the role and objectives set through performance plans and our Leaders' Agreement implemented this year. We also utilise the NHS Leadership 360 degree review process. The Remuneration Committee considers the matter of succession planning, although all executive directors hold permanent contracts.

The notice period for executive directors is six months and there and no additional arrangements for enhanced termination payments or compensation for early termination of contract.

The Trust is not liable for any compensation payments to former senior managers or amounts payable to third parties for the permanent services of a senior manager.

SINGLE TOTAL FIGURE REMUNERATION TABLE

		2017-18						2016-17
Name and Title	Period (See Note 7)	Salary (bands of £5,000) £000	Taxable expenses payments to nearest £100	Performance pay & bonuses (bands of £5,000) £000	Long term performance pay (bands of £5,000) £000	All Pension-related benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Total (bands of £5,000) £000
Dr Maureen Dalziel - Chair	01/04/2017 - 29/09/2017	15-20	0	0	0	-	15-20	35-40
Joe Fielder - Chair	01/11/2017 - 31/03/2018	15-20	0	0	0	-	15-20	-
Matthew Hopkins - Chief Executive (See Note 1)		200-205	0	0	0	40.0 - 42.5	240 - 245	395-400
Chris Bown -Interim Chief Executive Officer (See Note 3)	24/07/2017 - 01/09/2017	70-75	31	0	0	0	70-75	0
Jason Seez - Director of Strategy and Planning		135-140	0	0	0	32.5 - 35.0	170 - 175	280-285
Deborah Tarrant - Director of People & Organisational Development		125-130	0	0	0	(12.5-15.0)	110 - 115	230-235
Sarah Tedford - Chief Operating Officer (See Note 5)		150-155	0	0	0	47.5 - 50.0	200 - 205	145-150
Jeff Buggle - Acting Chief Executive (See Note 2)		65-70	7	0	0	0.0 - 2.5	65 - 70	180-185
Steve Collins - Acting Director of Finance & Investment (See Note 4)	06/04/2017 - 22/12/2017	120-125	0	0	0	45.0 - 47.5	170 - 175	10-15
Anne Robson - Interim Director of People & Organisational Development (See Note 6)	01/04/2017 - 12/09/2017	85-90	0	0	0	0	85 - 90	45-50
Kathryn Halford - Chief Nurse		150-155	0	0	0	27.5 - 30.0	175 - 180	410-415
Dr Nadeem Moghal - Medical Director		180-185	0	0	0	85.0 - 87.5	265 - 270	260-265
Rachel Royall - Director of Communications & Marketing	01/04/2017 - 31/05/2017	15-20	0	0	0	12.5 - 15.0	30- 35	145-150
Ian O'Connor - Interim Director of Finance & Investment	01/01/2018 - 31/03/2018	35-40	0	0	0	0.0 - 2.5	35 - 40	0
Shelagh Smith - Acting Chief Operating Officer	05/01/2018 - 31/03/2018	35-40	0	0	0	(102.5 - 105.0)	(67.5 - 70.0)	0
Magda Smith - Acting Medical Director	01/04/2017 - 04/09/2017	65-70	0	0	0	42.5 - 45.0	110 - 115	0
Jon Scott - Interim Chief Operating Officer	04/09/2017 - 04/01/2018	110-115	0	0	0	35.0 - 37.5	145 - 150	0
Peter Hunt - Director of Communications and Engagement	20/11/2017 - 31/03/2018	40-45	0	0	0	15.0 -17.5	55 - 60	0
Eric Sorensen - Non-executive Director (Acting Trust Chair from 29/09/2017-01/11/2017)		5-10	0	0	0	0	5-10	5-10
Dusty Amroliwala - Non-executive Director	01/04/2017 - 30/06/2017	0-5	0	0	0	0	0-5	5-10
Mark Lam - Non-executive Director		5-10	0	0	0	0	5-10	5-10
Jackie Westway - Non-executive Director	21/08/2017 - 31/03/2018	0-5	0	0	0	0	0-5	0
Joan Saddler - Non-executive Director		5-10	0	0	0	0	5-10	5-10
Tom Philips - Non-executive Director		**5-10**	**0**	**0**	**0**	**0**	**5-10**	**5-10**
Median remuneration of all staff in the Trust (£)					**33,058**			**33,205**
Highest paid director of the Trust midpoint of banded remuneration (£5k band)					**200-205**			**200-205**
Ratio of the above two figures					**6.1**			**6.1**

Notes

(1) Due to a planned period of absence Matthew Hopkins was not present to discharge his duties as Chief Executive from the 1st of April to the 31st of July 2017.

(2) Jeff Buggle was Acting Chief Executive until 21st July 2017 when he left the Trust.

(3) Chris Bown took over the Acting Chief Executive role from Jeff Buggle until Matthew Hopkins (Substantive Postholder) returned from sickness absence.

(4) Steve Collins was asked to act into the role of Director of Finance and Investment from the 14th of March until he left the Trust on the 22nd of December 2017.

(5) Sarah Tedford left the Trust at the end of August 2017 on secondment to NHSI.

(6) Anne Robson (interim) was appointed to cover the role of Director of People and Organisational Development from 1st April - 12th of September 2017 following a period of absence for the substance Director postholder Deborah Tarrant.

(7) Unless the period is stated the Directors were here throughout the full financial year (ie 1st April 2017 - 31st March 2018).

Matthew Hopkins, Chief Executive

PENSION ENTITLEMENTS OF SENIOR MANAGERS

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000) £000	Total related lump sum at age 60 at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension £100
Matthew Hopkins - Chief Executive	0.0 - 2.5	5.0 - 7.5	80.0 - 85.0	250.0 - 255.0	1,437	1,574	122	0
Jason Seez - Director of Planning & Governance	0.0 - 2.5	(0.00 -2.5)	45.0 - 50.0	110.0 - 115.0	627	689	56	0
Deborah Tarrant -Director of People & Organisational Development	(0.00 -2.5)	(7.5-10.0)	40.0 - 45.0	115.0 - 120.0	797	825	20	0
Sarah Tedford - Chief Operating Officer	0.0 - 2.5	5.0 - 7.5	40.0 - 45.0	125.0 - 130.0	801	876	67	0
Jeff Buggle - Acting Chief Executive	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Steve Collins -Acting Director of Finance & Investment	0	0	0.0 - 5.0	0.0 - 5.0	0	22	22	0
Kathryn Halford - Chief Nurse	0.0 - 2.5	2.5 - 5.0	55.0 - 60.0	170.0 - 175.0	1,053	1,150	86	0
Dr Nadeem Moghal - Medical Director	2.5 - 5.0	10.0 - 12.5	65.0 - 70.0	195.0 - 200.0	1,231	1,385	142	0
Rachel Royall - Director of Communications and Engagement	0.0 - 2.5	0.0 - 2.5	5.0 - 10.0	0.0 - 5.0	54	62	8	0
Ian O'Connor - Acting Director of Finance & Investment	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Shelagh Smith - Acting Chief Operating Officer	(5.0 - 7.5)	(0.0 - 2.5)	40.0 - 45.0	65.0 - 70.0	733	767	27	0
Magda Smith - Medical Director (Acting)	0.0 - 2.5	5.0 - 7.5	55.0 - 60.0	170.0 - 175.0	1,103	1,184	70	0
Jon Scott - Interim Chief Operating Officer	0.0 - 2.5	(0.00 -2.5)	15.0- 20.0	45.0 - 50.0	374	412	34	0
Peter Hunt - Director of Communications and Engagement	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	9	9	0

There are no entries for Non-Executive Directors in the table because their remuneration is non-pensionable. Some Executive Directors are either not eligible or are not in the NHS Pension.

CASH EQUIVALENT TRANSFER VALUES

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) regulations 2008.

REAL INCREASE IN CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. A CETV is not provided once a scheme member reaches age 60.

Matthew Hopkins,
Chief Executive

COMPENSATION FOR LOSS OF OFFICE

There have been no payments made to executive or non-executive directors in the year for loss of office.

Fair pay (ratios) disclosure

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.

	2017-18	2016-17
Band of the highest paid director's total remuneration (£000)	200-205	200-205
Median pay remuneration (£)	33,058	33,205
Median pay multiple	6.1	6.1
Range of staff remuneration	19,224-204,500	19,034-204,500

The highest paid director salary was £204,500 (2016/17, £204,500) in the current year against a median salary of £33,058 (2015/16, £33,205), resulting in no change to the median pay multiple.

The banded remuneration of the highest-paid director in the Trust in the financial year 2017/18 was in the band £200k-£205k (2016/17, £200k-£205k). This was 6.1 times (2016/17, 6.1) the median remuneration of the workforce, which was £33,058 (2016/17, £33,205). Total remuneration includes salary and nonconsolidated performance-related payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff costs have been outlined in detail in note 8 of the accounts. In 2017/18, the Trust spent a total of £605m of which staff costs accounted for £370m (61%).

STAFF REPORT

We work in, and deliver services to, a diverse and multi-cultural community. Our workforce reflects the diversity of the population we serve. Working and being cared for in a culture that embraces inclusion and has a commitment to equality and diversity is key to a good patient and staff experience.

Ethnicity	Headcount
A White - British	2775
B White - Irish	149
C White - Any other White background	241
C2 White Northern Irish	4
C3 White Unspecified	8
CA White English	58
CB White Scottish	7
CC White Welsh	2
CE White Cypriot (non specific)	2
CFWhite Greek	10
CG White Greek Cypriot	4
CH White Turkish	2
CJ White Turkish Cypriot	1
CK White Italian	43
CM White Traveller	1
CP White Polish	31
CQ White ex-USSR	13
CR White Kosovan	3
CS White Albanian	3
CU White Croatian	2
CV White Serbian	1
CW White Other Ex-Yugoslav	1
CX White Mixed	9
CY White Other European	103
D Mixed - White & Black Caribbean	35
E Mixed - White & Black African	27
F Mixed - White & Asian	27
G Mixed - Any other mixed background	48
GA Mixed - Black & Asian	2
GB Mixed - Black & Chinese	1
GC Mixed - Black & White	2
GD Mixed - Chinese & White	1
GF Mixed - Other/Unspecified	16
H Asian or Asian British - Indian	497
J Asian or Asian British - Pakistani	172
K Asian or Asian British - Bangladeshi	101
L Asian or Asian British - Any other Asian background	247
LA Asian Mixed	6
LB Asian Punjabi	24
LC Asian Kashmiri	3
LD Asian East African	5
LE Asian Sri Lankan	18
LF Asian Tamil	15
LG Asian Sinhalese	5
LH Asian British	78
LJ Asian Caribbean	8
LK Asian Unspecified	10
M Black or Black British - Caribbean	185
N Black or Black British - African	738
P Black or Black British - Any other Black background	29
PA Black Somali	10
PB Black Mixed	1
PC Black Nigerian	99
PD Black British	80
PE Black Unspecified	7
R Chinese	57
S Any Other Ethnic Group	120
SC Filipino	324
SD Malaysian	9
SE Other Specified	3
Undefined	24
Z Not Stated	78
Grand Total	**6585**

The table below gives the gender breakdown within the Trust (as at 31 March 2018).

Headcount

	Female	Male
Board Level Director	1	4
Non Executive Director / Chair	2	4
Senior Manager	288	153
All Other Employees	4810	1323
Grand Total	**5101**	**1484**

The number of staff disclosed in the staff report are in absolute terms whereas the figure disclosed in note 10 of the accounts is an average for the year.

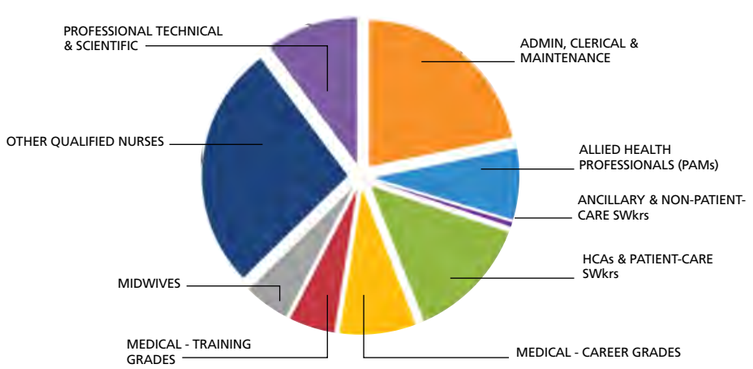
Senior managers are classed at those working at band 8a to 9, as well as Very Senior Managers (VSMs).

Our expert staff work across the following disciplines:

Staff Group	Headcount	%
Admin, Clerical & Maintenance	1434	21.8%
Allied Health Professionals (PAMs)	519	7.9%
Ancillary & Non-patient-care SWkrs	32	0.5%
HCAs & Patient-care SWkrs	913	13.9%
Medical - Career Grades	560	8.5%
Medical - Training Grades	337	5.1%
Midwives	333	5.1%
Other Qualified Nurses	1786	27.1%
Professional, Technical & Scientific	671	10.2%
Grand Total	**6585**	

We set a tough target for staff sickness levels over the course of the year of 2.8% and at the end of the year we did not hit the target, returning an overall rate of 3.4%

BHRUT Staff Groups %



STAFF POLICIES APPLIED DURING THE YEAR

We are proud to support the equality and diversity agenda and have an Equality, Diversity and Inclusion policy including supporting the employment of people with disabilities. We renewed our commitments under the Positive about Disability – "Two Ticks" symbol, encouraging applications from people with disabilities through the guaranteed interview scheme and we also continued to support employees who have become disabled during their working career to continue working within the Trust, albeit in a different or adapted role through our internal alternative employment process.

OFF-PAYROLL ENGAGEMENTS

TABLE 1- For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018 *Of which, the number that have existed:*	8
for less than one year at the time of reporting	6
for between 1 and 2 years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

TABLE 2- Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached siz months in duration, between 1 April 2017 and March 2018, form more than £245 per day and that last for longer than six months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3,202
Of which…	
Number assessed as caught by IR35	3,194
Number assessed as not caught by IR35	8
Number engaged directly (via PSC contracted to department) and are on the department payroll	
Number of engagements reassess for consistency/assurance purposes during the year	
Number of engagement that saw a change to IR35 status following the consistency review	

TABLE 3- Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or senior official with significant financial responsibility, between 1 April 2017 and 31 March 2018

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	3
Number of individuals on the payroll and off-payroll that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure must include both off-payroll and on-payroll engagements (2)	24

1. The Interim Chief Executive was appointed following a period of sickness absence of the substantive Chief Executive. The then Acting Chief Executive left the Trust to take a role in NHSI, prompting the Trust, with agreement from NHSI, to appoint an Interim Chief Executive until the return of the substantive Chief Executive from sick leave. This person covered the role from the 24th of July 2017 to the 1st of September 2017.
2. The Interim Director of People and Development was appointed to cover the role following a period of sickness absence of the substantive person in post. The interim role covered the period of 1st April 2017 to 12th September 2017.
3. The Interim Chief Operating Officer was also appointed to cover the role in response to the departure of the substantive person on secondment to a role in NHSI. This interim cover lasted from the 4th of September 2017 to the 4th of January 2018

Expenditure on consultancy

In 2017/18 the Trust spent £4,700k on consultancy services.

Exit Packages

Details of staff exit packages are included in Note 55 of the Accounts.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

OPINION

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

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

BASIS FOR OPINION

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

MATERIAL UNCERTAINTY RELATED TO GOING CONCERN

We draw attention to note 1.1.2 to the financial statements which indicates that the Trust has submitted a 2018/19 Plan to NHS Improvement which forecasts a £34.8 million deficit. These events and conditions, along with the other matters explained in note 1.1.2, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

OTHER INFORMATION IN THE ANNUAL REPORT

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

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

ANNUAL GOVERNANCE STATEMENT

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

REMUNERATION AND STAFF REPORT

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

DIRECTORS' AND ACCOUNTABLE OFFICER'S RESPONSIBILITIES

As explained more fully in the statement set out on page 71, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 73 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

AUDITOR'S RESPONSIBILITIES

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

REPORT ON THE TRUST'S ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN ITS USE OF RESOURCES

ADVERSE CONCLUSION

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Barking, Havering and Redbridge University Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

BASIS FOR ADVERSE CONCLUSION

In considering the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources and specifically in terms of sustainable resource deployment and informed decision making, we identified the points above relating to the in-year and cumulative deficit. In addition, the Trust has not yet succeeded in addressing the underlying deficit, which has increased in-year. The Trust entered special measures for finance on 9 February 2018 and these remain in place as at 31 March 2018. The Trust also breached its statutory break even duty in year by £49 million.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST CONTINUED

RESPECTIVE RESPONSIBILITIES IN RESPECT OF OUR REVIEW OF ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN THE USE OF RESOURCES

As explained in the statement set out on page 73, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

STATUTORY REPORTING MATTERS

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

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

We have nothing to report in these respects

OTHER MATTERS ON WHICH WE REPORT BY EXCEPTION: REFERRAL TO THE SECRETARY OF STATE

We have a duty under Section 30 of the Local Audit and Accountability Act 2014 to refer a matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust is about to make, or has made, a decision involving unlawful expenditure or is about to take, or has taken, unlawful action likely to cause a loss of deficiency.

On 1 April 2018 we wrote to the Secretary of State in accordance with Section 30(1)(a) of the 2014 Act in respect of the Trust's failure to deliver its breakeven duty as set out in paragraph 2(1) of Schedule 5 of the National Health Service Act 2006. The Trust's financial statements for financial year ended 31 March 2018 identify a cumulative deficit of £408.6m, with £49m of that incurred in the 2017/18 financial year.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Barking, Havering and Redbridge University Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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

29 May 2018

SECTION THREE:

FINANCIAL STATEMENTS AND NOTES

ACCOUNTS 2017-18

Statement of Comprehensive Income

	NOTE	**2017/18 £000s**	2016/17 £000s
Operating income from patient care activities	3	**515,754**	500,262
Other operating income	4	**53,853**	57,704
Operating expenses	6, 8	**(576,380)**	(564,550)
Operating surplus/(deficit) from continuing operations		**(6,773)**	(6,584)
Finance income	11	**287**	270
Finance expenses	12	**(28,539)**	(26,398)
PDC dividends payable		-	-
Net finance costs		**(28,252)**	(26,128)
Other gains / (losses)	13	**(10)**	37
Surplus / (deficit) for the year from continuing operations		**(35,035)**	(32,675)
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	**752**	-
Surplus / (deficit) for the year		**(34,283)**	(32,675)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	**(641)**	(524)
Total comprehensive income / (expense) for the period		**(34,924)**	(33,199)
Financial performance for the year			
Retained (deficit) for the year		**(34,283)**	(32,675)
Prior period adjustment to correct errors and other performance adjustments		-	-
Add back all I&E impairments / (reversals)		**(14,751)**	21,749
Adjustments in respect of donated gov't grant asset reserve elimination		**57**	52
Adjustment re absorption accounting		-	-
Adjusted retained deficit		**(48,977)**	(10,874)

Statement of Financial Position

	NOTE	**31 March 2018 £000s**	31 March 2017 £000s
Non-current assets:			
Intangible assets	15	**6,436**	5,543
Property, plant and equipment	16	**316,706**	296,171
Investment property	19	-	-
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	-	-
Trade and other receivables	24	**4,499**	4,530
Other assets	25	-	-
Total non-current assets		**327,641**	306,244
Current assets			
Inventories	23	**16,895**	18,069
Trade and other receivables	24	**52,780**	47,565
Other investments / financial assets	21	-	-
Other assets	25	-	-
Non-current assets held for sale / assets in disposal groups	26	**24**	54
Cash and cash equivalents	27	**3,249**	1,548
Total current assets		**72,948**	67,236
Current liabilities			
Trade and other payables	28	**(60,028)**	(53,501)
Borrowings	31	**(36,942)**	(9,247)
Other financial liabilities	29	-	-
Provisions	33	**(309)**	(560)
Other liabilities	30	**(5,251)**	(4,152)
Liabilities in disposal groups	26	-	-
Total current liabilities		**(102,530)**	(67,460)
Total assets less current liabilities		**298,059**	306,020
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	**(327,709)**	(308,286)
Other financial liabilities	29	-	-
Provisions	33	**(6,682)**	(2,886)
Other liabilities	30	**(3,638)**	(3,851)
Total non-current liabilities		**(338,029)**	(315,023)
Total assets employed		**(39,970)**	(9,003)
Financed by			
Public dividend capital		**481,033**	477,076
Revaluation reserve		**1,302**	1,943
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		**(522,305)**	(488,022)
Total taxpayers' equity		**(39,970)**	(9,003)

The notes on pages 8 to 59 form part of these accounts.

Matthew Hopkins
Chief Executive
Date: 24/05/2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**477,076**	**1,943**	**-**	**-**	**-**	**(488,022)**	**(9,003)**
Surplus/(deficit) for the year	-	-	-	-	-	(34,283)	(34,283)
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	(641)	-	-	-	-	(641)
Revaluations	-	-	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	3,957	-	-	-	-	-	3,957
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2018	**481,033**	**1,302**	**-**	**-**	**-**	**(522,305)**	**(39,970)**

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

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**477,076**	**2,467**	**-**	**-**	**-**	**(455,347)**	**24,196**
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	**477,076**	**2,467**	**-**	**-**	**-**	**(455,347)**	**24,196**
Surplus/(deficit) for the year	-	-	-	-	-	(32,675)	(32,675)
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	(524)	-	-	-	-	(524)
Revaluations	-	-	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	1,500	-	-	-	-	-	1,500
Public dividend capital repaid	(1,500)	-	-	-	-	-	(1,500)
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2017	**477,076**	**1,943**	**-**	**-**	**-**	**(488,022)**	**(9,003)**

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.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

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

Statement of Cash Flows

	NOTE	2017-18 £000s	2016-17 £000s
Cash flows from operating activities			
Operating surplus / (deficit)		(6,021)	(6,584)
Non-cash income and expense:			
Depreciation and amortisation	6.1	14,051	14,623
Net impairments	7	(14,751)	21,749
Income recognised in respect of capital donations	4	(59)	(62)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(5,846)	2,462
(Increase) / decrease in inventories		1,174	(8,839)
Increase / (decrease) in payables and other liabilties		7,014	(12,666)
Increase / (decrease) in provisions		3,513	(309)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**(925)**	**10,374**
Cash flows from investing activities			
Interest received		287	110
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		-	-
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(11,374)	(10,730)
Sales of property, plant, equipment and investment property		65	144
Receipt of cash donations to purchase capital assets		59	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(10,963)**	**(10,476)**
Cash flows from financing activities			
Public dividend capital received		3,957	1,500
Public dividend capital repaid		-	(1,500)
Movement on loans from the Department of Health and Social Care		45,210	31,945
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		(8,373)	(8,466)
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		(26,506)	(23,247)
Other interest paid		(974)	(1,426)
PDC dividend (paid) / refunded		276	1,726
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**13,589**	**532**
Increase / (decrease) in cash and cash equivalents		1,701	430
Cash and cash equivalents at 1 April - brought forward		**1,548**	**1,118**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		1,548	1,118
Cash and cash equivalents transferred under absorption accounting	44	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	**27.1**	**3,249**	**1,548**

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES AND OTHER INFORMATION

1.1 BASIS OF PREPARATION

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1.1 ACCOUNTING CONVENTION

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

1.1.2 GOING CONCERN

Directors are required to consider whether the Trust meets the necessary criteria to prepare these financial statement on the basis of a going concern.

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

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

The Trust has submitted a 2018/19 plan to NHS Improvement for an in-year deficit of £34.8m. The Trust's financial priority is to introduce and seek to embed processes for Quality and Cost Improvement, as part of its longer term financial strategy.

In 2018/19 the Trust will continue to implement its strategy to include- working with stakeholders, including consultancy support, in delivering a QCIP target of 7%- requesting a total working capital loans of £104m to enable repayment of existing loans, as well as funding the operating deficit control total.- ensuring aged creditors are reduced to the minimum with improvements in the better payment practice code (BPPC)- delivering the actions of the Financial Governace Review. - delivering the annual income and expenditure targets run rates with zero tolerance to budgetary expenditure variance.

2018/19 healthcare contracts with Clinical Commissioning Groups (CCGs) in North East London, NHS England and Essex are in the process of being agreed and signed off.

The 2018/19 cash flow forecast is based on the assumptions in the 2018/19 Plan with monthly reporting of cash flow to NHS Trust Improvement (NHSI). Internally, 12 month rolling cash flow forecasts are updated daily and reviewed. Key uncertainties which may materially impact the Trusts performance are:

a) Delivery of planned, contracted activity, subject to those contracting being agreed;

b) Receipt of working capital and capital investment loans of £104m (but no receipt of sustainability and Transformation funding)

c) Continuing receipt of the £16m PFI support from NHS England;

d) Repayment of existing loan £28m loan and receipt of £10m capital loans; and

The QCIP and service improvement plans (which total savings of £39m) include key work stream targets to improve productivity in theatres, outpatients, and diagnostics as well improving efficiency in resourcing and medicines management.The Trust is engaged in expert determination process with CCGs to resolve a £29m unpaid income for 2017-18 activity.The Trust is working with other health economy partners as part of the development of the Sustainability and Transformation Program (STP) to identify service improvements and deliver long term financial sustainability.

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

1.2 CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

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

1.2.1 SOURCES OF ESTIMATION UNCERTAINTY

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

As part of the NHS contracting process the Trust makes judgements on the resource base required to support such services, and the income expectations for services delivered at the agreed activity levels. The NHS Pensions Scheme provides cover for past and present employees, and is subject to a full actuarial valuation every five years (see note 9). The Trust carries provisions in certain instances relating to early retirement, based on latest actuarial information provided by the NHS Pensions Agency. This is therefore subject to change which is recognised in the period to which it arises.

The Trust maintains insurance against potential legal claims, which are managed by the NHS Litigation Authority. The Trust makes provisions for the estimated excess liabilities due under this policy, in line with information provided by the NHS Litigation Authority. Uncertainty in estimation may relate to the timing of potential settlements, although the liability to the Trust will be limited to the level of the excess.

PFI assets include buildings and medical equipment. PFI buildings are treated in accordance with non-current building and land assets, which are valued at fair value on a modern equivalent asset basis, either by a periodic professional valuation, or where this is not done on an annual basis, by an estimate adjusting the latest valuation reflecting changes in market conditions. The Trust may determine when to professionally revalue its land and buildings, but the interval between professional valuations will be no more than five years. Equipment procured under the Managed Equipment Service is valued as per the contractor's financial model, including periodic lifecycle refreshes.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently treated similar to a finance lease liability in accordance with IAS 17. The implicit rate of interest is derived from the PFI provider's financial model and, for the building, is taken as the implied project rate of return. The liability is written down over the term of the PFI Project Agreement with each unitary payment. The liability is only increased if the Trust requests further capital expenditure directly financed by the PFI provider. For equipment within the PFI Managed Equipment Service (MES), a liability is recognised at the modelled asset replacement year and is measured at the implied cost to the Trust according to the MES provider's financial model. The implied rate of interest used is taken directly from the MES provider's financial model.

Land and building assets are valued on the basis explained in Notes 1.9 and 16. A professional firm of valuers has provided the Trust with a valuation based on estimated fair value and remaining useful life. As the Trust's land and buildings are infrastructural in nature, and thus do not have a conventional market value in use; the valuations are based on estimates provided by suitably qualified professionals in accordance with HM Treasury guidance. Future revaluations of property may result in further changes to the carrying values of non-current assets.

The trust's management determines the estimated useful lives and depreciation charges for all property, plant and equipment assets (with the exception of land). These estimates are based on past experience and practice across the health sector, as well as drawing on the technical expertise within the trust. Management will increase the depreciation charges where useful lives are less than previously estimated lives, or it will write off or write down assets that are obsolete, abandoned or sold. Useful lives for land, buildings and dwellings are determined by independent valuers and management reviews these for reasonableness.

Provisions cover a number of areas and are estimated as below;

- Pension provision is calculated based on individuals total estimated pension payments with reference to actuarial life xpectancy tables and discounted cash flows.
- Legal claim provision values are provided by our service providers based on outstanding cases.
- Redundancy provision is calculated based on payroll information in respect of the commitment agreed as at 31 March 2018.
- The Carbon Reduction Commitment (CRC) scheme provision is calculated based on utility during the previous financial year.
- Accruals are based on the value of invoices relating to the 2017-18 financial year received after 31 March 2018; orders receipted; previous invoice values when relating to an ongoing supplier of products or services; and costs directly advised by the supplier.

1.3 INTERESTS IN OTHER ENTITIES

Charitable Funds

The charity is registered with the Charity Commission for England and Wales (number 10259455) as "Barking, Havering and Redbridge University Hospitals NHS Charity Fund". The Trust is the corporate trustee (a sole trustee). The working name of the charity used for fundraising purposes is "King George and Queen's Hospital Charity".

At the end of the financial year the charity held capital and reserves of £1.97m, a decrease in year of £0.06m.

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies can be consolidated within the entity's financial statements. Such a consolidation has not been done in these accounts as the 2017-18 income and total funds are viewed below materiality. The Trust determined this by comparing the total charities turnover to the Trust's and concluded that as it was less than 5% it was immaterial, and consolidation was therefore not necessary.

The Charity continues to publish a separate set of accounts for 2017/18 in accordance with the Statement of Recommended Accounting Practice "Accounting and Reporting by Charities"; FRS 102.

1.4 INCOME

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

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

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 e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 EXPENDITURE ON EMPLOYEE BENEFITS

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

1.6 EXPENDITURE ON OTHER GOODS AND SERVICES

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

1.7 PROPERTY, PLANT AND EQUIPMENT

1.7.1 RECOGNITION

Property, plant and equipment is capitalised where:

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

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

1.7.2 MEASUREMENT

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

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

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

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

Subsequent expenditure

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or

of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

1.7.3 DERECOGNITION

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

1.7.4 DONATED AND GRANT FUNDED ASSETS

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

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

1.7.5 PRIVATE FINANCE INITIATIVE (PFI) AND LOCAL IMPROVEMENT FINANCE TRUST (LIFT) TRANSACTIONS

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Lifecycle replacement
The Trust pays a contribution to the lifecycle replacement costs of building assets requiring replacement through the annual unitary payment. In return, the PFI operator maintains a contractual obligation to maintain the facility to an agreed standard, but is under no direct obligation to spend the lifecycle funds at pre-determined intervals. The Trust receives no financial benefit for any lifecycle savings derived during the duration of the PFI agreement. Conversely, the Trust does not bear the risk of additional lifecycle costs should the facility require additional work. Where appropriate, lifecyle replacement costs are capitalised under Property, Plant and Equipment, to the extent that they are identifiable.

The Managed Equipment Service agreement contained within the PFI agreement includes expected lifecycle replacement of medical equipment at specified times at the expected end of useful life of the assets. Since the Trust does not physically possess these future assets at the same time, assets and liabilities are only recognised to the extent that they relate to the equipment available for use. In addition, future replacement of these assets can be varied by agreement. The lifecycle replacement of these assets effectively results in a series of finance leases in accordance with the individual replacement cycles.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as either a prepayment or an expense, depending on the certainty of the expenditure being incurred. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

The PFI operator is obliged under the Project Agreement to maintain the building to a required standard known as Estate Code Condition B. The condition of the building is assessed each year to the extent that it is maintained to that standard, and that assessment informs the lifecycle programme for the following year. The PFI operator is also required to hand back the building in Estate Code Condition B standard at the end of the term. Although a sum allocated to lifecycle expenditure is within the unitary payment paid by the Trust, the operator's risk is not limited to the extent that the work required is financed by the unitary payment. The Trust recognises as a result of the Project Agreement there is a possible asset or inflow (contingent asset) whose existence is confirmed by the condition of the building.

Assets contributed by the NHS trust to the operator for use in the
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.7.6 USEFUL ECONOMIC LIVES OF PROPERTY, PLANT AND EQUIPMENT

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	15	70
Dwellings	15	50
Plant & machinery	7	15
Transport equipment	7	15
Information technology	4	10
Furniture & fittings	7	15

Finance-leased assets (including land) are depreciated over the shorter of the useful economic 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.

1.8 INTANGIBLE ASSETS

1.8.1 RECOGNITION

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

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

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

1.8.2 MEASUREMENT

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.

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

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

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

1.8.3 USEFUL ECONOMIC LIVES OF INTANGIBLE ASSETS

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

	Min life Years	Max life Years
Information technology	3	5
Development expenditure	3	5
Websites	3	5
Software licences	3	5
Licences & trademarks	3	5
Patents	3	5
Other (purchased)	3	5
Goodwill	3	5

1.9 INVENTORIES

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

1.10 INVESTMENT PROPERTIES

The Trust does not have any investment properties

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 entity]'s cash management. Cash, bank and overdraft balances are recorded at current values.

1.12 CARBON REDUCTION COMMITMENT SCHEME (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability is measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.13 FINANCIAL INSTRUMENTS AND FINANCIAL LIABILITIES

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as fair value through income and expenditure. Financial liabilities are classified as "fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

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

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision

1.14 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.

1.14.1 THE TRUST AS LESSEE

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

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

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

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

1.14.2 THE TRUST AS LESSOR

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant

periodic rate of return on the trusts' net investment outstanding in respect of the leases.

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

1.15 PROVISIONS

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

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 33.2 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.

1.16 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 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, 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.

1.17 PUBLIC DIVIDEND CAPITAL

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

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

1.18 VALUE ADDED TAX

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

1.19 CORPORATION TAX

The Trust has no liability for Corporate tax as it is not a Foundation Trust and does not engage in any business with the sole aim of making profit.

1.20 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 (other than financial instruments measured at "fair value through income and expenditure") 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.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 THIRD PARTY ASSETS

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 27.2 to the accounts.

1.22 LOSSES AND SPECIAL PAYMENTS

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.23 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.

1.24 TRANSFERS OF FUNCTIONS ITO / FROM OTHER NHS BODIES / LOCAL GOVERNMENT BODIES

There was no transfer of functions between the Trust and other organisations in 2017-18.

1.25 EARLY ADOPTION OF STANDARDS, AMENDMENTS AND INTERPRETATIONS

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.26 STANDARDS, AMENDMENTS AND INTERPRETATIONS IN ISSUE BUT NOT YET EFFECTIVE OR ADOPTED

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

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

2 OPERATING SEGMENTS

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different from those of other business segments. A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments. The directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool. The Trust has also a single purpose in the provision of healthcare services.

3 OPERATING INCOME FROM PATIENT CARE ACTIVITIES

3.1 INCOME FROM PATIENT CARE ACTIVITIES (BY NATURE)

	2017/18 £000	2016/17 £000
Elective income	64,492	66,156
Non elective income	181,396	154,034
First outpatient income	39,362	30,242
Follow up outpatient income	34,302	33,639
A & E income	37,026	32,908
High cost drugs income from commissioners (excluding pass-through costs)	36,357	37,674
Other NHS clinical income	118,998	118,171
Private patient income	2,646	2,876
Other clinical income	1,176	24,562
Total income from activities	**515,754**	**500,262**

3.2 INCOME FROM PATIENT CARE ACTIVITIES (BY SOURCE)

	2017/18 £000	2016/17 £000
Income from patient care activities received from:		
NHS England	89,712	95,686
Clinical commissioning groups	415,693	390,738
Department of Health and Social Care	20	68
Other NHS providers	436	2,647
NHS other	70	739
Local authorities	4,260	4,332
Non-NHS: private patients	182	159
Non-NHS: overseas patients (chargeable to patient)	2,463	2,717
NHS injury scheme	2,777	3,044
Non NHS: other	141	132
Total income from activities	**515,754**	**500,262**
Of which:		
Related to continuing operations	515,754	500,262
Related to discontinued operations	-	-

3.3 OVERSEAS VISITORS (RELATING TO PATIENTS CHARGED DIRECTLY BY THE PROVIDER)

	2017/18 £000	2016/17 £000
Income recognised this year	2,463	2,717
Cash payments received in-year	419	469
Amounts added to provision for impairment of receivables	4,624	1,618
Amounts written off in-year	-	-

4 OTHER OPERATING INCOME

	2017/18 £000	2016/17 £000
Research and development	1,879	1,339
Education and training	15,758	15,981
Receipt of capital grants and donations	59	62
Charitable and other contributions to expenditure	715	311
Non-patient care services to other bodies	43	125
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	6,109	20,997
Rental revenue from operating leases	2,690	3,146
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	1,679	1,799
Other income	27,088	13,944
Total other operating income	**56,020**	**57,704**
Of which:		
Related to continuing operations	53,853	57,704
Related to discontinued operations	2,167	-

Within other income are balances, which relates to PFI support money £16,000k, estimates for Incomplete Spells £6,800k as well as an estimate for HCA severance payment £1,000k.

5 FEES AND CHARGES

	2017/18 £000	2016/17 £000
Income	3,366	5,282
Full cost	(2,525)	(2,597)
Surplus / (deficit)	**842**	**2,685**

This relates to income from HCA, private company that provided medical services from the Trust's premises as well as car parking income.

6.1 OPERATING EXPENSES

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	3,122	1,731
Purchase of healthcare from non-NHS and non-DHSC bodies	4,859	5,442
Purchase of social care	-	-
Staff and executive directors costs	369,739	350,449
Remuneration of non-executive directors	77	109
Supplies and services - clinical (excluding drugs costs)	38,961	29,450
Supplies and services - general	11,430	13,113
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	48,484	45,579
Inventories written down	-	-
Consultancy costs	4,700	2,676
Establishment	4,785	4,013
Premises	17,676	16,356
Transport (including patient travel)	4,377	4,442
Depreciation on property, plant and equipment	11,948	12,613
Amortisation on intangible assets	2,103	2,010
Net impairments	(14,751)	21,749
Increase/(decrease) in provision for impairment of receivables	8,508	228
Increase/(decrease) in other provisions	4,653	-
Change in provisions discount rate(s)	-	139
Audit fees payable to the external auditor		
audit services- statutory audit	71	130
other auditor remuneration (external auditor only)	11	27
Internal audit costs	135	140
Clinical negligence	30,705	27,995
Legal fees	1,415	1,100
Insurance	17	37
Research and development	-	-
Education and training	238	260
Rentals under operating leases	195	195
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	22,750	23,049
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Car parking & security	-	-
Hospitality	71	86
Losses, ex gratia & special payments	-	-
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	1,516	1,432
Total	**577,795**	**564,550**
Of which:		
Related to continuing operations	576,380	564,550
Related to discontinued operations	1,415	-

Statutory audit fee and Other auditor remuneration payable to the external auditor excluding VAT are £59k and £9k respectively

6.2 OTHER AUDITOR REMUNERATION

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	4
2. Audit-related assurance services	11	23
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**11**	**27**

The above remuneration are inclusive of VAT

6.3 LIMITATION ON AUDITOR'S LIABILITY

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).

7 IMPAIRMENT OF ASSETS

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	681	680
Loss as a result of catastrophe	-	-
Changes in market price	(15,432)	21,069
Other	-	-
Total net impairments charged to operating surplus / deficit	**(14,751)**	**21,749**
Impairments charged to the revaluation reserve	641	524
Total net impairments	**(14,110)**	**22,273**

These are mainly related to the Valuation of the Trust's Land and Buildings with changes related to market value movements.

8 EMPLOYEE BENEFITS

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	275,776	261,494
Social security costs	28,521	26,744
Apprenticeship levy	1,342	-
Employer's contributions to NHS pensions	30,248	29,358
Pension cost - other	22	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	21	-
Temporary staff (including agency)	34,323	34,360
Total gross staff costs	**370,253**	**351,956**
Recoveries in respect of seconded staff	-	-
Total staff costs	**370,253**	**351,956**
Of which		
Costs capitalised as part of assets	514	1,507

8.1 RETIREMENTS DUE TO ILL-HEALTH

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £755k (£136k in 2016/17).

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

9 PENSION COSTS

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

In addition to the NHS Pension Scheme the trust offers the National Employment Savings Scheme (NEST), an additional defined contribution workplace pension scheme.

10 OPERATING LEASES

Trust as a lessor

This note discloses income generated in operating lease agreements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessor.

1) A 60 year land lease at King George Hospital, Redbridge, granted in 2006 to operate an Independent Sector Treatment Centre.
2) A 10 year space lease at Queen's Hospital, granted in 2009 for a private healthcare provider to provide oncology medical services. This finished in January 2018.
3) The Trust leases ward space at King George Hospital to an NHS Foundation Trust.
4) The Trust leases space at both hospitals to Barts Health NHS Trust for renal services.
5) The Trust leases space at King George Hospital for GP services.
6) The Trust leases two staff accommodation blocks at King George Hospital to a Housing Association which manages tenancy occupation to NHS employees, keyworkers or other public sector workers.

	2017/18 **£000**	2016/17 £000
Operating lease revenue		
Minimum lease receipts	2,571	2,987
Contingent rent	119	159
Other	-	-
Total	**2,690**	**3,146**

	31 March 2018 **£000**	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	43	1,892
- later than one year and not later than five years;	174	1,746
- later than five years.	1,866	1,909
Total	**2,083**	**5,547**

Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessee. The Trust acts as an operating lessee for a number of leases under five years, which include laundry, linen and sterile services, and accommodation in Romford and Dagenham.

	2017/18 **£000**	2016/17 £000
Operating lease expense		
Minimum lease payments	195	195
Contingent rents	-	-
Less sublease payments received	-	-
Total	**195**	**195**

	31 March 2018 **£000**	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	476	146
- later than one year and not later than five years;	1,142	135
- later than five years.	-	-
Total	**1,618**	**281**
Future minimum sublease payments to be received	-	-

11 FINANCE INCOME

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

	2017/18 **£000**	2016/17 £000
Interest on bank accounts	28	22
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	248
Other finance income	259	-
Total	**287**	**270**

12.1 FINANCE EXPENDITURE

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

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,490	1,511
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	123	2
Main finance costs on PFI and LIFT schemes obligations	18,981	17,942
Contingent finance costs on PFI and LIFT scheme obligations	7,913	6,949
Total interest expense	**28,507**	**26,404**
Unwinding of discount on provisions	32	(6)
Other finance costs	-	-
Total finance costs	**28,539**	**26,398**

12.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998 / PUBLIC CONTRACT REGULATIONS 2015

	2017/18 £000	2016/17 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	123	2
Compensation paid to cover debt recovery costs under this legislation	-	-

13 OTHER GAINS / (LOSSES)

	2017/18 £000	2016/17 £000
Gains on disposal of assets	-	37
Losses on disposal of assets	(10)	-
Total gains / (losses) on disposal of assets	**(10)**	**37**
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**(10)**	**37**

14 DISCONTINUED OPERATIONS

	2017/18 £000	2016/17 £000
Operating income of discontinued operations	2,167	-
Operating expenses of discontinued operations	(1,415)	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**752**	**-**

A commercial agreement allowing a private healthcare provider to provide services from Queen's Hospital was terminated by mutual consent in January 2018, two years ahead of the expected ten year term.

15.1 INTANGIBLE ASSETS - 2017/18

	Licences & trademarks £000s	Internally generated information technology £000s	Development expenditure £000s	Total £000s
Valuation / gross cost at 1 April 2017 - brought forward	**263**	**11,470**	**979**	**12,712**
Transfers by absorption	-	-	-	-
Additions	-	-	-	-
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	2,996	-	2,996
Transfers to/ from assets held for sale	-	-	-	-
Disposals / derecognition	-	-	-	-
Gross cost at 31 March 2018	**263**	**14,466**	**979**	**15,708**
Amortisation at 1 April 2017 - brought forward	**263**	**6,623**	**283**	**7,169**
Transfers by absorption	-	-	-	-
Provided during the year	-	2,103	-	**2,103**
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-
Disposals / derecognition	-	-	-	-
Amortisation at 31 March 2018	**263**	**8,726**	**283**	**9,272**
Net book value at 31 March 2018		**5,740**	**696**	**6,436**
Net book value at 1 April 2017		**4,847**	**696**	**5,543**

15.2 INTANGIBLE ASSETS - 2016/17

Valuation / gross cost at 1 April 2016 - as previously stated	**263**	**14,080**	**979**	**15,322**
Prior period adjustments				
Valuation / gross cost at 1 April 2016 - restated	**263**	**14,080**	**979**	**15,322**
Transfers by absorption	-	-	-	-
Additions	-	596	-	596
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-
Disposals / derecognition	-	(3,206)	-	(3,206)
Valuation / gross cost at 31 March 2017	**263**	**11,470**	**979**	**12,712**
Amortisation at 1 April 2016 - as previously stated	**263**	**8,102**	-	**8,365**
Prior period adjustments				
Amortisation at 1 April 2016 - restated	**263**	**8,102**	-	**8,365**
Transfers by absorption	-	-	-	-
Provided during the year	-	1,727	283	**2,010**
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-
Disposals / derecognition	-	(3,206)	-	(3,206)
Amortisation at 31 March 2017	**263**	**6,623**	**283**	**7,169**
Net book value at 31 March 2017		**4,847**	**696**	**5,543**
Net book value at 1 April 2016		**5,978**	**979**	**6,957**

16.1 PROPERTY, PLANT AND EQUIPMENT - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**31,470**	**213,916**	**9,782**	**10,129**	**77,668**	**-**	**22,447**	**4,293**	**369,705**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	1,638	-	9,437	10,318	-	-	21	21,414
Impairments	-	76	-	-	(717)	-	-	-	(641)
Reversals of impairments	850	14,582	-	-	-	-	-	-	15,432
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	3,227	-	(13,132)	3,208	-	1,572	2,129	(2,996)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,007)	-	-	-	(1,007)
Valuation/gross cost at 31 March 2018	**32,320**	**233,439**	**9,782**	**6,434**	**89,470**	**-**	**24,019**	**6,443**	**401,907**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**3,320**	**9,772**	**-**	**45,894**	**-**	**12,274**	**2,274**	**73,534**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	3,532	-	-	5,995	-	2,240	181	11,948
Impairments	-	(1,476)	-	-	2,157	-	-	-	681
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(962)	-	-	-	(962)
Accumulated depreciation at 31 March 2018	**-**	**5,376**	**9,772**	**-**	**53,084**	**-**	**14,514**	**2,455**	**85,201**
Net book value at 31 March 2018	**32,320**	**228,063**	**10**	**6,434**	**36,386**	**-**	**9,505**	**3,988**	**316,706**
Net book value at 1 April 2017	**31,470**	**210,596**	**10**	**10,129**	**31,774**	**-**	**10,173**	**2,019**	**296,171**

16.2 PROPERTY, PLANT AND EQUIPMENT - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**30,620**	**236,939**	**9,782**	**4,060**	**101,326**	**57**	**32,996**	**4,975**	**420,755**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	30,620	236,939	9,782	4,060	101,326	57	32,996	4,975	420,755
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	2,294	-	9,296	5,443	-	-	-	17,033
Impairments	850	(26,234)	-	-	-	-	-	-	(25,384)
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	917	-	(3,227)	1,466	-	650	194	-
Transfers to / from assets held for sale	-	-	-	-	(54)	-	-	-	(54)
Disposals / derecognition	-	-	-	-	(30,513)	(57)	(11,199)	(876)	(42,645)
Valuation/gross cost at 31 March 2017	**31,470**	**213,916**	**9,782**	**10,129**	**77,668**	**-**	**22,447**	**4,293**	**369,705**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**3,791**	**9,772**	**-**	**69,557**	**57**	**20,586**	**2,807**	**106,570**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	3,791	9,772	-	69,557	57	20,586	2,807	106,570
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	3,320	-	-	6,063	-	2,887	343	12,613
Impairments	-	3,791)	-	680	-	-	-	-	(3,111)
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals/ derecognition	-	-	-	-	(30,406)	(57)	(11,199)	(876)	(42,538)
Accumulated depreciation at 31 March 2017	**-**	**3,320**	**9,772**	**-**	**45,894**	**-**	**12,274**	**2,274**	**73,534**
Net book value at 31 March 2017	**31,470**	**210,596**	**10**	**10,129**	**31,774**	**-**	**10,173**	**2,019**	**296,171**
Net book value at 1 April 2016	**30,620**	**233,148**	**10**	**4,060**	**31,769**	**-**	**12,410**	**2,168**	**314,185**

16.3 PROPERTY, PLANT AND EQUIPMENT FINANCING - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	32,320	52,481	10	6,434	15,324	-	9,505	3,988	120,062
Finance leased	-	-	-	-	-	-	-	-	-
On-SoFP PFI contracts and other service concession arrangements	-	175,443	-	-	20,098	-	-	-	195,541
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	139	-	-	964	-	-	-	1,103
NBV total at 31 March 2018	**32,320**	**228,063**	**10**	**6,434**	**36,386**	**-**	**9,505**	**3,988**	**316,706**

16.4 PROPERTY, PLANT AND EQUIPMENT FINANCING - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	31,470	53,251	10	10,129	16,045	-	10,173	2,019	123,097
Finance leased	-	-	-	-	-	-	-	-	-
On-SoFP PFI contracts and other service concession arrangements	-	157,203	-	-	14,863	-	-	-	172,066
PFI residual interests	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	142	-	-	866	-	-	-	1,008
NBV total at 31 March 2017	**31,470**	**210,596**	**10**	**10,129**	**31,774**	**-**	**10,173**	**2,019**	**296,171**

17 DONATIONS OF PROPERTY, PLANT AND EQUIPMENT

The following are the details of Assets received through donations through the Trust's Charities.

There are no restrictions imposed in the use of these assets:

	£'000s
Documentation System USB 300 & accessories	**5**
Sertaine Intensive care chair & cushions	**15**
Bladder Scan & Mobile cart	**7**
22" Touchscreen PCs & 10" tablets	**25**
Cube Birthing Couch	**7**

18 REVALUATIONS OF PROPERTY, PLANT AND EQUIPMENT

Category	Yrs Min	Yrs Max
Buildings (non dwelling)	15	70
Dwellings	15	50
Plant and Machinery	7	15
Transport	7	15
Information Technology	4	10
Furniture and Fittings	7	15

Professional revaluations of Land and Buildings are normally undertaken at least once in every five year period (last undertaken in 2017) and are normally revalued annually, by professional valuers, using indices.

In view of property price changes in the London region Land and Buildings were revalued as at 1st April 2017 by Cushman & Wakefield (professional valuers and RICS accredited).

The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal & Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

- land and non-specialised buildings – market value for existing use; and
- specialised buildings – depreciated replacement cost (DRC).

The property valuations are carried out primarily on the basis of (DRC) for specialised operational property (e.g. NHS patient treatment facilities) and Existing Use Value (EUV) for non-specialised operational property. The value of land for existing use purposes is assessed at EVU. For non-operational land including surplus land, the valuations are carried out at Market Value.

The Department of Health has adopted the Modern Equivalent Asset (MEA) approach for its DRC valuations rather than the previous identical replacement method.

The MEA approach used to value the property will normally be based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence.

Non Property based assets including Equipment and Fixtures, are held at depreciated historic cost as this is not considered to be materially different from fair value.

Gains arising from indexation and revaluation are taken to the revaluation reserve, except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.

Losses arising from indexation and revaluation are recognised as price/market movement impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset. Losses in excess of that amount are charged to the current year's Statement of Comprehensive Income.

A valuation on the basis of MEA on an alternative site basis, had the following accounting impacts:

Asset valuations: A reduction in the value of Trust land and buildings. The size of any new asset would be less than the existing total square footage representing economies gained through increased efficiencies in occupation;

Impairment and revaluation reserve: An adjustment to the revaluation reserve and an impairment charge to the Income & Expenditure account arising from the above;

PDC dividends paid: A decrease in the PDC dividends paid equal to 3.5% of the reduction in the value of the asset. Given that the PDC dividend is paid at 3.5% of average relevant net assets, of which the land and buildings form a significant part, there was a reduction in the dividend payable arising any reduction in the asset value.

In 2017-18, in line with Trust policy of valuation based on modern equivalent assets, and reflecting representations from the NHS Improvement, the Trust's sites were valued by applying the MEA on an alternate site basis. This approach is consistent with HM Treasury and the Royal Institute of Chartered Surveyors (RICS) guidance, and does not represent a change in accounting policy.

19.1 INVESTMENT PROPERTY

	2017/18 £000	2016/17 £000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments		-
Carrying value at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value	-	-
Reclassifications to/from PPE	-	-
Transfers to/from assets held for sale	-	-
Disposals	-	-
Carrying value at 31 March	**-**	**-**

19.2 INVESTMENT PROPERTY INCOME AND EXPENSES

	2017/18 £000	2016/17 £000
Direct operating expense arising from investment property which generated rental income in the period	-	-
Direct operating expense arising from investment property which did not generate rental income in the period	-	-
Total investment property expenses	**-**	**-**
Investment property income	-	-

20 INVESTMENTS IN ASSOCIATES AND JOINT VENTURES

	2017/18 £000	2016/17 £000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments	-	-
Carrying value at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	-
Share of profit / (loss)	-	-
Impairments	-	-
Reversal of impairment	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-
Disbursements / dividends received	-	-
Disposals	-	-
Share of Other Comprehensive Income recognised by joint ventures / associates	-	-
Other equity movements (translation gains / losses)	-	-
Carrying value at 31 March	**-**	**-**

21 OTHER INVESTMENTS / FINANCIAL ASSETS (NON-CURRENT)

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments	-	-
Carrying value at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value	-	-
Net impairment	-	-
Reversal of impairment	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-
Amortisation at the effective interest rate (assets held at amortised cost only where applicable)	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	-	-
Carrying value at 31 March	**-**	**-**

21.1 OTHER INVESTMENTS / FINANCIAL ASSETS (CURRENT)

	31 March	31 March
	2018	2017
	£000	£000
Loans receivable within 12 months transferred from non-current financial assets	-	-
NLF deposits (where not considered to be cash equivalents)	-	-
Other current financial assets	-	-
Total current investments / financial assets	**-**	**-**

22 DISCLOSURE OF INTERESTS IN OTHER ENTITIES

The Trust operates a Charity whose details are below.

The charity is registered with the Charity Commission for England and Wales (number 10259455) as "Barking, Havering and Redbridge University Hospitals NHS Charity Fund". The Trust is the corporate trustee (a sole trustee). The working name of the charity used for fundraising purposes is "King George and Queen's Hospital Charity".

23 INVENTORIES

	31 March	31 March
	2018	2017
	£000	£000
Drugs	3,192	3,843
Work In progress	-	-
Consumables	13,588	14,116
Energy	115	110
Other	-	-
Total inventories	**16,895**	**18,069**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £76,328k (2016/17: £70,740k).
Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

24.1 TRADE RECEIVABLES AND OTHER RECEIVABLES

	31 March	31 March
	2018	2017
	£000	£000
Current		
Trade receivables	52,168	40,840
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	(10,405)	(3,223)
Deposits and advances	-	-
Prepayments (non-PFI)	6,974	4,441
PFI prepayments - capital contributions	868	-
PFI lifecycle prepayments	-	1,986
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	-	276
VAT receivable	1,189	1,284
Corporation and other taxes receivable	-	-
Other receivables	1,986	1,961
Total current trade and other receivables	**52,780**	**47,565**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	16	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	684	139
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	3,799	4,391
Total non-current trade and other receivables	**4,499**	**4,530**
Of which receivables from NHS and DHSC group bodies:		
Current	39,858	28,851
Non-current	-	-

24.2 PROVISION FOR IMPAIRMENT OF RECEIVABLES

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**3,223**	**2,995**
Prior period adjustments	-	-
At 1 April - restated	**3,223**	**2,995**
Transfers by absorption	-	-
Increase in provision	8,508	163
Amounts utilised	(1,326)	-
Unused amounts reversed	-	65
At 31 March	**-**	**-**

The Trust used the rate of collection of debts and applied a provision equal to the rate of non collection, particularly for overseas debt at 80%.

24.3 PROVISION FOR IMPAIRMENT OF RECEIVABLES

	31 March 2018		31 March 2017	
Ageing of impaired financial assets	Trade and other financial assets £000s	Investments & Other receivables £000s	Trade and other financial £000s	Investments & Other receivables assets £000s
0 - 30 days	312	-	-	-
30-60 Days	276	-	-	-
60-90 days	119	-	1	-
90- 180 days	500	-	184	-
Over 180 days	9,198	-	3,038	-
Total	**10,405**	**-**	**3,223**	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	16,628	-	26,586	-
30-60 Days	10,818	-	1,009	-
60-90 days	998	-	1,222	-
90- 180 days	867	-	1,371	-
Over 180 days	4,977	-	9,105	-
Total	**34,288**	**-**	**39,293**	**-**

A significant proportion of the impaired balances relate to overseas debt which are not credit worthy as difficult to collect and needs the use of an external debt collection agency to locate debtors and collect, and sometimes a court action.

A significant proportion of the unimpaired debt relates to the charges of overperformance income to the Trust's commissioners. These are credit worthy as Commissioner income represents the Trust's main source of income, and are funded and backed by the government and therefore there is a lesser risk of default.

25 OTHER ASSETS

	31 March 2018	31 March 2017
	£000	£000
Current		
EU emissions trading scheme allowance	-	-
Other assets	-	-
Short term PFI finance lease asset	-	-
Total other current assets	**-**	**-**
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	**-**	**-**

26 NON-CURRENT ASSETS HELD FOR SALE AND ASSETS IN DISPOSAL GROUPS

	31 March 2018	31 March 2017
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**54**	**-**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**54**	**-**
Transfers by absorption	-	-
Assets classified as available for sale in the year	-	54
Assets sold in year	(30)	-
Impairment of assets held for sale	-	-
Reversal of impairment of assets held for sale	-	-
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**24**	**54**

26.1 LIABILITIES IN DISPOSAL GROUPS

	31 March 2018	31 March 2017
	£000	£000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

27.1 CASH AND CASH EQUIVALENTS MOVEMENTS

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

	2017/18	2016/17
	£000	£000
At 1 April	**1,548**	**1,118**
Prior period adjustments	-	-
At 1 April (restated)	**1,548**	**1,118**
Transfers by absorption	-	-
Net change in year	1,701	430
At 31 March	**3,249**	**1,548**
Broken down into:		
Cash at commercial banks and in hand	-	-
Cash with the Government Banking Service	3,249	1,548
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**3,249**	**1,548**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**3,249**	**1,548**

27.2 THIRD PARTY ASSETS HELD BY THE TRUST

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	-	-
Monies on deposit	6	4
Total third party assets	**6**	**4**

28.1 TRADE AND OTHER PAYABLES

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	36,963	33,112
Capital payables	3,091	3,331
Accruals	7,303	5,698
Receipts in advance (including payments on account)	-	-
Social security costs	4,006	3,738
VAT payables	-	-
Other taxes payable	3,694	3,453
PDC dividend payable	-	-
Accrued interest on loans	634	193
Other payables	4,337	3,976
Total current trade and other payables	**60,028**	**53,501**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	10,982	8,283
Non-current	-	-

28.2 EARLY RETIREMENTS IN NHS PAYABLES ABOVE

	31 March 2018 £000	**31 March 2018 Number**	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	-		4,122	

29 OTHER FINANCIAL LIABILITIES

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

30 OTHER LIABILITIES

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	5,251	4,152
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**5,251**	**4,152**
Non-current		
Deferred income	3,638	3,851
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**3,638**	**3,851**

31 BORROWINGS

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Scoial Care	29,072	976
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	7,870	8,271
Total current borrowings	**36,942**	**9,247**
Non-current		
Loans from the Department of Health and Scoial Care	88,363	71,248
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	239,346	237,038
Total non-current borrowings	**327,709**	**308,286**

32 FINANCIAL INSTRUMENTS

Trust as a lessor

Future lease receipts due under finance lease agreements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessor:

	31 March 2018 £000	31 March 2017 £000
Gross lease receivables	**-**	**-**
of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**-**	**-**
of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Trust as a lessee

Obligations under finance leases where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**-**	**-**
of which liabilities are due:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**-**	**-**
of which payable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

33.1 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS

	Pensions - early departure costs £000	Legal claims £000	Re-structuring £000	Continuing care £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	**2,377**	**605**	**-**	**-**	**-**	**145**	**319**	**3,446**
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	3,533	890	-	-	-	-	230	4,653
Utilised during the year	(380)	(150)	-	-	-	(61)	(549)	(1,140)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-
Unwinding of discount	19	13	-	-	-	-	-	32
At 31 March 2018	**5,549**	**1,358**	**-**	**-**	**-**	**84**	**-**	**6,991**
Expected timing of cash flows:								
- not later than one year;	200	69	-	-	-	40	-	309
- later than one year and not later than five years;	800	276	-	-	-	44	-	1,120
- later than five years.	4,549	1,013	-	-	-	-	-	5,562
Total	**5,549**	**1,358**	**-**	**-**	**-**	**84**	**-**	**6,991**

33.2 CLINICAL NEGLIGENCE LIABILITIES

At 31 March 2018, £438,925k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barking, Havering and Redbridge University Hospitals NHS Trust (31 March 2017: £360,540k).

34 CONTINGENT ASSETS AND LIABILITIES

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	**-**	**-**

35 CONTRACTUAL CAPITAL COMMITMENTS

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	3,906	4,316
Intangible assets	297	233
Total	**4,203**	**4,549**

36 OTHER FINANCIAL COMMITMENTS

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

37 DEFINED BENEFIT PENSION SCHEMES

Not Applicable

37.1 CHANGES IN THE DEFINED BENEFIT OBLIGATION AND FAIR VALUE OF PLAN ASSETS DURING THE YEAR

	2017/18	2016/17
	£000	£000
Present value of the defined benefit obligation at 1 April	**-**	**-**
Prior period adjustment	-	-
Present value of the defined benefit obligation at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Current service cost	-	-
Interest cost	-	-
Contribution by plan participants	-	-
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	-	-
Benefits paid	-	-
Past service costs	-	-
Business combinations	-	-
Curtailments and settlements	-	-
Present value of the defined benefit obligation at 31 March	**-**	**-**
Plan assets at fair value at 1 April	**-**	**-**
Prior period adjustment	-	-
Fair value of plan assets at 1 April -restated	**-**	**-**
Transfers by normal absorption	-	-
Interest income	-	-
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	-	-
- Actuarial gain / (losses)	-	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	-	-
Contributions by the plan participants	-	-
Benefits paid	-	-
Business combinations	-	-
Settlements	-	-
Plan assets at fair value at 31 March	**-**	**-**
Plan surplus/(deficit) at 31 March	**-**	**-**

37.2 RECONCILIATION OF THE PRESENT VALUE OF THE DEFINED BENEFIT OBLIGATION AND THE PRESENT VALUE OF THE PLAN ASSETS TO THE ASSETS AND LIABILITIES RECOGNISED IN THE BALANCE SHEET

	31 March 2018	31 March 2017
	£000	£000
Present value of the defined benefit obligation	-	-
Plan assets at fair value at	-	-
Fair value of any reimbursement right	-	-
The effect of the asset ceiling	-	-
Net (liability) / asset recognised in the SoFP	-	-

37.3 AMOUNTS RECOGNISED IN THE SOCI

	2017/18	2016/17
	£000	£000
Current service cost	-	-
Interest expense / income	-	-
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge) / gain recognised in SOCI	**-**	**-**

38.1 IMPUTED FINANCE LEASE OBLIGATIONS

Barking, Havering and Redbridge University Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018	31 March 2017
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**482,304**	**512,343**
Of which liabilities are due		
- not later than one year;	25,944	26,427
- later than one year and not later than five years;	97,467	93,134
- later than five years.	358,893	392,782
Finance charges allocated to future periods	(235,088)	(267,034)
Net PFI, LIFT or other service concession arrangement obligation	**247,216**	**245,309**
- not later than one year;	7,870	8,271
- later than one year and not later than five years;	35,652	18,618
- later than five years.	203,694	218,420

38.2 TOTAL ON-SOFP PFI, LIFT AND OTHER SERVICE CONCESSION ARRANGEMENT COMMITMENTS

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018	31 March 2017
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	4,205,688	4,277,216
Of which liabilities are due:		
- not later than one year;	60,952	58,592
- later than one year and not later than five years;	243,808	234,368
- later than five years.	3,900,928	3,984,256

38.3 ANALYSIS OF AMOUNTS PAYABLE TO SERVICE CONCESSION OPERATOR

This note provides an analysis of the trust's payments in 2017/18:

	31 March 2018	31 March 2017
	£000	£000
Unitary payment payable to service concession operator	60,952	58,592
Consisting of:		
- Interest charge	18,981	17,942
- Repayment of finance lease liability	8,373	8,462
- Service element and other charges to operating expenditure	22,628	22,945
- Capital lifecycle maintenance	1,638	2,294
- Revenue lifecycle maintenance	-	-
- Contingent rent	7,913	6,949
- Addition to lifecycle prepayment	1,419	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	122	104
Total amount paid to service concession operator	**61,074**	**58,696**

39 OFF-SOFP PFI, LIFT AND OTHER SERVICE CONCESSION ARRANGEMENTS

Barking, Havering and Redbridge University Hospitals NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2018	31 March 2017
	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	-	-
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**-**	**-**

40 FINANCIAL INSTRUMENTS

40.1 FINANCIAL RISK MANAGEMENT

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with CCGs/NHS England (Commissioners of healthcare) and the way those commissioners are financed, the 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 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 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, although it should be noted that some equipment and consumables are sourced from overseas and may be subject to price changes fluctuations given market volatility seen the UK's decision to leave the European Union.

Interest rate risk
The Trust borrows from government for revenue financing and capital expenditure, subject to approval by NHS Improvement and Department of Health. The borrowings are for 1 – 25 years and interest rates are confirmed by the Department of Health. These are fixed for the life of the loan and range between 1.5% and 3.5%. The Trust therefore has low exposure to future interest rate fluctuations.

Credit risk
The majority of the Trust's revenue comes from contracts with other public sector bodies, so the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 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 commissioners of healthcare (CCGs/NHS England), 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.

40.2 CARRYING VALUES OF FINANCIAL ASSETS

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	41,725	-	-	-	41,725
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	3,249	-	-	-	3,249
Total at 31 March 2018	**44,974**	**-**	**-**	**-**	**44,974**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	47,203	-	-	-	47,203
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,548	-	-	-	1,548
Total at 31 March 2017	**48,751**	**-**	**-**	**-**	**48,751**

40.3 CARRYING VALUE OF FINANCIAL LIABILITIES

	Other financial liabilities	Liabilities at fair value through	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	117,435	-	**117,435**
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	247,216	-	**247,216**
Trade and other payables excluding non financial liabilities	59,549	-	**59,549**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2018	**424,200**	**-**	**424,200**

	Other financial liabilities	Liabilities at fair value through	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	72,224	-	**72,224**
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	245,309	-	**245,309**
Trade and other payables excluding non financial liabilities	53,500	-	**53,500**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**371,033**	**-**	**371,033**

40.4 FAIR VALUES OF FINANCIAL ASSETS AND LIABILITIES

40.5 MATURITY OF FINANCIAL LIABILITIES

	31 March 2018	31 March 2017
	£000	£000
In one year or less	101,643	70,749
In more than one year but not more than two years	86,968	29,922
In more than two years but not more than five years	30,629	47,668
In more than five years	204,960	222,694
Total	**424,200**	**371,033**

41 LOSSES AND SPECIAL PAYMENTS

	2017/18		**2016/17**	
	Total number of cases Number	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	67	10	61	9
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	100	135
Stores losses and damage to property	-	-	-	-
Total losses	**67**	**10**	**161**	**144**
Special payments				
Compensation under court order or legally binding arbitration award	9	17	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	16	6	-	-
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**25**	**23**	**-**	**-**
Total losses and special payments	**92**	**33**	**161**	**144**
Compensation payments received		-		-

42 GIFTS

The value of any gifts received did not exceed £300,000

	2017/18		**2016/17**	
	Total number of cases Number	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Total gifts	**4**	**1**	**7**	**1**

43 RELATED PARTIES

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000s	£'000s	£'000s	£'000s
Steve Collins - Acting Director of Finance (Trisett Ltd)	3	-	-	-
Chris Bown - Interim Chief Exectutive (Veridus and Capita Excutive Recruitment)	-	-	71	-
Anne Robson - Interim Director of People & Organisation Development (Wise Move Consulting Ltd)	65	-	-	-
Anne Robson - Interim Director of People & Organisation Development (Interim Ltd)	21	-	-	-
The Trust also recorded the following transactions with organisations that some members of the board were associated with				
Capsticks Solicitors LLP	243		62	-
Intensive Care National audit & Research Centre(IGNARC)	12		4	
London Borough of Barking and Dagenham	43	1,747	183	82
Price Waterhouse	-	-	18	-
NHS Confederation	6		2	
Queen Mary University of London	-	42	-	4
The Department of Health is regarded as a related party. During the year Barking, Havering & Redbridge University Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are :				
Barking and Dagenham CCG, Havering CCG and Redbridge CCG*	54	365,676	2,250	23,914
Basildon and Brentwood CCG	-	21,212	-	206
Barts Health NHS Trust	2,885	1,524	1,449	536
Health Education England	6	12,520	183	-
Homerton University Hospital NHS Foundation Trust	200	220	92	95
Imperial College Healthcare NHS Trust	77	34	38	24
NHS Blood and Transplant (NHSBT)	560	70	548	-
NHS Business Services Authority (NHSBSA)	445	-	-	-
NHS England	-	32,289		8,137
NHS Improvement	-	1,021	-	270
NHS Litigation Authority (NHSLA)	30,720	-	15	-
NHS Property Services Limited	1,756	43	1,746	-
North East London NHS Foundation Trust	2,820	3,355	1,729	2,031
North Middlesex University Hospitals NHS Trust	34	40	21	42
St George's University Hospitals NHS Foundation Trust	34	126	26	34
University College London NHS Foundation Trust (UCL)	1,278	440	980	348
NHS Newham CCG	-	5,330	-	787
NHS Thurrock CCG	-	3,639	-	19
NHS Waltham Forest CCG	-	2,649	-	316
NHS West Essex CCG	-	7,859	-	177
London Regional Office	-	11,469	-	231
London Specialised Commissioning Hub	-	89,023	-	7,662
Kent and Medway NHS and Social Care Partnership Trust	-	35	-	35
Human Tissue Authority	5	-	-	-
NHSE Strategic Advisory Group	-	-	-	-

*Barking and Dagenham CCG, Havering CCG and Redbridge CCG commission services jointly for the Trust.

Therefore we have disclosed the aggregate position of our transactions with the three CCGs.

The Trust has one related party which is non-NHS or governmental departmental. It is the Barking Havering University Hospitals NHS Charity which recorded an income of £581k, expenditure of £609k, year end receivables of £3k, and payables of £98k.

44 TRANSFERS BY ABSORPTION

There has been no transfers by absorption in the year where the trust has been either the receiving or divesting party.

45 PRIOR PERIOD ADJUSTMENTS

There has been no prior period adjustments in the current year

46 EVENTS AFTER THE REPORTING DATE

There are no reportable events after the end of the reporting period, up to date of submitting these accounts

47 FINAL PERIOD OF OPERATION AS A TRUST OF NHS HEALTHCARE

Not applicable

48 BETTER PAYMENT PRACTICE CODE

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	80,645	254,207	84,933	260,262
Total non-NHS trade invoices paid within target	12,611	139,991	21,599	144,936
Percentage of non-NHS trade invoices paid within target	15.64%	55.07%	25.43%	55.69%
NHS Payables				
Total NHS trade invoices paid in the year	3,637	11,232	1,804	8,993
Total NHS trade invoices paid within target	339	1,480	639	5,948
Percentage of NHS trade invoices paid within target	9.32%	13.18%	35.42%	66.14%

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.

49 EXTERNAL FINANCING

The trust is given an external financing limit against which it is not permitted to overspend:

	2017/18 £000	2016/17 £000
Cash flow financing	39,093	23,049
Finance leases taken out in year		
Other capital receipts		
External financing requirement	39,093	23,049
External financing limit (EFL)	39,646	23,611
Under / (over) spend against EFL	553	562

50 CAPITAL RESOURCE LIMIT

	2017/18 £000	2016/17 £000
Gross capital expenditure	21,414	17,628
Less: Disposals	(75)	(108)
Less: Donated and granted capital additions	(59)	(62)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	21,280	17,458
Capital Resource Limit	22,119	18,320
Under / (over) spend against CRL	839	862

51 BREAKEVEN DUTY FINANCIAL PERFORMANCE

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(48,977)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	(48,977)

52 BREAKEVEN DUTY ROLLING ASSESSMENT

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		(22,281)	(32,986)	(49,913)	(39,492)	(37,754)	(37,950)	(33,719)	(10,874)	(48,977)
Breakeven duty cumulative position	(94,668)	(116,949)	(149,935)	(199,848)	(239,340)	(277,094)	(315,044)	(348,763)	(359,637)	(408,614)
Operating income		397,456	407,107	419,121	438,354	457,495	477,993	505,239	557,966	571,774
Cumulative breakeven position as a percentage of operating income		-29.42%	-36.83%	-47.68%	-54.60%	-60.57%	-65.91%	-69.03%	-64.46%	-71.46%

53 STAFF COSTS

	Permanent £'000s	Other £'000s	2017/18 Total £'000s	2016/17 Total £'000s
Salaries and wages	245,711	30,065	**275,776**	268,414
Social security costs	27,516	1,005	**28,521**	26,744
Apprenticeship levy	1,342	-	**1,342**	-
Employer's contributions to NHS pensions	29,482	766	**30,248**	29,358
Pension cost - other	20	2	**22**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	21	-	**21**	-
Temporary staff		34,323	**34,323**	34,360
Total gross staff costs	**304,092**	**66,161**	**370,253**	**358,876**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**304,092**	**66,161**	**370,253**	**358,876**
Of which				
Costs capitalised as part of assets	350	164	**514**	1,507
Average number of employees (WTE basis)				
Medical and dental	888	181	1,069	1,031
Ambulance staff	3	-	3	-
Administration and estates	443	165	608	1,472
Healthcare assistants and other support staff	1,900	206	2,106	995
Nursing, midwifery and health visiting staff	1,953	352	2,305	2,521
Nursing, midwifery and health visiting learners	-	-	-	47
Scientific, therapeutic and technical staff	542	39	580	1,064
Healthcare science staff	194	10	203	-
Social care staff	-	-	-	-
Other	14	-	14	-
Total average numbers	**5,936**	**953**	**6,889**	**7,130**
Of which:				
Number of employees (WTE) engaged on capital projects	7	2	9	30

54 STAFF SICKNESS ABSENCE AND ILL-HEALTH RETIREMENTS

	2017-18 Number	2016-17 Number
Total working Days Lost*	**46,114**	49,015
Total Staff Years	**5,884**	5,771
Average working Days Lost per member of staff	**7.84**	8.49

*Based on the 2017 calendar year, the DH considers these figures to be a reasonable proxy for financial year equivalents

55 REPORTING OF COMPENSATION SCHEMES - EXIT PACKAGES 2017/18

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	1	4	5
£10,001 - £25,000	1	-	1
£25,001 - 50,000	-	1	1
£50,001 - £100,000	-	2	2
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**2**	**7**	**9**
Total resource cost (£)	£20,000	£150,000	£170,000
Reporting of compensation schemes - exit packages 2016/17			
<£10,000	0	0	0
£10,001 - £25,000	0	0	0
£25,001 - 50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	0	0	0
Total resource cost (£)	0	0	0

EXIT PACKAGES: OTHER (NON-COMPULSORY) DEPARTURE PAYMENTS

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	4	15	-	-
Exit payments following Employment Tribunals or court orders	3	135	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	7	150	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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Rom Valley Way
Romford
Essex RM7 0AG

King George Hospital
Barley Lane
Goodmayes
Ilford IG3 8YB

These are the main hospitals we run our services from. Our teams also provide services at other clinics and sites across our community.

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