Barking, Havering and Redbridge University Hospitals NHS Trust

Annual Report and Accounts 2019 / 20

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FROM OUR CHAIR

Welcome to our annual report for 2019/20 - what an eventful year this has been, culminating in the Covid-19 pandemic which I am very proud saw us coping outstandingly well in unprecedented times.

I cannot praise our staff enough - what was achieved, at great pace, to ensure we were well placed to manage the evolving situation and provide safe, high quality care to all our patients, was outstanding - my heartfelt thanks to you all; and to your families who have supported you in that. I have witnessed the breaking down of barriers across organisations, and am proud of the way we have pulled together as a healthcare system and through the work done to improve relationships across our organisations.

The foundations of these improved relationships were, in part, achieved through the work undertaken in BHRUT and NELFT that led to both Boards signing off a Group Model. Whilst disappointed it has now been postponed indefinitely as we focus on Covid-19, this does allow for a broader debate within the Integrated Care System on the different possibilities for how we work together in the future. I am pleased we are already working together differently and collaboratively to transform care for our patients. I have been passionate about driving forward our digital strategy, a key enabler in delivering 21st century healthcare, and was pleased to see Umesh Gadhvi recently appointed as our joint Director of IM&T.

One of my key priorities was to set the strategic direction for a stable and effective leadership team; I am delighted our Board is undoubtedly in a far stronger position, highlighted when the Care Quality Commission (CQC) re-inspected us and rated us 'Good' for being 'Well Led'. It was encouraging that the CQC saw real progress across our hospitals; however there remains more to do. I welcomed Susan Lees and Lesley Seary CBE as non-executive directors to the Board; their expertise has provided additional rigour and real knowledge of our local authority partners. I thank Chris Bown for his contribution and hard work as interim CEO. In January I welcomed Tony Chambers as our new CEO, who has already demonstrated his strength of leadership and purpose since joining us.

I have always been open about our financial challenges and am pleased we met our end of year deficit target of £50.8m. This would not have been possible without material support from our commissioners, for which I thank them. Whilst real challenges still remain, I am encouraged we have a much better understanding of our deficit and how we will need to address and resolve it.

This year has seen improvements in our culture and staff engagement. I'm delighted by our staff survey results, achieving our highest response rate in 15 years. This gives us vital feedback and helps to inform the inroads we have made in engaging with our medical workforce and clinicians. I strongly believe in encouraging honest conversations built on mutual respect for every individual in whatever role they perform. This is assisted through excellence in our communications, and I feel we are definitely forging our identity as one team – TeamBHRUT – where every role and individual is truly valued by all.

Good, just and compassionate leadership not only feeds into how we govern ourselves; it nurtures a positive culture that underpins quality and continual improvement. I am pleased to record how The PRIDE Way methodology continued to help us to empower everyone to shape and improve services.

Patients are at the heart of all we do and our Patient Partnership Council (PPC) has gone from strength to strength. Together with our volunteers, they are instrumental in transforming care in our Trust and I wish to convey my thanks to Ron Wright for his Chairmanship of the PPC, and to Linda Van Den Hende for taking up the helm.

Lastly, I must pay tribute to King George & Queen's Hospitals Charity – thanks to their astonishing endeavours we can now offer robotic surgery, a milestone for us and our patients.

Together with my colleagues on the Board, I look forward to the year ahead, and to further transformation as we continue to strive towards becoming an outstanding organisation.

Joe Fielder
Chair

FROM OUR CHIEF EXECUTIVE

It is incredible to conceive it has been merely a matter of weeks since I joined the Trust in January, at the start of the days leading up to Covid-19. It has certainly been an interesting induction.

However from my very first day I discovered an organisation full of opportunities, of staff genuinely committed to doing the very best for their patients, and people and systems working together in a more purposeful way. Never has this been demonstrated more than during these unprecedented times. I could not be prouder of our staff – they rose to the challenge spectacularly to keep our patients and each other safe during what has been the biggest shake up of the NHS in our lifetimes. I cannot thank them enough. I must also extend my thanks to our system partners who are, in my mind, without a doubt part of TeamBHRUT.

It is through adversity that we find courage, and through courage that we find opportunity. As a result of these tragic circumstances we have transformed the way we work, from developing discharge pathways between acute and community care, through to delivering virtual outpatient services and a multitude of changes in between. There is no going back – the future must look different to the past if we are to do right by our patients and by our staff.

At this juncture I must thank my predecessor Chris Bown who was instrumental in ensuring we were so well placed to deal with the pandemic. It is also thanks to Chris that I took over the helm of an organisation that genuinely cares about its people; my focus from the outset has been on a culture of openness, safety, and respect, carrying on where he left off.

Evidence tells us that outstanding care is based on a simple formula - happy and engaged staff deliver a more positive experience for our patients. The key lies in looking after the health and wellbeing of our staff. Over the year we have been focused on this and a raft of new measures were implemented to support them during Covid-19, including wellbeing rooms and psychology services. These must and will continue.

One of the biggest challenges I knew lay ahead before I arrived was performance against the constitutional standards, and it is safe to say that meeting the standards has continued to be problematic through the year. Fundamentally to address this we need to really get underneath the issues - and this is where we leave the year in a very different place to where we started. Embedding the national Red2Green initiative and giving fresh focus to The PRIDE Way has helped us to identify where we need to focus our efforts; it has given our staff the tools to make the improvements they are best placed to undertake; and crucially it has moved us from a mind-set of ‘quick fix’ to one that seeks and encourages sustainable change.

As we develop our plans for the months ahead, my executive colleagues and I remain committed to improving performance and we will learn from the transformative ways of working we have seen towards the latter quarter of the year in particular.

Prior to Covid-19 we had started work on our clinical strategy; my thanks to everyone who took the time to get involved, through our internal and system wide workshops, online engagement, and attending our listening events. Understandably this work has been paused, however our learnings and experiences as we continue with our plans for managing Covid-19 will help to further inform our future strategy.

We have ended the year in circumstances we had never dreamed of at the start; and in this short time it has shown me that this Trust is one I am hugely proud to be a part of and to be called its Chief Executive. So in turn I would like to end with a few thank you’s – to my Board colleagues for their support; to our incredible staff for their warm welcome, their willingness and eagerness to

continually improve our care; to our partners and stakeholders who have helped us show just what can be achieved when we work together as one team with the patient at the heart of all our decision-making; and to our patients and our communities, who have made all of us in the NHS feel more appreciated than ever before. I have been truly touched.

Tony Chambers
Chief Executive

OUR YEAR IN PICTURES

April 2019

Our Stroke team were crowned the Stroke and Cardiovascular Team of the Year at the prestigious British Medical Journal (BMJ) Awards. It was in recognition of huge improvements and innovation in the service, taking the service's rating from a D to an A rating.

May 2019

Staff across our hospitals donned their trainers for the London Marathon, running the 26.2 mile course for a range of good causes.

June 2019

Five kind hearted children from Farnham Green Primary School, Ilford, made our elderly dementia patients' day at King George Hospital, by paying a visit to read to them.

July 2019

We celebrated the launch of our Digestive Diseases Centre, which was created to bring together a wide range of medical specialists to improve the way we treat digestive diseases.

August 2019

Josie Larkin, clinical bed and site manager, realised her dream of delivering a baby - in the car park at Queen's Hospital!

September 2019

Jack Stevens, Lead Nurse in Acute Medicine, was also in the right place at the right time, saving the life of a driver who suffered a heart attack at the wheel.

October 2019

Young patients, doctors, nurses and other staff on our children's ward demonstrated how 'Play is good for your health' during National Play in Hospital Week. A series of fun activities, from syringe painting to a teddy bear's hospital, kept young patients busy at our hospitals.

November 2019

We began a three-month trial offering blue wristbands to dementia patients to make them more easily identifiable, enabling staff to offer more support where needed.

December 2019

Our staff at Queen's Hospital had a special visitor – 11-month-old Daniel Andrews. Daniel was brought in by mum Candice, to hand over a £10,000 donation to the King George & Queen's Hospitals Charity to say thank you for the care and support provided by staff after he was born nine weeks early.

January 2020

Anshvir (pictured) was the first baby born in 2020 at Queen's Hospital, marking a new decade as well as a new year. He arrived at 43 minutes past midnight.

February 2020

Filming started for a new five-part documentary that will be aired on the BBC. The series follows our Intern team who support our newly qualified nurses, midwives and allied health professionals so they stay in our Trust and in the NHS.

March 2020

Kate Baker who had emergency brain surgery at our hospital, gave up her sales job and retrained as a health care assistant to support us when the Covid-19 pandemic struck.

SECTION 1 – PERFORMANCE REPORT

OUR 2019/20 OBJECTIVES

DELIVERING HIGH QUALITY CARE

Ensure we achieve a CQC "Good" rating for caring, safe, effective and responsive.

Improve Medicines Management and implement Quality Account Priorities.

RUNNING OUR HOSPITALS EFFICIENTLY

Deliver agreed trajectories for emergency care, planned care, cancer and diagnostics.

Reduce the number of 21 day stranded patients by 25% by the end of the year.

Reduce the number of outpatient attendees by 15% in 2019/20.

BECOMING AN EMPLOYER OF CHOICE

Improve percentage of staff rating the Trust as “a good place to work” from 53% to 56%.

Reduce vacancy rates from 13% to 11%.

Demonstrate the Trust commitment to retain a flexible and diverse workforce by improving our Equality, Diversity and Inclusion score from 8.3 to 8.5.

WORKING IN PARTNERSHIP

Transform care pathways across our Integrated Care System for patients benefit from the 50:50 partnership with CCG.

Complete a feasibility study for an ICS Academy & Innovation Centre.

MANAGING OUR FINANCES

Reduce our underlying deficit from £65m to £51m, including £28m of savings within the Trust.

Embed clear processes, roles and responsibilities to ensure strong financial governance and budgetary control.

PAEDIATRICS

5,617 PAEDIATRIC INPATIENTS (ADMISSIONS)

14,165 PAEDIATRIC OUTPATIENTS

EMERGENCY

309,551 ATTENDANCES (ALL TYPES)

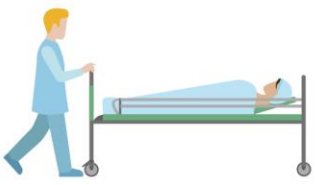
75,822 EMERGENCY ADMISSIONS

64,850 AMBULANCE ARRIVALS

PLANNED CARE

48,363 DAY CASE PROCEDURES

725,197 OUTPATIENT APPOINTMENTS 1,981 A DAY



18,823 THEATRE OPERATIONS

IMPACT OF COVID 19

We are very proud of the way in which out teams responded to the global pandemic and they have taken extraordinary steps to maintain the health and safety of our population.

“The way our staff and our organisation have stepped up”, wrote one of our senior consultants “has been a fantastic display of the true values on which the NHS was founded”. United by a common goal – to mitigate, as best we can, the impact of Covid-19 – our doctors, nurses, and healthcare assistants; our porters and our cleaners; our admin, IT, corporate, procurement, estates and pharmacy staff; and our AHPs, therapists and scientists have all, together, transformed our Trust.

Its present state is totally different to its recent past.

Three months ago, our outpatient departments were operating in ways that had not changed for decades. Last month, almost 5,700 appointments were held over the phone. We moved from having three Covid-19 wards at the start of the pandemic, to running 20 as we neared the first peak in the number of infected patients. We protected those with cancer by moving their treatments to a ‘Covid-free’ nearby hospital and we did the same for people needing trauma care.

At our hospitals, as our teams dealt with what one of our doctors described as a “brutal and relentless” virus, we increased our intensive care capacity five-fold. Such a bald, factual sentence doesn’t begin to capture what an extraordinary achievement that was, and the same teams who achieved that feat, also managed to get a renal dialysis unit up and running in critical care in just ten days.

All this, and more, was achieved – in part – because we simplified decision-making; moved at pace; and empowered our staff to deliver. The pressing need was for our employees to be flexible; agile; and to work in multi-disciplinary teams in areas where that wasn’t always the norm. We weren’t left wanting. All our doctors have embraced a rota that ensures care is delivered 24/7. Nurses in outpatients overcame their understandable concerns and learnt new skills in ITU bringing their immense experience to the team. Seven-day working is now undertaken by, among others, our physios and our children’s nurses.

Vital staff testing was delivered by pathology, HR and occupational colleagues working together. As well as monitoring our spending, those in finance have helped our visitors at our front doors and set up a production line to aid the creation of more than 25,000 goggles and 3,000 visors.

Time and again, people have left their comfort zone and taken on, with relish, new ways of working. Callum has swapped a desk-based role for one where he clocks up 20,000 steps a day delivering personal protective equipment (PPE) to our staff. Coral has moved from sexual health to working on a ward for the first time in ten years. And Mercia caught one of the last flights out of South Africa so she could re-join our Trust and work again with our infection prevention and control colleagues.

And we weren’t alone. The support from right across BHR has been amazing and humbling. We’ve had vital assistance from, among others, Mayors, councillors, community groups, Lions Clubs, Rotary Clubs, cafes, electrical firms, food stores and many other businesses. One furloughed taxi driver has devoted his days to collecting hot food from an Indian restaurant and delivering it to our hospitals. Members of the public have been knitting, sewing, running and walking – to raise funds to support our charity.

Our charity has played a key role supporting the needs of our staff. One aspect of their work has been to coordinate and distribute the extraordinary range of donations we have been privileged to receive. These have included in excess of 100,000 portions of food and drink; 12,500 Easter eggs; and sofas for our staff to use in our wellbeing rooms.

The pace of change has been exhausting and extraordinary. BHRUT after Covid-19 struck, bears little resemblance to how the Trust functioned before. We've filmed some of our staff so they can better articulate their experiences and their desire not to jeopardise what has been done as we now seize hold of a once in a generation opportunity to improve care for the better.

Slogans, at their worst, can be vacuous. At their best, they capture the essence of something and lodge in the brain. As the new BHRUT moves forward, as part of a new NHS, it will be guided in the coming months by three simple words: **No going back**.

This annual report summarises key events and activities for the Trust during the year. The impact and response to COVID-19 for us, as well as many other organisations, has had a profound effect on the way that we deliver services and consequently the performance of the organisation is difficult to compare to national standards and targets for the last few months of the year. Readers of this report are therefore asked to consider the following in their interpretation of our performance;

- The impact of COVID-19 was felt by trusts at the very end of the 2019/20 financial year, with significant impact continuing into 2020/21. This is reflected in our performance. It is difficult to disclose the continuing impact after the year end as at the point of writing this report, there are still many decisions to be made about how we deliver services in the future.

- The performance report overview includes commentary on matters including finances, operational performance and workforce. All of these may have been affected by COVID-19. We gave consideration to whether commentary on the impact of COVID-19 in each area is best addressed in each part, or whether it is better covered in its own sub-section. We decided to address it in each part as required.

DELIVERING HIGH QUALITY CARE

Ensure we achieve a CQC "Good" rating for caring, safe, effective and responsive.

Improve Medicines Management and implement Quality Account Priorities.

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 continued focus on improving our quality of care, and with success in embedding and sustaining improvements.

The following gives an overview of the Trust's performance against its operating plan objectives.

Care Quality Commission (CQC) Report 2020

We were pleased to welcome back the CQC to the Trust between September and November 2019. The CQC inspected urgent and emergency services, critical care and end of life care services across both main sites.

The CQC also inspected outpatients and services for children and young people at King George Hospital. A Well-led assessment of the Trust was carried out between 8 and 9 October 2019. The final report was published on 9 January 2020.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Queens Hospital	Requires improvement →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Good ↑ Jan 2020	Requires improvement →← Jan 2020
King George Hospital	Requires improvement →← Jan 2020	Good ↑ Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020
Overall trust	Requires improvement →← Jan 2020	Good ↑ Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Good ↑ Jan 2020	Requires improvement →← Jan 2020

There were three cores services inspected at Queen's Hospital. The change in rating of those services inspected did not affect the overall rating of the hospital which remains as 'Requires Improvement'. Caring remained Good; Safe and Responsive were rated as Requires Improvement. However, Well-led improved to Good.

We were very pleased that the CQC recognised our end of life care services at Queen's Hospital as Outstanding, particularly that all teams contributing to end of life care at Queen's were effective in delivering high quality services. Wards were well supported to deliver good quality end of

life care to patients, which was supported by leaders, specialist teams and mortuary staff. End of life care was seen as everyone's responsibility.

There were five core services inspected at King George Hospital. The change in rating of those services inspected did not affect the overall rating of the hospital which remains Requires Improvement. Safe, responsive and well led remained Requires Improvement and Caring remained Good. However, the effective domain improved to Good. The Trust was rated as Good overall for Well-led and Use of Resources was rated as Requires Improvement.

Overall the Trust was rated as Requires Improvement for Safe and Responsive. Effective, Caring and Well-led were rated Good.

There were a number of outstanding practices at the Trust which were recognised within the report. These referred to:

- The introduction of the nursing associate role into the organisation, which bridges the gap between health and care assistants and registered nurses, and improves staffing levels and the delivery of care to patients.
- The five experienced nurses as part of the Intern programme, which provides mentoring and coaching support to newly qualified nurses, and is the first scheme of its kind in the country.
- The Trust being acknowledged nationally for its commitment to carbon reduction and the organisation's Sustainability team receiving two national sustainability awards.

It was felt that the Trust was moving in the right direction, and that the report recognised the kind and compassionate care provided to patients, with the improvement in the financial governance, which meant the Trust has moved from Inadequate to Requires Improvement for the Use of Resources Assessment by NHS Improvement.

A CQC improvement plan has been developed; this will focus firstly on the 'Must Do' and 'Should Do' actions. Divisions will then further scrutinise the CQC report and add further actions which are specific to their services. Compliance with the Improvement Plan is closely monitored by the Quality Governance Steering Group.

On 20 January 2020 the CQC carried out an unannounced responsive inspection of the Emergency Departments at King George and Queen's hospitals. This inspection was triggered in response to a poor Emergency Department performance. A Provider Information Request (PIR) was received and supporting evidence was submitted. A letter was subsequently received from the CQC on 22 January in which they raised a number of concerns.

A response was sent by the Trust to the CQC on 24 January detailing immediate actions that had been put into place. On 30 January an action plan detailing 29 actions alongside a comprehensive letter of response was drafted by the Chief Nurse and submitted to the CQC. Subsequently the CQC informed us that they were satisfied that we had taken their concerns very seriously and that we were committed to providing safe care which we could evidence and sustain. Delivery of the action plan is monitored weekly at a CQC Huddle chaired by the Chief Nurse/Deputy Chief Executive. Briefing updates are provided to the CQC Inspection Manager by the Director of Nursing for Quality and Safety on a weekly basis.

Overall we are pleased that we have achieved our objective to achieve a CQC rating of Good for Effective and Caring and recognise that we have further work to do to improve our ratings for Safe and Responsive, in order to improve our overall rating from Requires Improvement to Good.

Ratings for Queens Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Requires improvement → ← Jan 2020	Good ↑ Jan 2020	Requires improvement → ← Jan 2020
Medical care (including older people's care)	Good ↑ Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018
Surgery	Good ↑ Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Requires improvement → ← Jun 2018	Good ↑ Jun 2018
Critical care	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Maternity	Requires improvement → ← Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Services for children and young people	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
End of life care	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017
Overall*	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Requires improvement → ← Jan 2020	Good ↑ Jan 2020	Requires improvement → ← Jan 2020

Ratings for King George Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Requires Improvement ↓ Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Medical care (including older people's care)	Requires Improvement → ← Jun 2018	Good ↑ Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018
Surgery	Good ↑ Jun 2018	Good → ← Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018	Requires Improvement ↓ Jun 2018	Good ↑ Jun 2018
Critical care	Requires Improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Services for children and young people	Requires Improvement → ← Jan 2020	Requires Improvement → ← Jan 2020	Good → ← Jan 2020	Requires Improvement → ← Jan 2020	Good ↑ Jan 2020	Requires Improvement → ← Jan 2020
End of life care	Good → ← Jan 2020	Good ↑ Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
Outpatients	Requires Improvement Jan 2020	Not rated	Good Jan 2020	Requires Improvement Jan 2020	Requires Improvement Jan 2020	Requires Improvement Jan 2020
Overall*	Requires Improvement → ← Jan 2020	Good ↑ Jan 2020	Good → ← Jan 2020	Requires Improvement → ← Jan 2020	Requires Improvement → ← Jan 2020	Requires Improvement → ← Jan 2020

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 are well attended at both King George and Queen's hospitals.

Quality and Safety

Our Quality and Safety team continue with their efforts to help all our frontline staff deliver high quality, safe care to our patients. For 2019/20 we had a number of priority areas which are addressed below.

Incident reporting

We aimed to maintain the minimum number of incidents reported to 45 per 1,000 bed days. Reporting incidents by bed day is a helpful method to compare hospitals' performance regardless of size. A high rate of incident reporting in low and no harm categories is a positive patient safety culture.

We have used improvement methods as part of our work with the Virginia Mason Institute to improve incident reporting levels. This has included reviewing access, timeliness of reporting and response within the organisation. We continue to encourage staff to report all types of incidents as without this knowledge it is not possible to learn and improve safety. The result of this improvement work shows that we have significantly improved reporting levels and sustained them throughout the year.

We achieved better than our targets throughout the year, and our figures overall (54 per 1,000 bed days) put us in the top 20% nationally against peer acute trusts. From a significantly lower historic base, this represents a sustained dramatic improvement.

We had also aimed to increase the number of incidents not resulting in harm to more than 75% (national average 74.3%) but came up just short with 73.9%, although it is worth noting that the target was met in four months of the year peaking at 78.2% in November 2019. We continue to encourage incident reporting, the correct grading of incidents, and how learning is identified and embedded prior to closure.

Monitoring patient deterioration

We have seen significant improvement since introducing electronic observations within the organisation via VitalPAC. This is due to the correct calculation of the National Early Warning Score, a tool to detect sick patents.

Never Events

We aimed to declare zero Never Events within the organisation, however we saw nine incidents occur. All nine Never Events related to retained foreign objects post procedure. All incidents were reported and investigated as per the NHS Serious Incident Framework 2015. In all instances we have highlighted and widely disseminated the circumstances and learning to ensure the chances of similar occurrences are greatly diminished.

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.

For the 2019/20 period we aimed to reduce hospital acquired pressure ulcers by 3% overall and to have zero category 4 acquired pressure ulcers. Overall we achieved a 20.6% decrease compared to 2018/2019; this reflects 101 category 2; 4 category 3, and 3 deep tissue injuries. There were zero category 4 acquired pressure ulcers.

We have reviewed and will continue to investigate all incidents of Category 2 and above, sharing the learning, and will be continuing to progress changes to pressure ulcer prevention and management training in line with 2018 guidance from NHS Improvement which will take a comprehensive and structured approach.

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 want to avoid falls in our hospitals to avoid patients injuring themselves. It is therefore imperative that we both understand and minimise the risk of falling.

Falls prevention and management is a high priority for the Trust and falls are closely monitored and followed up, both within the Divisions and Trustwide. Analysis is undertaken with regard to level of harm, location and cause of the fall and a Root Cause Analysis is carried out for all falls resulting in moderate and above harm.

For 2019/20 we sought a 3% reduction in the overall number of falls per 1,000 bed days. We were very pleased that we achieved this part of our target. We decreased falls with no-low harm compared to last year (1,215 in 2018/19 and 1,158in 2019/20). We aimed to have no more than 46 falls with moderate harm and above in 2019/20 and we actually had 42.

During the year our Falls e-learning package has been launched and is mandatory for completion by all relevant staff every 3 years.

A falls sensor pilot was carried out on Sunrise A and B last January and the trial equipment was kept for use in that area. We have procured some falls sensors for the Hyper-acute stroke unit and Harvest B ward which came through at the end of the year. The usage, uptake and benefits to patients will be analysed in the coming months.

Infection prevention and control

For Clostridium difficile infection (CDI), our maximum allowed number of cases in 2019/20 was 24. Our total number of cases for the year was 29, which is higher than the annual threshold and a worsening since last year. This includes a new subset of cases which are community onset hospital associated CDI of which there were 10.

There was a significant body of work over the year with training, ward-based inspections, cleaning and guidance from the infection prevention and control team which had a positive impact.

For MRSA, our target, as is the case nationally, is for a zero threshold for cases which occur as a result of health care. We reported 3 cases.

We have begun a project aimed at reducing blood culture contamination rates which are a contributory factor to some cases of MRSA and can result in a delay in prompt treatment of patients. This project will be undertaken with our Emergency Department where the majority of blood cultures are taken in order to promptly identify cases of sepsis. Work to roll this out will continue into the next year.

Ward Accreditation Programme

The development of the ward accreditation programme enables us to consider identified metrics, aligned to each of our corporate aims and our nursing strategy, in a triangulated fashion, enabling more proactive identification of risk, good practice and performance management.

The BHRUT Programme is a bespoke model based on, and complimentary to, other internal and external assessments. External visits to learn from other trusts at varying stages of the design have been completed including University College London Hospitals, University Hospitals Coventry & Warwickshire, Western Sussex Hospitals and Salford Royal.

The approach has been to establish a programme

that will improve quality, patient safety and outcomes for patients and carers alongside an improved staff experience. It is designed to support ward managers, clinicians and the wider multi-disciplinary team to understand how they deliver care, identify what works well and where further improvements are needed, whilst also recognising and celebrating success.

The first phase of the programme launched on 10 March 2020. Due to the Covid-19 position the plan for all adult inpatient wards to have undergone a first assessment before the end of September 2020 has been impacted. Virtual work will be undertaken but it is anticipated that the impact will be a potential six month delay to the programme.

Once all adult inpatient wards have undergone first assessment an adapted assessment tool will be used to assess all specialist areas, for example, Paediatrics, ITU, Maternity, Theatres, Outpatients and so on.

Improving Patient Experience

Patient experience

The views 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 experience of 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 (FFT) Care Opinion, NHS Choices, social media and via comment and feedback cards.

Learning from patient feedback

Despite our best efforts and intentions, we don't always get things right. We aim to continue taking a thorough and comprehensive approach to tackling any concerns which are raised.

Our grading system 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 acknowledged 100% of complaints within three days, but came just short of our target to hit 90% of complaint responses within the agreed timescales. We also wanted to reduce the numbers of reactivated complaints and were successful in achieving our target of 15% reactivations.

We will continue to ensure Patient Advice and Liaison staff attend wards daily and interacting with all patients where appropriate, which will continue with expansion into the Emergency Departments on both sites.

We also intend to align the complaints core team staff to specific divisions, and plan weekly divisional complaints meetings where core team staff can discuss recent trends identified and any recommended actions required.

Friends and Family test

We continue to work with external partner "iWant Great Care" to help us gather and analyse data relating to our FFT scores. We received more than 98,000 surveys this year from patients who had experienced our care or services, either on an inpatient ward, in the Emergency Departments, or through Maternity or Outpatients. This is a significant evidence base from which we can further refine and improve in coming years. We review the comments and the data every month to see how we are performing and to focus our improvement work.

We received 73,076 positive comments. These were received through our FFT surveys, comment cards, NHS Choices, compliments and thank you cards.

We also use the FFT scores and other examples of teams' commitment to improving services for patients to help identify and reward our Team of

the Week. This is valuable recognition of our staff for a job well done and motivates them to continue encouraging patients to participate. The comments and feedback we receive from patients continues to help us improve our services.

Accessible services

We know that some of the people who attend our hospitals as patients, visitors or even as staff, may have an additional accessibility need and we continually strive to meet individual needs. This year has seen the Trust focus on how we communicate with patients who have additional communication or information needs, for example, because they are deaf, visually impaired or have a learning disability.

During October, we asked Healthwatch Redbridge to help us understand more about how our patients with additional communication and information needs experience our hospitals. The Accessible Information Standard was introduced in 2016 and sets out how we should support our patients. We have worked hard to make sure that we meet individual needs and wanted to check whether this was happening in reality.

We agreed that Healthwatch Redbridge would undertake a series of visits with appropriate service users to understand their experience, find out what is working well and identify any further areas for improvement. Visits were conducted across three hospital departments (Audiology, Eye Clinic, and the Urgent Treatment Centre and Emergency Department) and one ward (Amber A). The aim of these visits was to identify how Queen's Hospital was meeting the standard and assess whether the needs of people with communication impairments were being fully met.

Healthwatch Redbridge volunteers provided essential insight through their visits and this was reflected in the final report. There were a number of areas that Healthwatch Redbridge felt the Trust was doing really well. These included provision of the hospital passport for patients with a learning disability and the support provided by the learning disability liaison team. The visiting team were also very impressed with the visibility of volunteers throughout the hospital and that volunteers often stopped to asked people if they required assistance.

There were also areas that required review or improvement and these form the basis of an action plan that the Trust is currently working on delivering. It has been agreed that this partnership work with Healthwatch Redbridge will continue across King George Hospital next year.

In addition, we recognise that a number of people who come to our hospitals have mobility needs. We have a number of accessible toilet facilities across our hospitals but we knew that we also needed an accessible changing facility for the use of older children and adults who may need support with toilet needs.

In September 2019, we opened our new accessible changing facility Queen's Hospital. This facility will ensure our patients and visitors with additional needs are able to maintain their privacy and dignity whilst at our hospital. We have had some initial discussions with Changing Places and hope that this facility will be accredited as a Changing Places facility following the application process. We are now exploring how we can develop the same facility at King George Hospital.

King George and Queen's Hospitals Charity

King George & Queens Hospitals Charity sits right at the heart of both the Trust and the community. Each year the charity becomes better known and support and donations have been rising steadily.

The aim of the charity is to enhance the hospital journey for everyone - patients, staff and visitors. Charity funds are spent on projects over and above the core NHS responsibilities to provide innovation in clinical equipment and technology, research and education, and creating a better environment including refurbishments of patient areas, comfort

and entertainment for ward and waiting areas.

Requests and ideas are put forward to the charity by both staff and patients. Charity funds are used to supply goods or services that fall outside of the current NHS core essential budget. This could be anything from a piece of innovative medical equipment, extra training or research, technology and information, or a refurbishment to enhance the comfort of both patients and their families.

Funds are raised through a platform of home grown events, campaigns and retail stalls in hospital sites, along with donations from individuals and business. The charity team is thriving and over the course of the last year has raised around £956,000, an increase of around 16% on the previous year. In addition to this the charity has also benefitted from legacies in the amount of £2,723,000 including a single legacy of £562,000 in cash and £1,630,000 in property which has been used to purchase a Da Vinci robot for the hospital.

This year the charity embarked on one of their most exciting projects as the first down payment was made on a Da Vinci Xi robotic arm for cancer surgery at Queen's Hospital. The equipment cost £1.675m and will mean a less invasive surgery technique along with faster rehabilitation for patients in their own community.

A total refurbishment of the bereavement viewing room suite and the creation of a training seminar room for surgery were two more examples of the projects charity funds have provided during the year. All the money the charity receives is reinvested in our hospitals, via the Charitable Funds Committee, which meets regularly to discuss applications.

"SHOLA'S" STORY

It is important that we listen to and learn from patient stories at every level of our organisation and our Trust Board regularly opens their meeting by welcoming and hearing from a patient or visitor. The patient or visitor is asked to tell their story, positive or negative, in their own words and this is an opportunity to understand what has happened and look at where the experience can be improved or shared.

During 2019, the Trust Board heard from Shola, who shared his BHRUT journey. Shola is a 65 year old man who had just returned from an overseas visit. He had no health issues other than an upset stomach whilst overseas, but nothing more serious than that.

When he returned to the UK, he had some leg weakness. He eventually came into Queen's in May 2019 and the team looking after him initially thought he had had a mild stroke. However after further tests, he was diagnosed with Guillain-Barre Syndrome. This is a very rare and serious condition which affects the nerves to feet, hands and limbs causing problems such as numbness, weakness and pain. Although the condition can be life-threatening and some people are left with long-term problems, most people will eventually make a full recovery.

Shola very quickly deteriorated until he was paralysed and could not move. This meant he required a hoist for all transfers. Shola's wife was becoming very concerned for him. Having lost his independence, his mood was very low and he was struggling with all that was happening to him.

He was referred to the therapy team who helped him with exercises to improve his mobility and retraining the nerves. The therapy team were trialling a new piece of equipment- the Motor Med and believed that Shola would benefit from using this and it was agreed to give him access to this new piece of equipment. The Motor Med works passively and actively so initially the machine did the work for Shola until his body was ready to take over and work on the equipment actively.

The Motor Med has had a significant impact on Shola's recovery – helping his low mood and providing motivation to recover as well as supporting him to improve his physical health. This equipment combined with treatment and therapy has led to Shola making a very good recovery and he was able to walk unaided into the July 2019 Trust Board meeting to tell his story.

The PRIDE Way

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

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 are now in the final year of partnership with VMI, so, at the beginning of 2019, we made a conscious effort to inject new momentum into this work. A group of executives and divisional directors went to Seattle to see first-hand just what Virginia Mason is all about, and how they operate. It was an inspiring trip which brought home just what the potential opportunities are if we can get The PRIDE Way right.

We are now training 196 senior managers in the Trust who have actively taken this into their teams to cascade the methodology, with 41 graduating and 100 staff have attended the one day PRIDE Way training course.

It is more than just the 'what' we do. It is also about the 'how'. The key is in the way we behave and lead – that is what will ensure the improvements stick and will help us to address the issues we see each year in our staff survey results.

We've also done more to try to show that there are so many simple tips, ideas and tools which people can use every day in their roles, to identify areas for improvement and find ways to bring these to life and sustain them.

BHRUT and NELFT Diabetic Foot Multi-disciplinary Team

A new diabetic foot multi-disciplinary team has been set up with dedicated clinics launched.

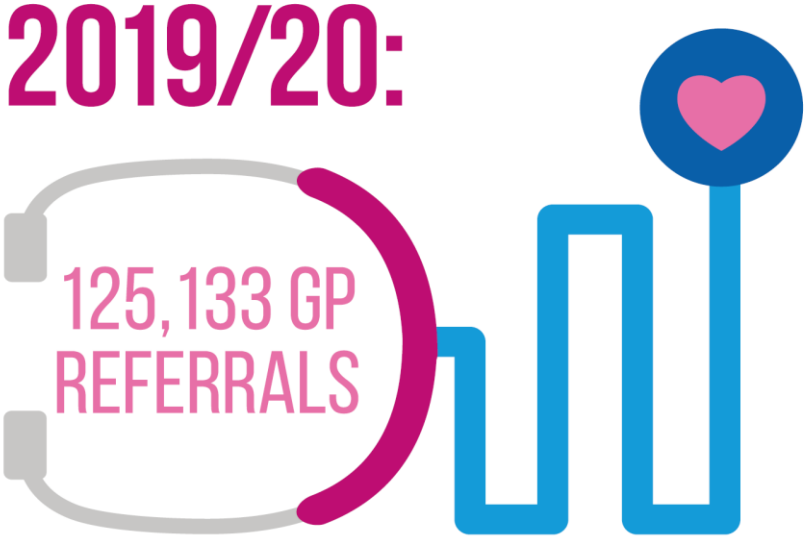
The team was set up as a joint collaboration between our Trust and North East London Foundation Trust (NELFT) as a response to local health needs and national guidance. The clinics are available at both Queen's and King George hospitals.

These clinical sessions are for patients experiencing limb-threatening and life-threatening diabetic foot problems. Open referral access is made via a patient's GP.

We encourage GPs, Podiatrists, and Emergency Departments to use this pathway as it will reduce the emergency admissions rate for our diabetic patients. There will be access to dedicated podiatrists, vascular surgeons, diabetologists, and orthopaedic input.

We expect that this new service will reduce diabetes-related lower limb and foot amputation rates, reduce average length of stay in hospital, reduce number of admissions via the Emergency Department and support ward rounds and provide in-reach to patients on wards.

OUR HOSPITALS IN 2019/20:



MATERNITY

8,116 BABIES DELIVERED THIS YEAR

RUNNING OUR HOSPITALS EFFICIENTLY

Deliver agreed trajectories for emergency care, planned care, cancer and diagnostics.

Reduce the number of 21 day stranded patients by 25% by the end of the year.

Reduce the number of outpatient attendees by 15% in 2019/20.

Constitutional Standards

Four Hour Emergency Access Standard

Towards the end of last year, we saw a decline in performance against the four-hour emergency access standard which we have begun to redress. In March the figure was 72.59% which falls short of our agreed target set with our local system of 82.8%. The improvements we are seeing, so far, are down to the changes we have made at King George Hospital where we have established a unit for our frail elderly patients. One of its objectives is to prevent unnecessary admissions. We have also just launched an acute frailty service at Queen's Hospital which has the same goal.

We want to relieve the congestion in our two Emergency Departments (ED) and to encourage our specialist doctors to see and treat the patients who have been referred to them away from these very pressurised areas of our hospitals. This way we will only have those patients in the ED who absolutely need to be there. We accept that, at the moment, the experience in our ED for our patients and our staff is not as good as it should be. The work we are undertaking should mean we are in a better position to face the inevitable pressure that will continue to occur this winter.

However, we accept that we are not providing the level of service that we should. With the pressure

operational priorities for the year ahead, across our Trust.

Red2Green

seemingly set to continue, this will be one of the top

To tackle the perennial problem of patient flow, which impacts on our ability to treat patients promptly, we embarked on a major trust-wide campaign which launched before Christmas, and has so far proven to be a huge success.

We decided to use the Red2Green system which other trusts have employed to great effect.

Red2Green is a national initiative that will help us easily identify if our patients are having a 'green' day, where they get the care or treatment they need and are closer to getting home, or a 'red' day, a wasted day in hospital where they are no closer to being discharged. The visual system means we are able to quickly identify where patients need to have decisions made about their care.

We employed a dedicated team to focus on this programme of activity (which will continue indefinitely) and thanks to a high-profile campaign we have tried to keep this at the forefront of our teams' minds.

From 1-7 July 2019, we held a Perfect Week in our hospitals, which was led by our Red2Green team. The focus of Perfect Week was to improve our four-hour performance, reduce length of stay and delays for our patients and establish our Red2Green pledges.

We saw some huge successes; across both hospitals, we discharged 934 patients, 38 more than the previous week – basically an entire ward of empty beds! Overall, we went into the weekend following Perfect Week with 110 empty beds, an achievement which reflected staff and volunteers' commitment to getting our patients home, the best place for them once they're medically fit.

We were supported by Redbridge Joint Assessment and Discharge Service (JAD) and Clinical Commissioning Groups (CCGs) at our daily long length of stay meetings. This is really important as working with our healthcare partners is key to making sure our patients receive the right care in the right place at the right time.

Our third Perfect Week – Halloweek – was held from Monday 28 October and it was once again a week to focus on cutting delays, getting our patients home as quickly as possible, and reducing long length of stay (patients staying over 21 days).

One of their big successes was Bluebell A hitting its 95% target for pre-5pm discharges. Matron Annette Curran said: "We changed our board rounds, reducing them from twice a day to just once. This allowed us to free up half an hour every day for all our doctor and therapists, so they could focus on our patients. That amounted to a lot of additional hours in the day. "It made such a difference that we're considering rolling it out in other areas."

As for what made Halloweek different from previous Perfect Weeks, deputy matron, Anita O'Donnell added "It was easier to focus on pre-5pm discharges as it was dark, which is more visible. We don't want to be sending elderly patients out into the cold and dark. Having taken part in Perfect Weeks before, we also had a clearer understanding of what was expected, and there was more clinical buy-in. On Bluebell A they really owned their improvement as it was a chance to measure their success."

During Halloweek, getting patients home before dark was a big focus and overall we managed to get 80 per cent discharged before 5pm. We also reduced long length of stay by 16%, discharged 30 more patients before 12noon, and reduced outliers (patients in the wrong beds), which meant our patients were in the right place to get the care they needed.

As well as the hard work of our clinical colleagues, volunteers from our non-clinical staff supported Halloweek as ward sponsors – helping with tricks for treats, which were challenges for wards to complete, and talking to wards about their escalation process for delays, so we could see what was working and what wasn't.

Referral To Treatment (RTT) – Elective Care

The historical issues around the management of patients waiting for elective care have been well documented.

We anticipated that the year would be challenging as we continued to balance activity with our commissioners, and so it proved. We did not hit the constitutional target of 92% of patients being treated within 18 weeks of referral, returning a performance of 78% and a decline compared with last year.

Our waiting list increased from 39,274 at the end of March 2019 to 40,830 at the end of March 2020.

Whilst we have not met the overall improvement trajectory, we have delivered significant improvements in performance in gastroenterology, have maintained the previous year's improvements in oral / maxillo-facial surgery performance, and a number of other specialties have been compliant with the national targets (breast surgery, diabetic services, geriatric medicine, paediatrics and audiology. We recognise that there is significant work ahead of us to improve this.

As a health system, we have been working jointly to agree common pathways between primary care and secondary care as part of our 'Improving Referrals Together' (IRT) programme. Working with commissioners, we have put in Advice and Guidance arrangements to enable GPs to request input on patients from our clinicians, without having to refer, although there is work to be done to improve this service across all specialties. In the year ahead, one of our top priorities is a transformation of how our outpatients work. This will involve working with commissioners and GPs to deliver new models of care which are needed.

Outpatients

In March 2020, it was necessary to suspend outpatient activity at the Trust as a result of the Covid-19 outbreak, however in the midst of a crisis, we took radical steps to deliver outpatient services differently by rapidly increasing the number of telephone and video outpatient appointments. Clinicians spoke to their patients about their condition and any test results and the clinician was able to make a medical plan for their care. This was very well received by these patients as it avoided the need to visit our Hospitals during the pandemic but didn't delay their care.

GP referrals continue to drive the overall referral trend. Our local commissioners have advised GPs to refer to BHRUT as the provider of choice. This has been evidenced over the last four months with GP referrals up 14% compared to the same period last year.

Cancer services

Our cancer performance has been challenging this year. For 2019/20, 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 standard which stipulates that 85% of patients should have received treatment within 62 days of urgent referral.

We did not meet all standards for 2019/20; for the 31 day target we achieved the standard for the full year, however there were four months where we missed the monthly target, and for the 62 day standard we met the target in four months out of 12. For the two week standard, we only hit the target in the last two months of the year. The factors driving these challenges have included constraints within our prostate pathway, the impact on staff of the pension tax issue, staff vacancies and a lack of capacity in our histopathology services.

We recognise that in light of previous achievements in cancer treatment this is a disappointing outcome and are focussing on a number of actions to improve performance including additional investment in pre-operative assessment capacity, and increased clinic capacity, particularly for lower GI. We have explored template biopsy capacity in the independent sector to improve prostate pathway, extending triage services and straight-to-test (for lower GI). We have also looked at extending capacity for pathology through outsourcing.

Electronic Prescribing and Medicines Administration system

The Trust has invested £1.5m in a new Electronic Prescribing and Medicines Administration (EPMA) system. Electronic Prescribing is "the utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail

for the entire medicines use process".

Use of medication is the most common intervention made in medicine and is a critical component of modern healthcare. Having an EPMA system is a key enabler for all five of our Trust objectives, the Trust's operational plans, is an integral part of the Financial Recovery Plan, and supports the East London Heath and Care Partnership digital strategy, the NHS Long Term Plan and Patient Safety Strategy.

The key objectives of this investment in an EPMA solution at BHRUT are to improve patient safety by:-

- Improving the quality of prescribing and medicines administration processes. There were in excess of 2,000 medication related incidents reported in the Trust in 2017-18, 2018-19 and we know from pockets of more intensive work that medication errors are largely underreported.

- Reducing clinical risk/patient harm by reducing the risk of error and the incidence of adverse events associated with prescribing and medicines administration processes.

- Improving patient care and flow through improving the quality and timeliness of prescribing and medicines administration processes.

- Supporting medicines optimisation – in relation to choice of the best medicines for the clinical condition, for the patient.

- Supporting the antimicrobial stewardship agenda - we are currently the 10th highest user of Antibiotics for acute trusts in England. EPMA can help manage the antibiotics prescribed more effectively and also facilitate timely review and stopping of antibiotics.

- Supporting staff in the prescribing and administration of medicines by including decision support tools within the e-prescribing suite.

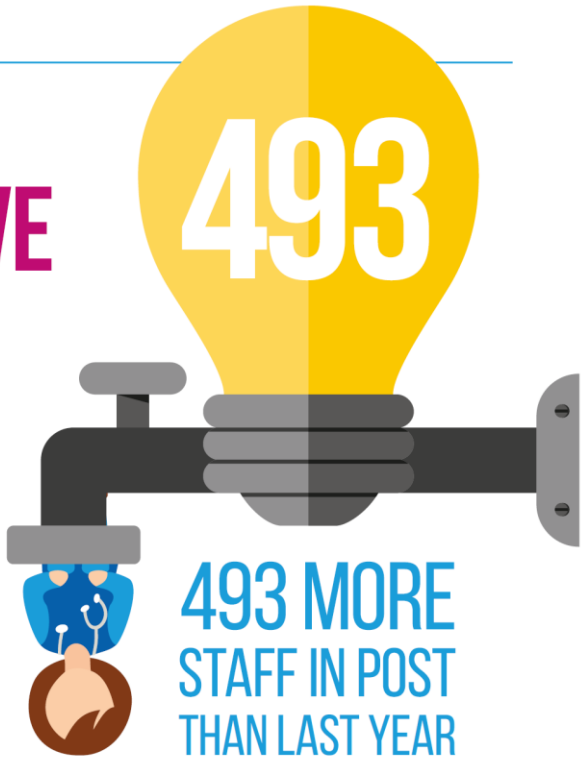
- Improving access to information when required at the point of patient care.

- Enabling more timely and accurate transfer of a patient's medication information and integration of care through use of an appropriate EPMA system.

OUR HOSPITALS HAVE

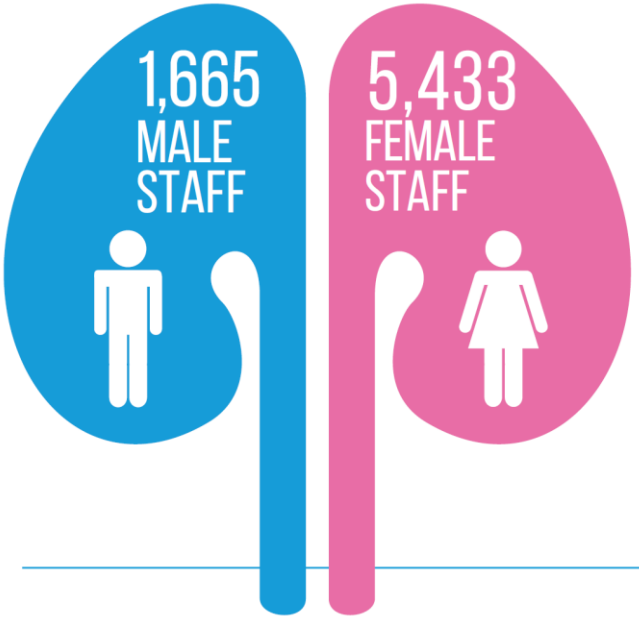
560
VOLUNTEERS WHO BETWEEN THEM HAVE GIVEN
39,107
HOURS OF SUPPORT

PROVIDED
372
WORK EXPERIENCE AND APPRENTICE PLACEMENTS



493 MORE
STAFF IN POST
THAN LAST YEAR

7,098
STAFF OF WHOM 78%
ARE IN DIRECT CLINICAL CARE ROLES



BECOMING AN EMPLOYER OF CHOICE

Improve percentage of staff rating the Trust as "a good place to work" from 53% to 56%.

Reduce vacancy rates from 13% to 11%.

Demonstrate the Trust commitment to retain a flexible and diverse workforce by improving our Equality, Diversity and Inclusion score from 8.3 to 8.5.

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.

At the end of March our vacancy rate stood at 10% (compared to 14% at the same point in 2019). This is higher than we would like. However we have increased the number of staff we employ and increased our establishment.

We are still spending too much money on agency staff, however, during the year, our total spend on agency staff was 7% of our entire pay bill. We continue to consider ways that we can reduce this level.

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.

We set a challenging target for sickness absence of 2.6%, and although during certain months we saw good progress towards that target, our average absence rate before the onset of Covid-19 was 3.6% - marginally better than last year (3.8%). Our absence rate in March 2020, following the Covid-19 outbreak was 6.15%

Recruitment and Retention

Over the past year we have made excellent progress in recruiting permanent staff. We recruited 1,039 new staff members, including a record number of nursing staff. During the same period, 714 left the Trust and therefore we have increased our permanent workforce by 325 (or more than 5%) during the year.

Our focus continues to be the recruitment and retention of clinical staff. Progress continues to be made with the increase in both medical and nursing staff across all divisions. This has been achieved with the continued focused work within the Acute Division on medical recruitment and realising the benefits of both the student nurse cohort as well as the international recruitment campaign.

Staff Survey

The annual NHS Staff Survey published in February 2020 highlighted a number of improvements at the Trust.

Almost six out of ten staff at the Trust completed the survey which is sent to NHS staff nationally and asks questions on their experiences at work and their wellbeing. Our response rate of 57 per cent was an increase of ten per cent from 2018 and the highest in 15 years.

Staff responses shared improvements in areas such as morale, team working and the quality of care provided compared to 2018.

We see it as really encouraging to see that our colleagues have reported a better experience at work compared to 2018. Some areas where we have improved most were senior managers acting on the feedback of staff, and effective communication between managers and their teams. We also outperform similar trusts with staff having dedicated time to discuss their career with their manager at personal performance reviews.

One area where results for our Trust had worsened since the last survey was staff experiencing physical violence from members of the public. We believe that any violence or abuse towards our staff is unacceptable and we are taking the increase of reported incidents seriously. The Trust is working with the police and is going to be introducing a number of initiatives this year which focus on keeping our staff safe at work.

In the NHS there is a clear link between the experience of staff and how satisfied patients are with their care. We're pleased the results reflect improvements for our staff, because by making our hospitals better places to work, we are making them better places to receive care.

The PRIDE Way and Culture Change

In the final months of the 2019 financial year we began rolling out a major programme of work to identify and tackle our cultural challenges. This was led by a Cultural Change team comprising colleagues from across the organisation and included a confidential survey as part of a tried and tested the joint NHS Improvement and the King's Fund's toolkit asking a broad range of staff for their views on our current position and our leadership behaviours.

The outcome of the Discovery phase (the diagnostic) was presented to the Trust Executive and Trust Board in July 2019. The second phase of the work (the Design phase) began in the summer. During August and September 2019, 40 'road-shows' took place sharing the diagnostic findings across the Trust. Thirteen Culture Change Team workshops commenced in September 2019 and completed in December 2019 to design interventions to address the issues identified in the diagnostic.

As an output of this work, a Culture and Leadership Strategy has been drafted with the aim of launching early in the 2020/21 year as part of the Respect for People campaign. The strategy describes the cultural and leadership ambitions of the organisation which are scalable and flexible.

The aim of this strategy is to develop a compassionate, inclusive and high-quality PRIDE Way culture which is underpinned by exemplary leadership. Through this we will make a positive impact on staff experience, retention, continuous improvement and the care of our patients.

The interventions detailed in the strategy aim to impact the whole organisation focusing on behavioural, process and system changes to develop the conditions for continuous improvement and high-quality care. These have been developed through staff engagement, best-

practice, evidence-based and internal expert input; aligned to national, local and organisational drivers.

The interventions have been planned to impact over two to three years but are flexible to the changing landscape and priorities of the Trust; the impact will be measured through the monitoring of key performance indicators for culture which will be developed into one Culture Dashboard. Inclusive within this approach will be a standard way of monitoring the Cultural Transformation Continuum which Virginia Mason Institute (VMI) uses to measure the embedding process of their production system.

DNA of the future Nursing, Midwifery and Allied Health Professional (AHP) Workforce Programme

This programme presents a 'road map' for how we enable the development of a sustainable nursing, midwifery and AHP workforce over the next ten years and comprises a series of profession specific 'Career Maps' to illustrate what is possible in terms of career options, career entry roles, workplace-based learning options, and career options post registration.

The career maps for Nursing, Midwifery and AHPs, outline the diversity of career entry routes and career development opportunities for its students, apprentices, healthcare assistants and post registration staff. Each workforce has its own plan and is illustrated visually using language and terms understood by all.

The basic premise of this model is that individuals that work and live locally are more likely to stay within the local community for a significant proportion of their professional careers, and may well encourage families and friends to join the workforce to become nurses, midwives and AHPs. Though the career maps focus on nursing, midwifery and AHPs, its principles are generic and are being used to address the workforce challenges for other groups (we are currently developing them for the pharmacy workforce).

Our 'growing-your-own' model formalises its intent and approach to becoming an 'Employer of Choice', for students, apprentices and advanced practitioners alike. We define 'growing-your-own' as the processes and systems to attract, recruit, develop, nurture, and retain individuals from the local population so as to ensure they start and maintain their careers at BHRUT.

Senior Nurse Intern Scheme

Started late in 2017, this dedicated team of 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 the team is now five strong. We would typically recruit around 150 band 5 (newly qualified) nurses every year.

From this group, we would typically expect around 22-24 per cent (so around 35-40, would leave within their first year). In the 18 months since introducing this new approach, we have cut that attrition rate to circa eight per cent – a huge improvement.

In July 2019, the Senior Intern team attended the RCNi awards as finalists in the Innovations in your Speciality category for recognition of their ground-breaking work they are doing to retain newly qualified nurses.

Beverley Sawer, Lead Senior Intern, said: "To be shortlisted from over 700 applications is amazing! Although we did not win, the best thing for us is to know that our new nurses appreciate our support. We don't want any of them to feel like leaving is their only option. "I remember when I first started

out as a nurse, how disorientating it can be on the wards for the first time. I'm sure having a senior colleague to help would have meant the world to me."

This trail-blazing initiative is soon to be the subject of documentary series to be aired on the BBC called "Saving our Nurses". Watch this space.

Academy of Surgery

Recruitment is a huge national issue for the NHS; so our surgery division has come up with an innovative way of attracting new doctors to our Trust from all over the world, which has been a huge success.

The Academy of Surgery is a two-year programme where doctors are able to spend six months each in four different speciality areas, giving them a taste of what's on offer, aiding their decision in where to specialise. Other teams across our Trust have also got involved, giving our new doctors a chance to also try a stint in our Emergency Department, or with our Oncology team.

Doctors on this scheme benefit from vital support, helping them to achieve their career goals, and we're also offering a sponsored MSc in a subject of their choice, while we benefit from their expertise, and are less reliant of agency or locum doctors.
We welcomed over 20 doctors to join our first 'class' in the Academy of Surgery - from countries including Egypt, Iraq, Pakistan, Sri Lanka and Greece.

They have been really positive about the scheme, about the support they are afforded, through clinical and educational supervision, and the unique way our programme allows them to work extensively in different specialties to get a real feel for the work. We've been delighted with the results.

Volunteers

Volunteering is generally considered an altruistic activity where an individual or group provides services for no financial or social gain "to benefit another person who is not their family, group or organisation".

Every day at our Trust , hundreds of unpaid heroes quietly make a difference to the lives of patients, their relatives, hospital staff and each other by generously giving their time, skills and empathy without cost or recourse to funds other than basic out of pocket expenses.

By working with us, volunteers offer an opportunity to help us improve our patients' and staff's experience, as well as reminding us, in their role as a volunteer or patient partner, that the patient is at the centre of all we do. In return we hope that whatever their motivation to volunteer with us, whether they volunteer to say thank you for the care they or a loved one has received, or they are planning a career in medicine, we hope that they all benefit from the experience and feel valued for their contribution.

The Voluntary Services department provides activities with a particular focus on improving our patient and staff experience. Supporting local people, by way of direct or indirect involvement in the services they and their families use, allows us to always remember the voice of our patient at the heart of all we do.

Currently we have an army of 560 volunteers who are ready to serve our patients, staff and our services. Our volunteers donate thousands of hours annually; in 2019-20 they gave over 38,000 hours, 12,000 more hours than 2018-19, and for that we are very grateful. For example if you have ever visited one of our hospitals and you were a little lost, there is a good chance one of our wayfinder volunteers helped you find exactly where you needed to be. In 2019-20, our information desk and wayfinder volunteers assisted over 136,000 people find their location.

This year has been like no other for the voluntary

services at BHRUT. During the last quarter of 2019-20, volunteers, patient partners and any voluntary activities within our organisation was paused. This was an unprecedented decision for an unprecedented national emergency - Covid-19. The global pandemic meant that volunteering took a slightly different direction and both reignited a love for the NHS and volunteering.

NHS England called for 250,000 volunteers to support the NHS, in particular the Nightingale Hospital set up to support Covid-19 patients as well as vulnerable patients. The call was answered with a staggering 750,000 people signing up within a few days. Volunteering at BHRUT for the final quarter meant that people were working from home whilst self-isolating.

We hope that whilst you read our report, what is demonstrated is the positive impact volunteers and volunteering has on our organisation, staff, patients and on the NHS as a whole.

Nursing Associates

We are very proud of our effort 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 healthcare assistants who have completed a care certificate and registered nurses.

Our first tranche of registered nursing associates successfully completed the pilot programme and joined the workforce in May 2019 (51/60 successfully completed; 91% retention rate). Our first 20 registered nursing associates started the joint BHRUT/University of East London 'Bridging Programme' (nursing associate to registered nurse training) in May, as an apprenticeship programme. 20 out of 60 Nursing Associates started nurse apprentice training in 2019 with University of East London (UEL) 'Bridging Programme' with ten due to complete training in January 2021 and the second ten due to complete training in September 2021.

We developed a new operating model for preceptorship as part of our recruitment and retention strategy for newly registered nurses, midwives and AHPs. A joint BHRUT/University of East London Advanced Clinical Practice Research Project was launched in September 2019. Funding was secured to commission a university based qualitative researcher to lead research project and develop a research credible report for subsequent publication in peer reviewed journals.

Our first ever multi-professional Advanced Clinical Practice Forum was established in September 2019.

Support Groups

Given some of the challenges with staff engagement we know exist, we have been trying hard to ensure that we are promoting and encouraging staff to engage with the various networks and forums which we have to support staff groups, and making it clear to managers that staff should be encouraged and permitted to attend wherever possible.

We are pleased that these are active groups, but we can always get better engagement, as a means of sharing ideas, experiences and feedback, so hopefully that will continue to be seen in the year ahead.

These networks and forums have driven important initiatives in our hospitals including the Inspire Programme and an Inclusive Recruitment Project resulting in the appointment of Diversity Partners.

Our Ethnic Minority Network meets regularly and was a particular area of focus in the latter months of the financial year as we deal with the issues we know exist around BAME (Black, Asian and Minority Ethnic) representation and opportunity

within our Trust.

We also have an Ability not Disability Staff Forum, which particularly welcomes staff with a disability or learning difficulties and aims to identify how we can improve disabled staff's experience.

And our LGBT+ Staff Forum meets regularly too, with the aim of identifying how we can be more LGBT+ friendly for both staff and patients.

Celebrating our Teams

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.

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.

Team of the Week continues to be a popular way that staff can be publicly recognised for their efforts, via FFT results and also nominations, along with our primary staff award scheme, the "You Made a Difference Awards".

We know there are colleagues who go above and beyond the call of duty day after day, so we hope these re-launched and refreshed awards will encourage our teams to nominate the very best of BHRUT so we can all celebrate their contributions.

WORKING IN PARTNERSHIP

Transform care pathways across our Integrated Care System for patients benefit from the 50:50 partnership with CCG.

Complete a feasibility study for an ICS Academy & Innovation Centre.

Partnership Working

We are working with our mental health, community and primary care partners and each of the boroughs of Barking and Dagenham, Havering and Redbridge to transfer services and improve care pathways. We are committed to creating a successful North East London Integrated Care System (NEL ICS). Barking and Dagenham, Havering and Redbridge (BHR) is an integrated care partnership within the North East London Integrated Care System (NEL ICS).

Towards a NEL ICS

This year has continued to see an acceleration of effort as we work collaboratively towards establishing an integrated ways of working across our boroughs.

The NEL 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.

Our ambition is to be one of the country's leading ICS, driving better value and health outcomes for our local population. We are also active in the context of 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.

Development of a Group Model

In Spring 2019, the Trust's Chair in Common, Joe Fielder, commissioned Sir David Dalton to consider options for a Group Model for BHRUT and NELFT, which would support delivery of outstanding, integrated health and care for our rapidly increasing population.

Both Boards agreed with Sir David Dalton's recommendations to consider a future Group Model, subject to a case for change outlining what the benefits will be for our communities and staff.

This work has now been postponed indefinitely as we focus on Covid-19.

Clinical Strategy

As the previous year ended, we embarked on a major body of work to develop a refreshed BHRUT Clinical Strategy. This has required significant engagement with partners, stakeholders, patients, public and staff as we work towards delivering a joined-up and effective health and social care system which meets the needs of our communities.

Barking and Dagenham, Havering and Redbridge (BHR) is an integrated care partnership within the ICS. It focuses on the populations of the three boroughs which is approximately 780,000 people. BHRUT is the acute provider within this partnership which includes NELFT, three local authorities, three GP Federations and 15 primary care networks. NHS services are commissioned by the BHR CCGs which will transform from April 2021 into the one North East London commissioning body.

In the face of difficult challenges, there is great opportunity for us to make a step change in how we enable improved health and deliver care for our population. The large population growth means we will be able to welcome new colleagues into our organisation who choose to live and work in the area.

In simple terms, the strategy describes "what should happen where" to meet the growing and changing needs of our population and rests on three pillars: running highly reliable hospitals; accelerating integrated borough based partnerships; and collaborating with NEL partners. This strategy emphasises the purposeful transformation required to develop the best care pathways for residents and assumes strong daily control and continuous improvement to make tomorrow better than today.

1. Running highly reliable hospitals

We will draw on our vision 'to provide outstanding healthcare to our community, delivered with PRIDE' in a compassionate and respectful environment. As part of this we will reimagine how we deliver care and the use of space. This includes improving urgent and emergency care capacity and capability at both hospitals, delivering an outstanding care model that offers effective triage, an excellent emergency village and clear routes to onwards care.

We will also increase focus on planned care to improve reliability with a care model that improves mobility, independence and outcomes. We will continue to deliver high quality maternity services whilst working closely with system partners.

On cancer, we will build on the good service we already provide and forge new links with other partners to drive earlier diagnosis and access to the most specialist treatment for those that need it. We will provide care in the right place at the right time by configuring services appropriately at our two main sites as well as offering more care virtually and in the community. In doing this we will improve outcomes and experience for patients as well as staff.

2. Accelerating integrated borough based partnerships

We are at the foothills of system working and plan to develop more meaningful working relationships with our BHR system partners in primary care, the local authorities and with NELFT.

We have a role to play to work differently together to improve health, reduce inequalities in outcomes and meet the varying physical and mental health needs of our population. We will work with partners to produce a holistic strategy for population health management in the coming months, which will have an emphasis on starting well, living well and aging well.

Building on the foundations already built together we will begin transforming services by focusing our efforts on providing anticipatory care for people with long term needs, supporting people to live in good health for longer with the input of excellent multidisciplinary teams. One component of this is ensuring we deliver activity in the right place, and support people to retain their independence, rather than hospital being the default setting of care.

3. Collaborating with NEL partners

As some aspects of healthcare become increasingly specialist, we must work with our partners to ensure we are giving all our patients access to the care they need, by delivering pathways across

organisational boundaries. In the NEL ICS we are planning for the devolution of specialised commissioning and are part of an Acute Collaboration involving Barts Health NHS Trust and Homerton University Hospital NHS Foundation Trust to develop the NEL-wide acute strategy.

We will support research and innovation at our hospital sites with academic partners and will provide even better care models as a result of working strongly in partnership with other organisations.

To achieve this, we will dedicate resource to these three pillars as part of our business as usual activity.

Engaging Patients

Our Patient Partnership Council (PPC) 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 understand patient experiences of care and to help us 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 and 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.

We have a number of dedicated patient partner 'leads' who 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 Trust, 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.

Stakeholder Engagement

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

We hold regular meetings and briefings with our MPs, Councillors and portfolio holders within our Councils 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.

Senior executives have represented us at all Health Overview Scrutiny Committees, and Health and Wellbeing Boards across Barking & Dagenham; Havering and Redbridge. We welcome these sessions as a good opportunity to explore key issues in depth with elected representatives and to support a collaborative system-wide approach to improving services for our communities.

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.

Our relationships with the media are in a good place and we have built new relationships with key journalists, correspondents and producers.

We have taken some good opportunities to achieve exposure for our work and our people, for example around our Stroke team, our continued positive performance in cancer, and the Senior Nurse Interns, as well as facilitating filming for documentaries.

We have continued to 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

We will continue to improve the way we work with, and support, our GPs in Barking and Dagenham, Havering and Redbridge (BHR). We are working closely with the GP Federations and Primary Care Networks (PCNs) in each of the boroughs to work together to improve models of care for our communities.

Our Role in Delivering the East London Health & Care Partnership Plan

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

On 15 November 2019, ELHCP published their Strategy Delivery Plan for north east London which recognised that as a system we are committed to working together in a collaborative way to deliver local health and care services which mean our local people have more options, better support and properly joined up care at the right time in the best care setting.

Integral to this will be how we develop our North East London Integrated Care System (ICS) by April 2021. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with local authorities at 'place' level and, through systems, commissioners will make shared decisions with providers on population health, service redesign and the Long Term Plan implementation.

The challenges we face over the next five to ten years are stark, and cannot be addressed simply by doing more of the same. We are facing substantial population growth.

In order to continue to respond to the health and care needs of our local population we need to do things radically differently. Our response will be three-fold:

- Greater emphasis on preventing ill health, and empowering local people to take more control over their health and lifestyle choices (prevention and personalisation)
- Ensuring the health and care services we provide are integrated, joined up and appropriate for people's needs (integrated care)
- Rapidly modernising local approaches to health and care provision, utilising the academic and research base we have in north east London for the good of our local population (modernisation).

MANAGING OUR FINANCES

Reduce our underlying deficit from £65m to £51m, including £28m of savings within the Trust.

Embed clear processes, roles and responsibilities to ensure strong financial governance and budgetary control.

2019/20 has been an important year in continuing to stabilise the Trust's financial position and is the first year in the Trust's system-wide two year recovery plan. The Trust has continued to build robust and effective relationships with commissioners and regulators, to build upon the existing foundations for a brighter integrated system future. This has included the agreement of a four year contract up to March 2024 with our principal commissioners.

Although we remain in Financial Special Measures we successfully reported a deficit of £50.8m in line with our control total and thus earned the full £27.7m Provider Sustainability and Financial Recovery Funds available. We must, however, recognise the reported position was supported by non-recurrent benefits, the most significant being £10m support from our local CCGs. The underlying deficit is actually £62.5m.

We continue to believe in our Financial Recovery Plan and have confidence in the evidence based opportunities identified. However operational pressures have proven a significant barrier in resourcing the necessary clinical and senior operational leadership needed to deliver. We must therefore identify ways to enable our outstanding clinical leaders, free up time of our excellent operational teams and provide them with the necessary corporate services support. We will do this whilst continuing to focus on reducing waste using the Trust's The PRIDE Way methodology.

Delivery of the plan required £28m of savings (5%) and an assumed level of locally commissioned clinical income which was underpinned by a signed contract with our main commissioner, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCG).

Cash loans of £52.3m were drawn down from the Department of Health and Social Care (DHSC) during the year to support our revenue position in line with the Trust's operating plan plus loans in advance of Financial Resources Funding (FRF) and Provider Sustainability Funding (PSF) payment.

Capital Expenditure

We are required to deploy cash available for capital investment initially to repayment of PFI principal and to repayment of other capital loans and finance leases. In addition to this the Trust received funding from other sources allowing us to invest £19.4m to finance a capital programme. With these funds we delivered the following investment in our infrastructure:

Category	£'m
Information Technology	8.0
IT Application backlog	2.4
Backlog Maintenance	5.0
King Georges Hospital - Cathlab	1.0
ePMA	1.5
Ethos	1.5
Grand Total	**19.4**

Being in financial deficit and financing our PFI makes the level of Trust-generated cash for

investment in capital very limited for a provider of our size. An application for an emergency capital loan support of £9.0m was made to DHSC and approved in October 2019 for spending by the end of March 2020; this was achieved. In addition there was a further loan application of £3.0m approved for investment in the Trust's IT infrastructure. This was also received, and the investment delivered by March 2020.

Working Capital

We have managed our working capital to ensure sustained significant improvement in payment to suppliers, such that the Trust has sustained average performance above 90% against the Better Payment Practice Code and in a number of months we have exceeded 95%. The Trust also received positive news towards the end of the financial year that £245m of historic NHS debt will be converted into Public Dividend Capital and will not therefore be repayable or attract interest.

We have continued to deliver against the recommendations of the Grant Thornton and Deloitte financial governance reports and Audit and Risk Assurance Committee has given approval for the few remaining actions to be transferred to business as usual.

Delivering a Financial Recovery Plan

During November and December 2018, the Trust developed a Financial Recovery Plan (FRP) to answer 'what would need to be achieved to breakeven by March 2021?'. This was predicated on an evidence based diagnosis which demonstrated that there were no material structural drivers of our deficit, however, there were significant strategic and operational opportunities which required ambition and the right culture to sustainably change for the better. This would include the necessity to work as a system in order to deliver real savings rather than simply moving the financial challenge between the key system players.

Our internal aim needs to continue to target upper quartile Model Hospital cost performance. However, this alone will not be enough. Demand on the Trust's services are unaffordable to the local health economy and to resolve this will require a level of system working aligned to the national plan for Integrated Care Systems (ICS). We have made very positive progress in this area and remain committed to work as an ICS for the benefit of the population. Working with our system partners we have begun to redesign pathways for the benefit of our patients and to deliver financial value. Current plans focused on outpatients, older people's services and patients with long term conditions will need to be fast tracked in 2020/21.

The 2019/20 savings target was £28.4m gross of £10.0m cost of delivery. The actual gross delivery was £12.9m (adverse by £15.5m) although this was offset by cost of delivery being £4.8m lower than planned, which left net delivery at £7.7m and £10.7m adverse to plan. The principle driver in this underperformance was slippage in delivery of planned schemes. Whilst this is disappointing, we did recognise the risks of delivering at pace in the original plan and it does highlight the need for greater delivery at pace in 2020/21; this is reflected in the Trust's medium term ambitions up to 2023/24.

We have adopted the following principles to ensure that the Trust is better able to meet its ambition of financial breakeven:

1. Ensure outstanding dedicated clinical leadership for each work stream (to ensure that outcomes are patient focused and clinically led).

2. Create the capacity for operational excellence. Identify and empower the appropriate process owner to identify best practice and recognise that we want our best people designing our future with appropriate training and support.

3. Ensure the provision of first class corporate

support with dedicated resource: HR; IT; business intelligence; finance; procurement; estates, Kaizen Project Office and Programme Support Office.

We and the CCG are serious about working together and have established an agreement to focus our energies on pursuing real savings which will be shared equally.

Financial Outlook

The Trust has submitted a financial plan to NHS Improvement in line with the surplus control total (including PSF, FRF and Marginal Rate Emergency Tariff (MRET) funding) which is consistent with the ambition set out in our FRP.

Further work on financial planning has been suspended as a consequence of the Covid-19 outbreak and will resume in due course. The Trust has made changes to its governance arrangements by implementing a silver and gold command structure and ensuring that both have appropriate delegated authority to make sound decisions at pace for the benefit of patient care in the crisis environment in which we currently find ourselves.

We need to continue to invest significantly to address the remaining IT and estates backlog, plus investing to enable transformational and strategic change.

Although the year ahead will undoubtedly be challenging, we have established a clear and evidenced based plan to deliver an ambitious level of improvement and by working with partners in our ICS there is a clear and consistent direction for achieving a financially sustainable position.

OUR PERFORMANCE REPORT

This section provides the highlights of key performance through the year.

Overview

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

Towards the end of last year, we saw a decline in our four-hour emergency access performance which we have begun to redress. In March the figure was 75.03% which falls short of our agreed target set with our local system of 83.2%.

The improvements we are seeing, so far, are down to the changes we have made at King George Hospital where we have established a unit for our frail elderly patients. One of its objectives is to prevent unnecessary admissions and ensure patients who do not require inpatient resources can be treated and cared for in a more appropriate environment. We have also just launched an acute frailty service at Queen's Hospital which has the same goal.

We want to relieve the congestion in our two EDs and to encourage our specialist doctors to see and treat the patients who have been referred to them away from these very pressurised areas of our hospitals. This way we will only have those patients in the ED who absolutely need to be there.

We accept that, at the moment, the experience in our EDs for our patients and our staff is not as good as it should be. The work we are undertaking should mean we are in a better position to face the inevitable pressure that will continue to occur this winter.

We worked closely across the winter with a range of partners to try to find ways to improve performance, and have reintroduced Red2Green as a means of reducing patient stays and improving flow with some very positive results; we now need to successfully embed this practice across the organisation. We have also had a number of 'Perfect Week' events at the Trust, the aim of which were to rapidly improve patient flow to produce a step-change in performance, safety and patient experience.

The Red2Green/SAFER concept was at the core of our Perfect Week with an increased focus on the escalation process and board round challenge to create a zero tolerance on delays in the system. Wards also offered individual improvement projects to improve patient flow during the week.

Another major challenge for the year was bringing our finances back under control, so it is pleasing that we have achieved our agreed control total for the year. However, this is really only the first year of what is a three year financial system recovery program. There will be many challenges ahead as we continue to tackle our deficit and move towards a breakeven operating position which will allow the Trust greater ability to invest in quality services.

Performance against the cancer standards has been challenging this year. I am pleased to report that we did meet the 31 day standard for the full year with 96.5% of our patients receiving a diagnosis and first definitive treatment within 31 days (against a target of 96%). However, there were four months where we missed the monthly target. We did not achieve the urgent referral within two weeks standard (88.73% against a target of 93%), although we did meet the target in the last two months of the year and hope to build on this improvement in the future. We were also

unable to achieve the 62 day wait target of 85% for the whole year, with the overall performance for the year at 78.3%.

Prior to the impact of Covid-19, Referral To Treatment performance (18-week pathway for elective referrals) has continued to find difficulty in keeping pace with demand which has impacted. We will not deliver our local trajectory of 88% as overall performance for the year was 77.65%.

There are a number of steps we are taking to address these challenges including increased local capacity through the use of the independent sector providers and other waiting list initiatives. We have also worked to increase clinical triage with support from the CCGs under their 'Improving Referrals Together' scheme with our GP colleagues as well as extending work with community providers where treatment outside of our hospital is clinically appropriate and safe.

Compliance to the diagnostic standard has been challenging since a fire in our Endoscopy suite in 2018. The fire also affected our endoscope decontamination facilities, requiring a mobile decontamination unit and for some activity to be outsourced. The Trust became compliant with the DM01 standard in October 2019 and was also achieved in November 2019, January 2020 and February 2020. Radiology capacity has remained a challenge throughout the year which required some activity to be outsourced.

As we know, our performances are based in no small part on working in partnership with our local health economy, particularly our CCGs and local GPs and we thank them all for their input and support.

Fundamentally, we will all have to think differently in the future about how we provide services and how we deliver the NHS Long Term Plan. We continue to make good progress this year towards becoming an Integrated Care System, and I expect that momentum to continue to grow, both locally across our boroughs and also across the wider East London Health & Care Partnership.

Our maternity care is a continued point of pride, with fantastic feedback from women using the service, and we continue to provide one-to-one care in labour, as well as our CQC 'Good' rating. The demand remains very high – we are one of the biggest units in the country, and the biggest unit in London with the number of births at Queen's Hospital and in the community continuing to grow.

Measuring incident reporting is an important yardstick to assess the awareness and culture of safety within an organisation. Within our Trust, we have seen a dramatic improvement in recent years. We are now reporting far more. Where we fell short this year was on increasing the number of incidents with no patient harm, and reducing the numbers of serious incidents resulting in harm.

We had nine Never Events this year. All have been investigated thoroughly (including with the Healthcare and Safety Investigation Branch) with a full risk assessment and training provided to ensure we minimise the risk of them occurring again.

We achieved our targets for staffing fill rates through successful recruitment of nursing staff, supported by our in-house temporary staffing supplier. A highly effective preceptorship programme provides mentoring and support for new staff and has resulted in improved retention of this staff group. The Trust has provided a range of development opportunities for nursing staff including rotation, apprenticeship programmes and staff shadowing arrangement whereby a different member of the nursing staff shadows the work of the Chief Nurse each week.

Finally, we identified here last year that we wanted to reduce the number of healthcare acquired infections we recorded. I am pleased to report that we saw improvements in numbers of

MRSA cases, however our Clostridium difficile (C.diff) cases increased. Further work is required to improve the position and our ambition remains to achieve zero infections.

Tony Chambers
Chief Executive
17 June 2020

Performance Analysis

The performance measures shown below 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.

A weekly Cancer Programme Board, chaired by the Deputy Chief Operating Officer, is in place to review performance, demand and capacity required.

A weekly Access Board takes place to review trends in performance, provide forecasts and ensure a strategic forum is in place to agree actions.

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 that are 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: 75.03%
Referral To Treatment	92% of our patients to be seen within 18 weeks of referral from their GP for elective care	Not achieved: 77.65%
Cancer: urgent referrals	93% of our patients to be seen in two weeks following an urgent referral from their GP	Not achieved: 88.73%
Cancer: 31 days	96% of our patients to have a diagnosis and first definitive treatment within 31 days of the decision to treat	Achieved: 96.5%
Cancer: 62 days	Target of 85% of patients receiving first treatment from the date of GP referral	Not achieved: 78.31%
Infection control: C diff	No more than 24 cases	Not achieved: 29
Infection control: MRSA	Zero cases of MRSA bacteraemia	Not achieved: 3

Performance Trends

Standard to achieve		2019/20 Target	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	2019/20 Total	2018/19	2017/18	2016/17	2015/16	2014/15
Infection Control	Number of Clostridium difficile cases	<24	11	5	9	4	29	9	15	29	36	33
	Number of MRSA blood stream infection cases	0	0	0	2	1	3	5	6	7	5	6
Access to Cancer services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96.00%	97.64%	96.56%	95.59%	96.28%	96.50%	98.32%	98.52%	98.67%	96.10%	98.00%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98.00%	100.00%	100.00%	100.00%	99.55%	99.88%	100.00%	100.00%	99.80%	99.70%	99.60%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94.00%	100.00%	95.00%	98.00%	98.44%	97.82%	98.73%	99.56%	99.15%	96.10%	98.30%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	94.00%	100.00%	100.00%	100.00%	99.05%	99.78%	99.66%	99.89%	99.47%	98.70%	98.70%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment *	85.00%	83.08%	86.03%	74.44%	69.94%	78.31%	86.92%	86.21%	74.22%	74.00%	81.20%
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	90.00%	100.00%	89.55%	88.57%	77.78%	88.93%	93.68%	96.78%	95.16%	93.70%	94.00%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	88.48%	84.80%	87.42%	95.28%	88.73%	93.87%	96.79%	95.20%	94.50%	91.30%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	95.43%	99.66%	97.82%	98.00%	97.61%	97.79%	97.89%	93.47%	93.20%	80.10%
Access to treatment	18 weeks referral to treatment - total incomplete	92.00%	81.77%	77.72%	76.31%	74.80%	77.65%	84.01%	90.80%	88.20%	Not reported	
Access to A&E	% of patients waiting a maximum of 4 hours in ED from arrival to admission, transfer or discharge *	95.00%	80.37%	78.45%	70.40%	70.63%	75.00%	80.68%	81.84%	85.65%	87.90%	85.30%
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	233	296	354	237	1120	1135	651	974	524	494
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	36	21	31	29	117	205	77	42	38	39

Risks

A growing and ageing 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 through the development of an integrated care system and in the design of new models of care.

There is a risk that financial pressures will impact on performance. As we have not achieved a break even position, our auditors have raised a Section 30 referral with the Secretary of State. 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 significant 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 impacts performance.

Brexit

Regarding the UK's exit from the EU, we have planned cross-organisationally to ensure we are best positioned to face any challenges, through our EU Exit Response team.

Much work has been done to secure supplies locally and nationally – our Procurement teams are in constant touch with the relevant government departments. We have made appropriate arrangements, particularly in terms of Pharmacy, which has been one of the priority areas.

We have made special efforts to contact all our valued EU staff to make sure they are supported. While the overall numbers of staff from the EU are not that high in our Trust, we have taken what we believe to be appropriate mitigating actions.

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.

It is also demonstrating that we consider the social and environmental impact ensures that the legal requirements in the Public Services (Social Value) Act (2012) and NHS Standards Contracts are met. In addition to this, we recognise the UK Government's commitment to take action on climate change with a target to cut carbon emissions by 100% by 2050 (also referred to as Net Zero).

To date, we are proud to announce that our buildings related carbon emissions are down by 42% against our target of 30% by March 2020. This target was set in line with the NHS Sustainable Development Unit (SDU) Strategy to reduce by 28% from a 2013 baseline by 2020. We have superseded this target by reducing our carbon emissions by an additional 14%.

We are also proud to state that this is the result of reducing a quarter of our energy consumption since 2012/13 and this has resulted in just over a £5 million savings (cumulative) inclusive of energy and carbon related costs.

We are also proud to share that the Trust is a recipient of £413K Salix Energy Efficiency Scheme Loan to upgrade lighting at King George Hospital. The project will be completed by summer 2020 and it will provide £105K annual savings through energy efficient LED lighting.

Supporting the National Ambition

The UK was the first major economy in the world to pass a law to tackle climate change. This means that the UK will aim to balance any emissions generated through emission cutting or removal efforts – so called 'Net Zero'. The achievement of this ambition depends on how quickly the country as a whole succeeds.

This ambition is supported by the Department of Health and Social Care, and in response, NHS England launched the 'For Greener NHS' campaign in January 2020. The causes of climate change and air pollution are linked to killer conditions like heart disease, stroke and lung cancer.

Other linked issues are extreme weather conditions such as flooding and spread of infectious diseases.

The For a Greener NHS campaign will help address these and support the NHS and its staff to tackle the climate health emergency, helping prevent illness, reducing pressure on emergency departments, and saving tens of thousands of lives. In preparation for its delivery, the NHS SDU has published revised Green Plan guidance with revised targets.

It is our duty to contribute towards the level of ambition set for reducing the carbon footprint of the NHS, public health and social care system by achieving Net Zero by 2050.

Sustainable Healthcare

A sustainable health and care system helps us develop systems that minimise health impacts and help develop preventative approaches. We recognise that 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 the rising cost of natural resources.

This is achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage. This involves giving particular attention to energy, travel, waste, procurement, water, infrastructure adaptation and buildings.

Key Sustainability Performance Highlights

The following are the key highlights of performance against the baseline year 2012/13:

Carbon

42%
Carbon reduction target 28% by 2020

- **9,952** tonnes of CO2 emissions saved
- **13%** EU ETS carbon credit savings in 2019
- **£0** cost to UK CRC compliance

Energy

99%
Electricity used is Renewable

- **24%** total energy consumption savings
- **100%** live real-time energy display for monitoring
- **CHP QA** certified CHP plant

Waste

6%
Increase in recycling

- **ZERO** domestic waste to landfill
- **29%** reduction in high cost incineration clinical waste
- **20%** less plastic waste by implementing reusable Sharps waste containers

Travel

Upto **5%**
Staff cycle to work against a target of 3%

- **125%** increase in the cycle parking facilities
- **Free** for Trust staff pool bike scheme
- **Largest** community in the country (FAXI car share scheme)
- **64,131 miles** saved by our staff through the car share

Awareness and Education

95%

- **Mandatory** Sustainability and Waste Management course
- **Mandatory** CPD Waste course accredited by RCN and IEMA
- **Awareness** in monthly Corporate Welcome day
- **Green Message** Sustainability newsletter publication
- **Intranet and Internet** specific pages by target areas

Financial Savings

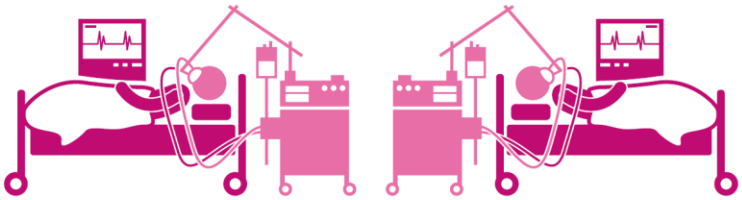
£5.11m

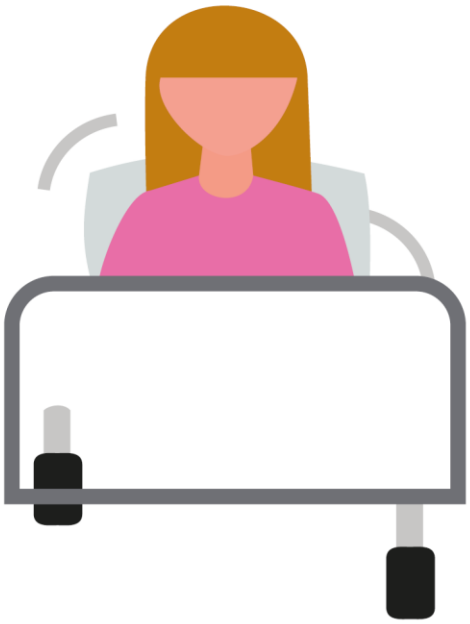
Following savings were achieved in 2019/20:

- **£305K** (approx.) on UK CRC Tax exemption
- **£725K** (approx.) in energy consumption cost savings
- **£30K** in energy savings through TRIAD
- **£2.5K** external funding to deliver travel plan initiatives
- **£118K** in waste savings through reusable sharps containers
- **£150K** in total waste management contracts rationalisation

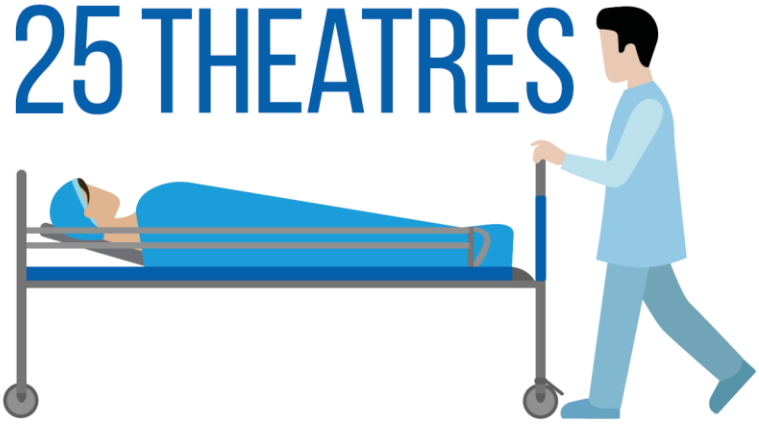
OUR HOSPITALS HAVE:

52 CRITICAL CARE BEDS





25 THEATRES



954 INPATIENT BEDS

62 MATERNITY BEDS

SECTION 2 –

ACCOUNTABILITY REPORT

Our Accountability Report

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by the Secretary of State for Health and Social Care. The Accountability Report takes account of the Department of Health and Social Care's guidance for NHS trusts in the manual for accounts, as follows:

- The Corporate Governance Report explains how the composition and organisation of the Trust's governance structures, developed in line with good governance standards, supports the Trust's objectives, and provide assurance that the Trust's risks are appropriately identified and managed.

- The Remuneration and Staff Report sets out the Trust's remuneration policy for directors and senior managers, reports on how that policy has been implemented, and sets out the amounts awarded to those individuals. It also details an analysis of staff numbers and costs and other relevant information relating to the workforce.

- The Trust's external auditor also provides a report of its audit of the annual accounts, remuneration and staff report and annual report.

Corporate Governance 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 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.

The Role of the Trust Board

The Trust Board is accountable, through the Chair, to NHSE/I and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

The Trust Board is held to account for stewardship of public money and delivery of services by NHSE/I and for quality of services by the Care Quality Commission (CQC).

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.

Leadership

The Chairman is responsible for the leadership of our Trust Board. He is responsible for ensuring the Board's effectiveness and setting its agenda. The Chairman 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 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.

The Trust Board at 31 March 2020 consisted of the Chairman, six Non-executive Directors, Chief Executive, Chief Medical Officer, Chief Nurse and Deputy Chief Executive, Chief Financial Officer, Director of People and Organisational Development, Chief Operating Officer and Director of Communications and Engagement.

As a benchmark of good corporate governance the Trust uses the criteria for independence listed in the UK Code of Governance to determine whether its Non-executive directors are independent. The Chairman was considered to be independent on his appointment in November 2017. Five of the Non-executive Directors are considered to be independent.

The Trust Board has the capability and experience necessary to deliver the Trust's objectives, and the governance structure the Trust has in place is appropriate to assure the Trust Board of this delivery.

The members of the Trust Board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. All directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability.

New directors receive an induction on joining the Board. In addition, the Board ensures that directors, especially non-executive directors, 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.

The performance of all directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for executive directors, by the Chief Executive; for non-executive directors by the Chairman, and for the Chairman by the Senior Independent Director, with sign off by NHS Improvement.

In compliance with the NHS Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust Board Directors have been assessed as being fit and proper persons to be directors of the Trust.

Appointments

During the year, there have been a number of changes to board members:

- Tony Chambers joined the Trust as Interim Chief Executive in January 2020 when Chris Bown, Interim Chief Executive left following the end of his fixed term contract.

- Susan Lees was appointed on 1 August 2019 for a one year term of office until 31 July 2020. Susan is a Non-Executive Director in Common with the North East London Foundation Trust.

- Lesley Seary CBE was also appointed on 1 August 2019 for a two year term of office until 31 July 2021.

- We extended the fixed term contract of Mr David Amos our interim Director of People and Organisational Development to 31 March 2021.

The biographies for each of our Trust Board directors are shown below:

Mr Joe Fielder

Chairman

Chair of the Remuneration and Terms of Service Committee

Joe was appointed as chairman in November 2017 and is chairman-in-common, being also the chairman of the North East London Foundation Trust (NELFT) 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. He worked previously in the international market with the Danish Great Nordic Group and was Deputy Managing Director of their UK business.

Joe was re-appointed Chairman by NHSI to 31 October 2021.

Jackie Westaway

- Independent Non-executive Director
- Appointed to the Board in August 2017 for a four year term of office.
- Vice Chair
- Chair of the Quality Assurance Committee
- Member of the Remuneration and Terms of Service Committee
- Member of the Audit and Risk Assurance 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 and a trustee of an Academy trust in East London.

Tom Phillips

- Independent Non-Executive Director
- Appointed to the Board in April 2017 for a four year term of office
- Senior Independent Director
- Chair of the Audit and Risk Assurance Committee
- Member of the Remuneration and Terms of Service Committee
- Member of the Finance and Investment Committee

Tom 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 at Kent and Medway NHS and Social Care Partnership Trust where he is also currently its Audit Chair, and is Chairman of Racecourse Technical Services Ltd.

Anthony Warrens

- Non-Executive Director
- Appointed to the Board in June 2011

- Extended for a further one year term until 30 June 2021
- Member of the Remuneration and Terms of Service Committee
- Member of the Quality Assurance Committee

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 past 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.

Joan Saddler OBE

- Independent Non-Executive Director
- Appointed in September 2014 for a four year term of office
- Re-appointed for a one-year term on 30 September 2019
- Member of the Remuneration and Terms of Service Committee
- Member of the Quality Assurance Committee
- Member of the People and Culture Committee

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.

Sue Lees

- Independent Non-Executive Director
- Non-Executive Director In Common with North East London Foundation Trust
- Appointed in August 2019 for a one year term of office with an option to extend in line with her contract at the North East London Foundation Trust
- Chair of the Finance and Investment Committee
- Member of the Remuneration and Terms of Service Committee
- Member of the Audit and Risk Assurance Committee

Sue was previously a Non-Executive Director Advisor to the Trust, having been appointed to that role in October 2017.

A qualified chartered accountant with more than 30 years' experience in both the private and public sectors, including periods working within the NHS and local government.

Sue has led large capital programmes, including the delivery of a number of new health care facilities within Barking, Dagenham, Havering and Brentwood.

She is currently the Chief Executive of Elevate East London, providing I.T., finance and customer services to local government. She has expertise in transformation of services, capital delivery, cost reduction and leading disparate teams.

Sue is also a Trustee of Studio 3 Arts, a locally based arts charity.

Lesley Seary CBE

- Independent Non-Executive Director
- Appointed in August 2019 for a two year term of office
- Chair of the People and Culture Committee
- Member of the Remuneration and Terms of Service Committee

Lesley has more than 30 years' experience in senior leadership roles in local government, including spending the last 8 years as Chief Executive of Islington Council. During that time she led a workforce of 4,500, managed a range of successful services and developed considerable experience of partnership working with both statutory and non-statutory organisations.

Lesley has worked extensively with local health partners in north central London at both STP and borough level, including the hospital trusts, Clinical Commissioning Group, GP Federation and GPs. She has worked with health partners on

health and social care integration as well as developing a strong approach to prevention and early intervention.

Lesley has a strong commitment to public services and to combatting health inequalities and delivering excellence in health and care.

Tony Chambers

- Appointed Chief Executive in January 2020

Tony is a highly experienced leader with a strong track record of managing large scale acute hospital services. He joined the NHS as a nurse in Bolton before moving into health management.

He has held senior roles in hospitals in Greater Manchester and West Yorkshire and in a large integrated health board in South Wales. For six years he was Chief Executive of the Countess of Chester Hospital NHS Foundation Trust. Most recently, he has worked at the Northern Care Alliance in Salford.

Chris Bown

- Interim Chief Executive from August 2018 until January 2020.

Chris Bown was appointed interim Chief Executive in August 2018. He performed the same role for our Trust for a short period in 2017.

Chris has more than 25 years of experience of working in senior leadership roles in the NHS and has helped to transform several Trusts that have experienced financial and organisational difficulties. Before joining us, Chris was leading the work of twenty-one partner organisations that make up the Bath and North East Somerset, Swindon and Wiltshire Sustainability and Transformation Partnership (STP).

Kathryn Halford OBE

- Chief Nurse and Deputy Chief Executive
- Member of the Quality Assurance Committee and the People and Culture Committee

Kathryn joined our Trust in January 2016 from Walsall Healthcare NHS Trust 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.

Dr Magda Smith

- Chief Medical Officer from January 2019 following a period acting up as Chief Medical Officer from September 2018
- Member of the Quality Assurance Committee and the People and Culture Committee

Dr Magda Smith has been a consultant physician and gastroenterologist at Barking, Havering and Redbridge University Hospitals NHS Trust for more than twenty years.

She has combined her consultant role with a number of leadership positions including Clinical Divisional Director and Associate Medical Director.

She is passionate about delivering good care to patients, developing teams that combine the best skills of all their members and ensuring that the voice of the patient is always listened to.

Nick Swift

- Chief Financial Officer from September 2018
- Member of the Finance and Investment Committee

After studying engineering at Exeter University, Nick qualified as a chartered accountant with Touche Ross in 1988 and then spent five years in New Zealand in both practice and commerce before starting a family and returning to the UK.

Nick brings over 20 years of board experience in a variety of international finance roles, most

recently as Chief Financial Officer for British Airways, from 2010 until 2016.

Since then, Nick has studied part-time for an MSc in Health and Medical Science at University College London, was a Non-Executive Director at East and North Herts NHS Trust and is a trustee at the girls education charity Camfed.

David Amos

- Interim Director of People and Organisational Development from January 2019
- Member of the Finance and Investment Committee and People and Culture Committee

David works as a healthcare HR and public services management consultant with a wide range of NHS and other organisations. He has had an extensive career in healthcare human resources leadership and general management.

After ten years in hospital general management, he was the HR director at St Mary's Hospital NHS Trust and the Workforce Director at University College London Hospitals NHS Foundation Trust.

Between the two HR director roles, he spent five years at the Department of Health, which included being the Deputy Director of HR for the NHS, responsible for recruitment and retention.

David spent a year at the Cabinet Office leading a project to promote jobs and skills across the public services during the economic downturn.

Shelagh Smith

- Chief Operating Officer from August 2018 following a period of six months as Interim Chief Operating Officer
- Member of the Finance and Investment Committee and the Quality Assurance Committee

Shelagh joined the 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.

Peter Hunt

- Director of Communications and Engagement from November 2017

Peter joined the Trust 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.

In addition to the Board of Directors, the Board has Board Advisers who provide additional support and capacity to the Chairman and Chief Executive by chairing consultant interview panels, and Human Resource hearings and appeals. Since 2016/17, they have been members of some Board Committees, as follows:

Mr Mehboob Khan - Quality Assurance Committee and People and Culture Committee.

Mr George Wood is the Chair of the Charitable Funds Committee and is a member of the Finance and Investment Committee.

Mr Eric Sorensen – Quality Assurance Committee and People and Culture Committee.

Ms Sandra Malone and Ms Caroline Roberts were not members of any Board Committees in 2019/20.

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 2019/20 to improve its corporate governance framework by continuing to drive improvement actions following the strategic governance review in 2015 which had identified a number of weaknesses.

In 2019/20 the Trust has:

- Strengthened the Board Assurance Framework to provide assurance to the Board in relation to the management of strategic risk. This involved a focus on clarity of controls and assurances provided.
- Developed a new Board Assurance Framework structure in the last quarter of 2019/20.
- Delivered and embedded the Board Development programme which had commenced in 2018/19, through the delivery of whole Board Away Day programmes and separate sessions for Non-Executive Directors and Executive Directors.
- Carried out the induction of two new Non-Executive directors recruited in the last quarter of 2018/19.
- Reviewed and updated the Conflicts of Interest and Managing Hospitality policy and implemented the associated registers for conflicts of interest and gifts and hospitality.
- Reviewed and changed the Board and committee scheduling to enable improved flow of information from committees to Board. The Board meetings are now held in the last week of the month with the committee meetings held at least the week before.
- Moved to Board meetings held every other month to enable regular strategy and seminar/development sessions in the intervening months.

In addition in 2019/20 the Trust continued to address the recommendations of the Grant Thornton report, published in 2018, which identified weaknesses in financial performance and governance. Further information is provided on this in the Review of Economy, Efficiency and Use of Resources section in the Annual Governance Statement section of this report.

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 2019/20, there were five Committees of the Board, each Chaired by a Non-Executive Director.

- Audit and Risk Assurance Committee
- Remuneration and Terms of Service Committee
- Quality Assurance Committee
- Finance and Investment Committee
- People and Organisational Development Committee

The Trust Board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely provide a report to the Trust Board showing how they are fulfilling their duties as required by the Trust Board, and highlighting any key issues and achievements. The role of each committee is outlined in the Annual Governance Statement section of the Annual Report.

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 11 Board meetings in public.

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

Attendance

The table below summarises Board Members' attendance at Trust Board Meetings together with Committee Members' attendance at their respective Committees for 2019/20.

Attendance

The table below summarises Board Members' attendance at Trust Board Meetings together with attendance at their respective Committees for 2019/20.

	Trust Board	Audit & Risk Assurance (ARA)	Finance and Investment (FIC)	Remuneration	Quality Assurance (QAC)	People and Culture (PCC)
Non-executive Directors						
Joe Fielder Chairman	10/11	-	-	4/4	-	-
Jackie Westaway Vice Chair Non-executive Director	9/11	5/6	-	4/4	6/6	-
Tom Phillips Senior Independent Director Non-executive Director	9/11	6/6	9/10	3/4	-	-
Susan Lees Non-executive Director	7/7	4/4	6/6	2/2	-	-
Lesley Seary Non-executive Director	6/7	3/4	-	2/2	-	3/3
Joan Saddler Non-executive Director	8/11	-	-	2/4	3/6	2/4
Prof Anthony Warrens Non-executive Director	7/11	-	-	1/4	0/6	-
Executive Directors						
Tony Chambers Chief Executive	3/3	-	3/3	-	-	-
Chris Bown Interim Chief Executive	8/8	-	7/7	-	-	1/1
Kathryn Halford Chief Nurse & Deputy Chief Executive	10/11	-	-	-	5/6	3/4
Dr Magda Smith Chief Medical Officer	11/11	-	-	-	6/6	3/4
Nick Swift Chief Financial Officer	11/11	-	10/10	-	-	-
David Amos Interim Director of People & Organisational Development	9/11	-	7/10	-	-	3/4
Shelagh Smith Chief Operating Officer	11/11	-	9/10	-	4/6	-
Peter Hunt Director of Communications & Engagement	11/11	-	-	-	-	-

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 dashed areas indicate that the director was not a member of that committee.

Further specific detail on the work of the Audit and Risk Assurance Committee is provided below.

Audit and Risk Assurance Committee

The Board has a well-established Audit and Risk Assurance Committee comprising of independent Non-Executive Directors. The 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 2019/20 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 all work related to security, fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Authority standards.
- Review the structure and process of the Board Assurance Framework.
- Review 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 2019/20 were Mr Tom Phillips (Chair), Ms Jackie Westaway, Ms Susan Lees (from August 2019) and Ms Lesley Seary (from August 2019).

Declarations 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. The register is available upon request from the Trust Secretary at bhrut.trust.secretary@nhs.net and is also published on the Trust website at: https://www.bhrhospitals.nhs.uk/publication-scheme

Information on personal data related incidents formally reported to the Information Commissioner's Officer can be found in the

Annual Governance Statement section of the Annual Report.

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 2020 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.

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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board

17 June 2020

Tony Chambers
Chief Executive

17 June 2020

Nick Swift
Chief Financial Officer

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

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

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

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

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

Signed 

Tony Chambers, Chief Executive

Date: 17 June 2020

Annual Governance Statement 2019/20

Scope of Responsibility

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

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going 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 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risks

The impact of the Covid-19 pandemic was felt by the Trust at the very end of the 2019/20 financial year and will have significant impact into 2020/21.

At the outset the Trust recognised the need to ensure that its governance structure would enable a prompt response to the significant change in circumstances. A number of measures were either introduced or adapted from existing governance mechanisms to achieve this.

A Gold and Silver Command structure was established for decisions relating to Covid-19. In addition, the weekly Trust Executive Committee re-focussed the emphasis of its agenda to cover the Trust's response to Covid-19 whilst maintaining urgent decision making in relation to non Covid-19 issues.

The Trust Board approved changes to its delegated authority powers in the Standing Financial Instructions to ensure that decisions could be made appropriately for rapid deployment of resources. This included agreeing capital and revenue expenditure limits for Gold and Silver Command and changes to authority limits for business as usual expenditure. The changes included an increase in the numbers of executive directors able to approve both capital and revenue expenditure together with increased approval limits. In addition, the approval limits for the Trust Executive Team and the Finance and Investment Committee were increased.

Plans were established at the outset to ensure that the current and potential financial impact on the Trust as a result of the Covid-19 pandemic would be regularly reported to the Trust's Finance and Investment Committee.

In addition, the Trust took into account the guidance published by NHS England/ Improvement on 28 March 2020 '*Reducing Burden and Releasing Capacity in NHS Providers and Commissioners to manage the Covid-19 Pandemic'.* The Trust adopted an approach to continue to hold its Board Meetings with a focussed agenda and virtually. The approach to Board Committee meetings was also to continue to hold these with streamlined agendas.

A weekly telephone briefing was held between the Chief Executive, the Chair and the Non-Executive Directors to enable the Non-Executive team to be kept up to date with the changing position on Covid-19 and to enable the Non-Executive Directors to ask questions of the Chief Executive in relation to the impact of Covid-19 on the organisation.

The approaches described above enabled the Trust to maintain control over its decision making and governance during the latter part of the last quarter in 2019/20 as the impact of the Covid-19 pandemic was felt.

At the time of writing the Annual Report the mechanisms described above remain in operation and Covid-19 is continuing to impact into 2020/21. Work is under way to consider how services will be organised in the future to balance operational daily management alongside our response to the Covid-19 position. The work will depend on effective partnerships both locally and also regionally across north east London. It is therefore anticipated that the risk and control environment will develop and change further during the current year.

During the course of 2019/20 the Trust continued to build on improvements to its risk management processes. The Trust has ensured that its risk management system received the appropriate leadership and management. We have a Risk Management Strategy and Policy, which applies to all our staff.

At the strategic level, our board assurance framework (BAF) provides a current view around the principal risks to achieving our strategic objectives. It enables us to assess and evaluate whether we have the appropriate controls and assurances in place, to be able to identify any gaps in controls and assurances and identify planned actions to address these.

BAF risks are assigned to executive directors and to a Board Committee. Risk appetite is determined by the Board in accordance with the Trust Risk Management Strategy.

An internal audit of the BAF and risk management commenced in Quarter 4 of 2019/20. The review had initially intended to include the risk management arrangements below the corporate risk register and within divisions. However, the reprioritisation of divisions to deal with the Covid-19 pandemic meant that the review was limited to the BAF review and its evolution and development as well as the risk escalation from the Corporate Risk Register to the BAF. The outcome of the audit was one of 'reasonable assurance' which meant that the improvement reported in 2018/19 was maintained.

During the year, the BAF was regularly updated and reviewed by the Board, as well as periodically being presented to the Audit Committee.

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, and the Chief Nurse and Deputy Chief Executive is the executive lead for risk management.

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. Risks are escalated from the divisional risk registers to the corporate risk register and extreme risks are reviewed for consideration of transfer to the BAF.

Our Risk and Compliance Group reports to the Quality Governance Steering Group. A Patient Partner is a member of the Risk and Compliance Group and this provides a valuable service user perspective on the organisation's risks. 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.

The Audit Committee invites divisional directors and corporate directors to attend meetings to present their risk registers. The Trust Executive Committee reviews the Trust corporate risk register.

The training and development programme for risk was reviewed and brought in-house during 2019/20. A face to face training package was developed and from mid-February 2020 all staff have been able to access monthly training delivered by members of the Trust's Quality and Safety Team. The training covers the principles of safety, risk management and risk mitigation. The training enables our staff at all levels to fulfil their responsibilities 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 Health Overview and Scrutiny Committees and Health and Wellbeing boards; 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 work programme minimises the risk of fraud within our Trust and is compliant with the NHS Counter Fraud Authority Standards. The annual programme of work is approved by the Trust's Audit and Risk Assurance Committee which also receives updates on progress on counter fraud activity at each of its meetings.

Preventative measures include reviewing our policies to ensure they are, as far as possible, fraud-proof, using intelligence, best practice and guidance from NHS Counter Fraud Authority. They also proactively work to ensure staff are aware that they can make confidential referrals to them. The proactive work includes communications, presentations and fraud awareness literature. 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. When system weaknesses are identified as a result of investigations or proactive exercises, recommendations are made and implemented in relevant departments to ensure Trust policies and processes are robust to withstand any further occurrences of fraud.

The Local Counter Fraud Specialist (LCFS) liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust.

To measure and assess the risk of fraud at the Trust and to ensure that the delivery of services is risk based, a Fraud Risk Assessment Report (FRAR) was undertaken in 2019/20. This was in line with the principles of the Trust's risk management framework. The LCFS liaised with key stakeholders to address any identified weaknesses. The results of the FRAR led the LCFS to recommend a number of proactive reviews. The LCFS attends the Trust Risk and Compliance Group where regular overview reports on the FRAR are received.

The Audit and Risk Assurance Committee gains assurance on behalf of the Trust Board that risk management is properly implemented and controlled within the Trust. In 2019/20, the committee met six times, and retains the capacity to meet more often, if necessary, and oversees the integrity of the Trust's risk management processes and the Board Assurance Framework

(BAF). In response to the Covid-19 pandemic, the Counter Fraud Team updated the FRAR in light of the emerging and changing fraud risks; and to reflect the heightened risk to the Trust due to the relaxation of departmental procedures to ensure appropriate staffing levels and vital supply of goods and services.

The Quality Assurance Committee meets bi-monthly as the high-level committee which scrutinises quality assurance and quality 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 quarterly to oversee, for Board assurance, all workforce and culture related issues in the Trust. The Trust also has a Trust Executive Committee (TEC), chaired by the Chief Executive, which provides a fortnightly 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 for the escalation of issues to the Board, on committee agendas 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:

- Executive 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
- Patient and staff surveys and feedback, NHS Resolution and Care Quality Commission assessments, Ombudsman and other sources of external scrutiny and accreditation

The Risk and Control Framework

The Trust has a Risk Management Strategy which is reviewed by the Trust Executive Committee and Audit 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.

Throughout the financial year, the Trust continued its work to embed risk management in 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.

- Executive directors regularly review the Board Assurance Framework (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 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 risks on the Trust's Board Assurance Framework over the last year and into the current year were:

- Not being able to embed quality, safety and risk management systems which could lead to a negative impact on patient outcomes, patient experience and patient engagement

- A failure to embed learning – including learning from deaths – within the organisation which could result in repeated incidents

- A failure to prescribe and administer medicines correctly could lead to patient harm

- Not being able to design and implement appropriate ICT resulting in clinical services not operating optimally

- The failure to deliver the Constitutional Standards and other key operational targets which would have detrimental consequences, such as impact on patients, reputational loss and contractual fining

- Inability to deliver the operational plan

- Not being able to embed an appropriate high-performing culture throughout the whole Trust

- A failure to recruit and retain appropriate numbers of permanent, capable staff to deliver the operational plan

- Inability to sustainably deliver income and expenditure and financial recovery and £28m gross savings

- A failure to secure capital funding to allow the Trust to deliver the financial recovery plan and operate from/with a fit for purpose asset base

- The £10m of gross savings as a benefit of partnership working failing to be achieved

- Failure to develop new ways of working that deliver recurring savings whilst maintaining the quality of care

- Feasibility of the academy does not progress in time to meet master planning timelines.

At the end of the final quarter of 2019/20 the Covid-19 pandemic impacted on the Trust. The risks associated with this have been closely monitored and added to the Trust's risk register. In May 2020, our Quality Assurance Committee and Trust Board received assurance on our management of risk associated with Covid-19 through an Infection Prevention and Control Covid-19 specific Board Assurance Framework.

During the final quarter of 2019/20 a review of the format and content of the Trust's Board Assurance Framework commenced. A revised format was presented to the Audit Committee in

March 2020 which presented the concept of a risk on a page with information set out telling the story of each risk starting with the origins of the risk, the impacts that would occur if the risk were to transpire and improved clarity on controls and assurances. Work will continue in the early part of 2020/21 on the revised framework.

The Trust is one of five trusts in the UK working as part of a ground-breaking partnership with the Virginia Mason Institute (VMI) to, amongst other culture development, introduce a standardised approach to quality improvement using lean methodology throughout the organisation: we refer to this as the PRIDE Way programme.

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. The Trust's progress of its PRIDE Way programme has achieved a significant increase in senior managers commencing The PRIDE Way for Leaders training in 2019/20 with reports on progress received at Trust Board.

Quality key performance indicators (KPIs), including the number of never events, serious incidents and explanations of follow-up actions, are monitored by our Board. There were 157 Serious Incidents reported during the year with four being subsequently de-escalated, and nine 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 was set a deficit control total of £50.8m. Achievement of this would earn an additional £27.7m in Provider Sustainability and Financial Recovery Funds. The target was broadly consistent with the ambition set out in year one of our Financial Recovery Plan which answered the question 'what would need to be achieved to breakeven by March 2021?' It is pleasing to say that we met our financial target however we have not yet delivered the recurrent efficiencies we continue to target through waste reduction that will improve the services we provide to our patients whilst saving money. This means the underlying deficit remains at £62.5m.

We continue to be confident that the opportunities to resolve the financial position are well understood, however the pace of change has been very difficult when coupled with the operational demands and the need for cultural change. With the changing regulatory landscape, our plans and trajectories have been scrutinised by the STP and the general view is that financial recovery will take longer than two years. This view is consistent with Operating Plan guidance for 20/21 before it was suspended for Covid-19, which set a far lower efficiency expectation for the period out to 2023/24.

We continue to manage our working capital closely and have maintained the improvements made in supplier payment metrics ending the year paying 96.4% of non-NHS suppliers within 30 days.

It has been a positive year for capital investment. Having secured £15.9m of funding in addition to £3.5m we were able to self-finance we have invested £19.4m into asset base. This has allowed us to begin addressing our significant IT infrastructure backlog with £8m of investment, invest in IT applications as we move towards an Electronic Patient Record, replace the Cath Lab at King George Hospital, upgrade one of the LINACs at Queen's so we remain at the cutting edge of cancer treatment and undertake backlog maintenance and equipment replacement.

The Trust's Standing Financial Instructions and Scheme of Delegation were reviewed during 2019/20 and a number of changes made which were approved at the Audit and Risk Assurance Committee and ratified by the Trust Board in September 2019.

The Board reviews and monitors monthly performance reports to meet the requirements of the NHS England/Improvement 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 undertakes an annual self-certification process whereby it provides evidence of compliance against the NHS Provider Licence. The purpose of the self-certification process is to enable the Board to confirm or otherwise that it meets the obligations set out in the licence having taken into account relevant evidence together with any risks and associated mitigations.

During 2019/20 the Board received a report in May 2019 setting out such evidence and concluded that it confirmed the Trust's compliance. Work has been undertaken to review the Trust's compliance for 2019/20 which will be received for approval by the Trust Board at a meeting on 17 June 2020. The work undertaken has identified that the Trust remains compliant.

Overall responsibility for quality governance rests jointly with the Chief Nurse and Deputy Chief Executive, and Chief Medical Officer. The Chief Medical Officer is the Trust's Caldicott Guardian. The Chief Nurse and Deputy Chief Executive is our executive lead for improving patient experience.

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

The Care Quality Commission (CQC) inspected the Trust between 3 September 2019 and 14 November 2019, with the final report published on 9 January 2020.

The services inspected were the Urgent and Emergency services, Critical Care and End of Life Care across Queen's Hospital and King George Hospital. The Outpatient and Children and Young People services at King George Hospital were also inspected. A Well-Led assessment was carried out between 8 October and 9 October 2019.

Overall the rating for Queen's Hospital remained at Requires Improvement. Caring remained Good, and Safe and Responsive were rated as Requires Improvement. However, Well-led improved to a rating of Good. The End of Life Care services at Queen's Hospital were rated as Outstanding.

Overall the rating at King George Hospital remained at 'Requires Improvement'.
Safe, Responsive and Well Led remained at Requires Improvement and Caring retained its Good rating. However, the Effective domain improved to Good.

Overall the Trust was rated as 'Requires Improvement' for Safe and Responsive, and 'Good' for Effective, Caring and Well-led.

Use of Resources was rated as Requires Improvement.

The Care Quality Commission report recognised the following outstanding practices at the Trust:

- The introduction of the nursing associate role into the organisation, which bridges the gap between health and care assistants and registered nurses, and improves staffing levels and the delivery of care to patients

- The five experienced nurses as part of the intern programme, which provides mentoring and coaching support to newly qualified nurses, and is the first scheme of its kind in the country

- The Trust being acknowledged nationally for its commitment to carbon reduction and the organisation's Sustainability team receiving two national sustainability awards

Overall, it was recognised that the Trust was moving in the right direction, and that the report recognised the kind and compassionate care provided to patients, with the improvement in financial governance, which meant the Trust has moved from Inadequate to Requires

Improvement by NHS Improvement for Use of Resources.

We are pleased that we have achieved our objective to achieve a CQC rating of Good for Effective and Caring and recognise that we have further work to do to improve our ratings for Safe and Responsive, in order to improve our overall rating from Requires Improvement to Good.

The CQC inspection identified five 'Must Do' and 61 'Should Do' actions. In response the Trust has developed a CQC Improvement Plan which is closely monitored by the Quality Governance Steering Group.

The CQC carried out an unannounced responsive inspection on 20 January 2020 of the Emergency Departments at King George and Queen's Hospital. This inspection was triggered in response to poor Emergency Department performance. Following the inspection a number of Provider Information Requests were made by the CQC to which the Trust responded fully.

On 30 January 2020, an action plan detailing 29 actions alongside a comprehensive letter of response was drafted by the Chief Nurse and submitted to the CQC. Subsequently the CQC informed the Trust that they were satisfied that we had taken their concerns very seriously and that we were committed to providing safe care which we could evidence and sustain.

Delivery of the action plan is monitored weekly at a CQC Huddle chaired by the Chief Nurse/Deputy Chief Executive. Briefing updates are provided to the CQC Inspection Manager by the Director of Nursing for Quality and Safety weekly and the Trust Board has been kept updated on progress.

There is an overarching action plan to improve use of resources. The CQC has not taken any enforcement action against the Trust during 2019/20.

Due to the Trust being in Financial Special Measures (and previously having been in Quality Special Measures), the Trust Board gave a number of formal undertakings to the Regulator, progress against which has been presented to the Board on a regular basis.

We have complied with the relevant guidance on Corporate Governance. The Board continued the Board Development programme which had started in 2018/19. Three Board Away Days were held which enabled the Board to reflect on priorities, behaviours and working assumptions around key strategic issues, including the development of its clinical strategy, the development of the Integrated Care System, the Group Model with the North East London Foundation Trust and safe staffing. The Board also completed training on a number of key areas including safeguarding children and vulnerable adults and financial red flag training.

In early February 2020 the Board held a Board to Board meeting with the Board of the North East London Foundation Trust (NELFT). The purpose of the meeting was for both boards to explore a number of key areas for the development of a Group Model which had been agreed in principle by both Boards during the summer of 2019. Areas discussed at the meeting included the patient and service user benefit of the proposed changes; consideration of a strategic risk assessment and the key milestones and road map to deliver an operational Committee in Common with NELFT for the start of the 2021/22 financial year. At the end of May 2020 the Board took a decision to indefinitely postpone the Group Model work as we focus on Covid-19.

During the last quarter of the year a review was undertaken of the Board and Committee meeting schedule. This resulted in agreement to move from monthly to bi-monthly Board Meetings in public to provide time in the intervening months to focus on development seminars and strategic sessions. In addition, the schedule of the Board's sub-committees was reviewed and amended to provide greater time between the committees and the Board for improved reporting into the Board.

We achieved our goals that were set for 2019/20 to accomplish one of our key objectives; 'Becoming an Employer of Choice'. These were:

- To increase our staff survey response to 50%. A response rate of 57% was achieved, our highest recorded rate. Much focus was undertaken from all tiers of our leadership to achieve this with a clear message of a higher response rate provide a richer source of feedback

- Improve our staff rating of our hospitals as 'a good place to work' from 53% to 56%. In the 2019 survey 57% of our staff recommended us a good place to work, an increase of 4% from the previous year. The staff survey results highlighted staff felt able to contribute more to decision making and be actively involved in improving patient care

- To reduce our vacancy rate from 13% to 11%. By March 2020 our vacancy rate reduced to 10.6%. This was achieved by a focus on recruiting international nurses and our student nurses as well as improvements to our medical recruitment processes. Our retention rates also improved reducing our need to recruit in certain areas

- Our Equality, Diversity and Inclusion score improved from 8.3 to 8.5. Our BME, Ability not Disability and LGBT+ networks are now well established and are supporting our work in improving fairness in career progression and improving staff experience

An important part of our work around inclusion is our local annual analysis as part of the national NHS Workforce Race Equality Standard (WRES). WRES shines a light on the experience of black, Asian and minority ethnic (BAME) colleagues across the NHS.

Our own workforce is 50% BAME and WRES provides a framework for local action in response to our analysis to improve their experience. Nationally and locally across the NHS BAME colleagues report a poorer experience. We delivered our analysis and action plan to deadline in 2019 and throughout 2019/20.

The analysis comprises nine indicators comparing BAME and white staff experience. Four are on workforce data, four drawn from national NHS Staff Survey questions and one indicator for BAME representation on boards. The 2019 national WRES Data Analysis Report for NHS Trusts showed that we could do better on indicator 6, percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months, and indicator 7, percentage believing that trust provides equal opportunities for career progression or promotion.

In response to these we have adopted the NHS Improvement/NHS England compassionate and inclusive Leadership model as well as an Inclusive Recruitment Project. Both are ongoing and on track to deliver real gains in 2020/21.

A newly created Workforce Race Equality Steering Group provides proactive expertise, support and guidance on the above and complements our Ethnic Minority Network's contribution. Overall progress against WRES and the overarching equality, diversity and inclusion agenda is assured by the People and Culture Committee.

The Trust continues to deliver the requirements of developing workforce safeguards. Using published self-assessment standards demonstrating 'levels of attainment' the organisation continues to show a mature advanced delivery of e-rostering across medical (all grades), nursing (ward and specialist) and Allied Healthcare Professionals. Building on the existing workforce safeguard processes, particularly our reporting processes, the organisation has strengthened its daily operational and strategic review process to fully encompass clinical outcomes and evidence based tools.

During 2019/20 bi-annual nursing and midwifery staffing reviews were completed and presented to the Trust Board. The reviews included acuity and dependency assessment and benchmarks to calculate and assess establishments.

Register of Interests and Gifts and Hospitality

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

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 has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and 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

The key processes that have been applied to ensure that resources are used economically, efficiently and effectively across the Trust involve a hierarchy of scrutiny of the use of resources throughout the Trust. The Audit Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives. The Committee receives and considers reports from both Internal and External Auditors and approves the Annual Report and Accounts for submission to the Board of Directors. The Committee exercises Non-Executive scrutiny over the Executive Directors for the efficient use of public funds.

The Audit and Risk Assurance Committee carries out an annual self-assessment of its performance and reports this formally to the Trust Board. Any changes that may be deemed necessary to its terms of reference are also made to reflect best practice.

Internal Audit presents a proposed schedule of audits to the Committee, which is then agreed, executed and reported upon. Via the Committee, the Executive Directors are held to account for any actions arising because of audit findings through challenge at the Committee. In addition, each executive attends the meeting as required, to update on issues within their area.

The Audit and Risk Assurance Committee reports to the Board of Directors and the Board seeks assurance from the Committee that it is satisfied that the Trust is using resources in an efficient and effective manner.

Monthly finance and performance reports are provided for the Board. 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.

Whilst the Trust met its control total this year, this was achieved non-recurrently and the Trust Board have reflected upon the challenge of the underlying run rate and set out on a path to improve the financial sustainability of the Trust through the second year of its Financial Recovery Plan.

In October 2017, the Trust suffered from a severe cash shortfall, manifested largely in a significant increase in pressure felt from suppliers who had not been paid for some time.

In December 2017, The Trust formally engaged Grant Thornton to carry out a report on Financial Performance and Financial Governance.

The Grant Thornton report was duly published in March 2018 and a formal action plan to address the recommendations of the report was prepared by the Trust. A task and finish Steering Group was set up to oversee the completion of the action plan and to report back to the Trust Board and Finance and Investment Committee whose remit was also extended to pick up the Use of Resources and Deloitte reviews.

During 2019/20, and following a review by the Trust's internal auditors, the Trust Audit and Risk Assurance Committee agreed that as the majority of actions had been completed, and the remaining items could be safely considered to be part of Business as Usual for a large Acute Trust. The Trust is therefore now going through a formal process to close down the Action Plan and once completed the Steering Group will be closed.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit. The Data Security Protection Toolkit is a mandatory requirement across all areas of the NHS and is based on ten data security standards.

The Data Security and Protection Toolkit gives a Statement of Assurance which is monitored through a self-assessed checklist process through the NHS Digital Data Security website. This statement not only provides NHS Digital with a report on the Barking, Havering and Redbridge University Hospitals NHS Trust current status but also gives an assessment of its current work in relation to Information Governance.

The Trust places a high level of importance on its ability to achieve full compliance on the Data Security Protection Toolkit, thus ensuring it has the systems, policies and processes in place to protect patient information. Due to the Covid-19 pandemic, the deadline for this year's submission has been extended to September 2020. At the last review, the Trust was compliant in all but a single assertion relating to Business Continuity Plan testing. The completion of this has been delayed due to the pandemic and is due to be reviewed in May 2020.

The Trust continues to review policies and procedures to ensure compliance and meet the standards introduced by the Data Protection Act 2018. Following these changes the Trust has employed a new Data Protection Officer and is currently in the process of expanding the Information Governance team. Core governance and processes are being reviewed in order to improve responsiveness to the changing technological landscape and to aid transformational change within the Trust.

Between April 2019 and March 2020 there were five data breaches reported to the Information Commissioner's Office. No action was taken against the Trust and the Trust is doing all it can to ensure it protects and manages data appropriately.

The Trust's internal auditors undertook an advisory audit on the Trust's arrangements for General Data Protection Regulations Governance, and they identified a number of areas where further work is required by the Trust to meet the requirements of the legislation.

Data Quality and Governance

The Trust has in place a comprehensive elective care data quality improvement and training 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 (elective) 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. The Trust also has in place an elective access policy which had been reviewed in 2019/20 by a third party – the Intensive Support Team from NHS Improvement

Accurate elective care data for patient is essential for the efficient running of the Trust and to maximise utilisation of resources for the benefit of patients and staff. The Trust has a strategy, work plan, validation processes, metrics, key performance indicators and performs periodical audits to continually improve elective care data quality. Competency based modular training packages are delivered to staff to minimise data quality errors and this ensures that elective care data quality is within the top quartile.

Operational delivery of data quality improvement methods is overseen by the Programme Director, Data Quality Improvement. In order to provide assurance that the Trust has robust underlying data, external data quality audits are being carried out by our internal auditors (RSM), NHS Elective Care Improvement Support Team (IST), North of England Commissioning Support (NECS) and annual internal RTT Data Quality Assurance Audit by the Trust Data Quality Assurance Team. Appropriate reports are reviewed by the Operational Management Group with recommendations for improvements being agreed and acted upon.

The preparation of the returns is quality assured by the Programme Director, Data Quality Improvement and is reviewed and approved by our Deputy Chief Operating Officer (elective) before submission. We use performance data that is uploaded by us and partners e.g. London Ambulance Service and agreed with the Clinical Commissioning Group and NHS Improvement – to deliver one version of the truth. This is done in conjunction with the Commissioning Support Unit who ensures consistency. The Trust also works closely with the regulator to secure feedback on submissions to improve quality on an on-going basis.

Key improvements were carried out during the year to address issues identified in internal and external audits. These included:

- Addressing the provision of consistent training and competency for staff interacting in the elective pathway. An '18 Week Referral to Treatment Fundamentals' online training was developed and implemented

- The governance structure to address audit outcomes was strengthened with reports sent to the Trust's Access Board and Referral to Treatment operational meetings with exceptional reporting to the Trust Operational Management Group

- Changes were made to the Trust's Medway system to minimise input errors

- Data processing changes were made to address accuracy issues in the referral to treatment waiting list

- A non referral to treatment patient tracking list was revised and published with key performance indicators

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Assurance Committee and Quality Assurance 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. The Head of Internal Audit has issued the following opinion based on the work undertaken in 2019/20, as at 24 April 2020: "there are weaknesses in the framework of governance, risk management and control such that it could become inadequate and ineffective".

The Head of Internal Audit has advised that the opinion is based on there being weaknesses in the control framework, particularly over the design and operation of the systems of control to achieve their intended outcomes. The opinion was based on a number of factors including the number of partial assurance reports issued during 2019/20. In total nine partial assurance reports were issued which was an increase of four on 2018/19. The partial assurance reports were:

- Procurement
- Consultant Job Planning
- Digital Maturity including I.T. Service Desk Provision
- Divisional Governance – Surgery
- Getting It Right First Time (GIRFT)
- Information Security Governance and Monitoring
- Data Quality – Information Team
- Delivery of Quality Cost Improvements (QCIPs)
- Recruitment Efficiency

Internal Audit also undertook several reviews in 2019/20 where reasonable assurance opinions were assigned and have not identified any significant control issues. These were:

- Financial Governance – Delivery of the Grant Thornton, Deloitte and CQC Action Plan
- Development of Quality Cost Improvement Programmes
- E-Rostering
- Records Management
- Freedom to Speak Up
- Board Assurance Framework and Risk Management
- Key financial controls

All internal audit reports are presented to the Audit and Risk Assurance Committee. The Trust implements management actions to address weaknesses identified within the internal audit reports and progress on implementation is overseen by the Audit and Risk Assurance Committee. The Committee requests the attendance of senior management to its meetings to address issues in relation to internal audit outcomes and progress.

Whilst the Trust had made reasonable progress in 2018/19 at implementing agreed actions, the position had deteriorated during 2019/20 and was a factor in the Head of Internal Audit's

opinion. The Head of Internal Audit has reported that inadequate progress had been made in implementing the actions and at the time of providing his opinion for 2019/20 there remained a high number of actions that had not been implemented by their agreed date with 44 of the 63 open actions overdue.

The Audit and Risk Assurance Committee expressed serious concern about the lack of progress in implementing the recommendations with the result that control weaknesses were not being addressed. The Chair of the Committee escalated this to the Trust Board and as Chief Executive I am addressing these issues with my Executive team members individually at one to one meetings and also collectively on a monthly basis through a review of all outstanding audit recommendations at our Trust Executive Committee.

Conclusion

In conclusion I can confirm that there is one significant control issue which has been identified in my Annual Governance Statement. Despite improvement in the financial position with the control total being met in 2019/20, there remains a considerable underlying deficit which is taking longer to reduce than was originally forecast and the Trust remains in Financial Special Measures.

Signed 

Tony Chambers
Chief Executive

Date: 17 June 2020

Remuneration and Staff Report

Remuneration Report

Our approach to remuneration policy is 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.

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.

TABLE 1

Salary and Pension entitlements of senior managers
Remuneration

Name and Title (all figures in £'000)	Period (See Note 1) From	To	2019-20 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	2018/19 Total (bands of £5,000) £000
Joe Fielder - Chair	01/04/2019	31/03/2020	35-40	0	0	0	0	35-40	35-40
Tony Chambers - Chief Executive	02/01/2020	31/03/2020	50-55	0	0	0	780.0-782.5	830-835	0
Chris Bown - Chief Executive	01/04/2019	12/01/2020	175-180	0	0	0	0.0 - 2.5	175-180	140-145
Shelagh Smith - Chief Operating Officer	01/04/2019	31/03/2020	155-160	0	0	0	72.5 - 75.0	230-235	470-475
Dr Magda Smith - Medical Director	01/04/2019	31/03/2020	220-225	0	0	0	472.5-475.0	695-700	140-145
Nick Swift - Chief Finance Officer	01/04/2019	19/02/2020	180-185	0	0	0	0.0 - 2.5	180-185	105-110
Kathryn Halford - Chief Nurse	01/04/2019	31/03/2020	160-165	0	0	0	0.0 - 2.5	160-165	300-305
Peter Hunt - Director of Communications and Engagement	01/04/2019	31/03/2020	120-125	0	0	0	45.0 - 47.5	165-170	155-160
David Amos - Director of People & Organisational Development	01/04/2019	31/03/2020	140-145	0	0	0	0.0 - 2.5	140-145	30-35
Jackie Westway - Non-executive Director	01/04/2019	31/03/2020	5-10	0	0	0	0	5-10	5-10
Prof. Anthony Warrens - Non-executive Director	01/04/2019	31/03/2020	5-10	0	0	0	0	5-10	5-10
Joan Saddler - Non-executive Director	01/04/2019	31/03/2020	5-10	0	0	0	0	5-10	5-10
Tom Philips - Non-executive Director	01/04/2019	31/03/2020	5-10	0	0	0	0	5-10	5-10
Sue Lees - Non-executive Director	01/08/2019	31/03/2020	5-10	0	0	0	0	5-10	0-5
Lesley Seary- Non-executive Director	01/08/2019	31/03/2020	5-10	0	0	0	0	5-10	0-5
Median remuneration of all staff in the Trust (£)			34,961						34,488
Highest paid director of the Trust (£5k band)			230-235						205-210
Ratio of the above two figures			6.7						6.0

NOTES
(1) Unless the period is stated the Directors were here throughout the full financial year (ie 1st April 2019 - 31st March 2020).

TABLE 2

Salary and Pension entitlements of senior managers (continued)

Pension Benefits

Name and title (all figures in £'0)	Real increase in pension at age 60 (bands of £2500) £000	Real increase in lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2020 (bands of £5000) £000	Total related lump sum at age 60 at 31 March 2020 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Tony Chambers - Chief Executive	32.5 - 35.0	92.5 - 95.0	70.0 - 75.0	170.0 - 175.0	662	1,404	726	0
Chris Bown - Chief Executive	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Shelagh Smith - (Chief Operating Officer)	2.5 - 5.0	0.0 - 2.5	60.0 - 65.0	90.0 - 95.0	1,148	1,265	90	0
Dr Magda Smith - Medical Director	20.0 - 22.5	50.0 - 52.5	85.0 - 90.0	240.0 - 245.0	1,408	1,925	483	0
Nick Swift - Chief Finance Officer	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Kathryn Halford - Chief Nurse	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Peter Hunt (Director of Communications and Engagement)	0.0 - 2.5	0.0 - 2.5	5.0 - 10.0	0.0 - 5.0	41	76	34	0
David Amos - Director of People & Organisational Development	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	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.

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.

	2019-20	2018-19
Band of the highest paid director's total remuneration (£000)	230-235	205-210
Median pay remuneration (£)	34,961	34,488
Median pay multiple	6.7	6.0
Range of staff remuneration (£)	20,299-231,666	20,079-207,468

The highest paid director salary was £231,666 (2018/19, £207,468) in the current year against a median salary of £34,961 (2018/19, £34,488), resulting in a minor change to the median pay multiple.

The banded remuneration of the highest-paid director in the Trust in the financial year 2018/19 was in the band £230k-£235k (2018/19, £205k-£210k). This was 6.7 times (2018/19, 6.0) the median remuneration of the workforce, which was £34,961 (2018/19, £34,488). 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 9 of the accounts. In 2019/20, the Trust spent a total of £656m of which staff costs accounted for £418m (64%).

Expenditure on Consultancy

In 2019/20 the Trust spent £2,882k on Consultancy services.

Exit Packages

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

Staff Report

Staff Numbers and Costs

Staff costs and numbers of employees are captured in the accounts at note 55.

Staff Composition

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
White: British	2746
Black or Black British: African	824
White but not British or Irish	569
Asian or Asian British: Indian	564
Filipino	432
Asian or Asian British but Unlisted	415
Black or Black British but not Caribbean or African	291
Asian or Asian British: Pakistani	210
Black or Black British: Caribbean	197
An unlisted ethnic group	166
Asian or Asian British: Bangladeshi	152
Not stated or unavailable	152
White: Irish	131
Mixed: Other Mixed Background	79
Chinese	50
Mixed: White & Black Caribbean	50
Mixed: White & Asian	36
Mixed: White & Black African	34

The table below gives the gender breakdown within the Trust (as at 31 March 2020)

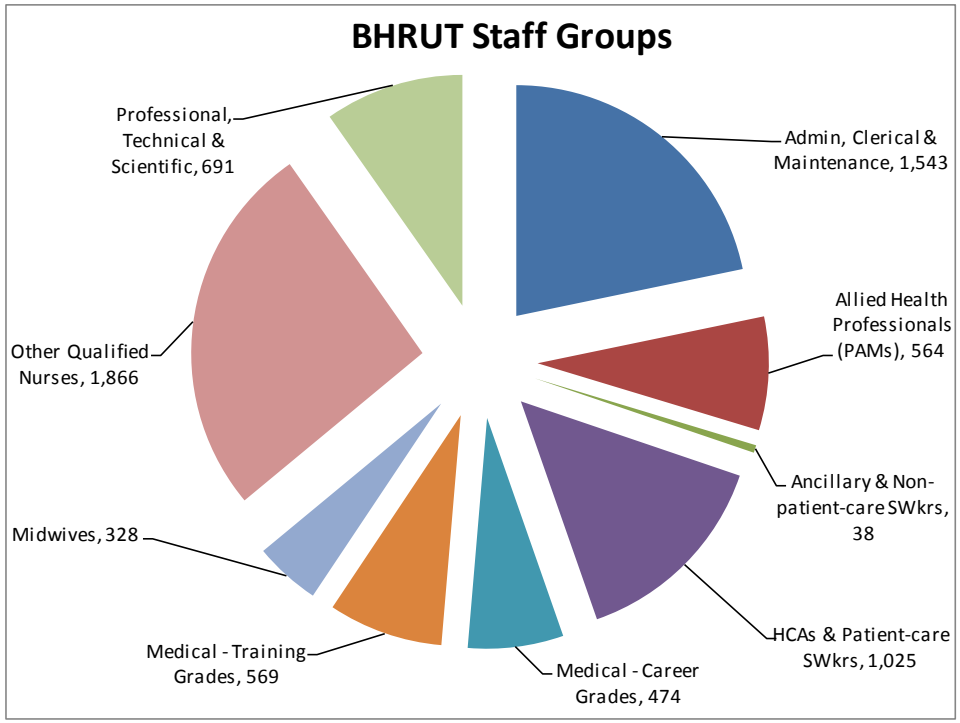
	Female	Male
Board Level Director	3	4
Non Exec / Chair	4	3
Senior Manager	322	163
All Other Employees	5,104	1,495

The number of senior managers by pay band is as follows:

Pay band	Staff No's
Band 8a	266
Band 8b	101
Band 8c	49
Band 8d	28
Band 9	32
VSM	9
Total	**485**

Our staff are broken down into the following specialist areas/disciplines:

Staff Group	Headcount	Ratio
Admin, Clerical & Maintenance	1,543	22%
Allied Health Professionals (PAMs)	564	8%
Ancillary & Non-patient-care SWkrs	38	1%
HCAs & Patient-care SWkrs	1,025	14%
Medical - Career Grades	474	7%
Medical - Training Grades	569	8%
Midwives	328	5%
Other Qualified Nurses	1,866	26%
Professional, Technical & Scientific	691	10%



The numbers of staff disclosed in the staff report are in absolute terms whereas the figure disclosed in 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).

Staff Sickness

We set a tough target for staff sickness levels over the course of the year of 2.6% and at the end of the year we did not hit the target, returning an overall rate of 3.8%

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: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	**1**
Of which, the number that have existed:	
for less than one year at the time of reporting	**1**
for between one and two years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

Table 2: New Off-payroll engagements

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

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	**2**
Of which...	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	**2**
No. of engagements reassessed for consistency / assurance purposes during the year.	
No. of engagements 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 officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.(2)	**14**

Tony Chambers, Chief Executive

Date: 17 June 2020

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 2020 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 two.

In our opinion, the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2019/20.

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 relating to going concern

We draw attention to note 1.2 in the financial statements which discloses that the Trust is reliant on the provision of £48.4 million of non-recurrent or performance-based financial support from the Department of Health and Social Care and the achievement of efficiency savings of £27.5 million to deliver its planned surplus of £5.0 million in 2020/21.These events and conditions, along with the other matters explained in note 1.2, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information in the Annual Report

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

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

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 65, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 66 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects 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 2020.

Basis for adverse conclusion

The Trust was placed into financial special measures by NHS Improvement on 12 February 2018. In advance of the suspension of the NHS funding regime on 17 March 2020, the Trust had agreed a financial recovery plan designed to bring the Trust to a breakeven financial position by 31 March 2021. This required the Trust to identify and make savings of £100 million over the two years to March 2021. During the year ended 31 March 2020 a savings target of £28.4 million was set through Quality Cost Improvement Schemes, of which the Trust was able to achieve £23.2 million. This leaves significant savings to be achieved in 2020/21 if the Trust is to meet its recovery plan and deliver its financial targets.

The Trust was subject to two independent governance reviews in 2018; a review of financial governance published on 29 March 2018 and a review of Board governance published on 2 August 2018. Action plans have been developed to address the recommendations of both reviews, but these were not fully implemented during the year ended 31 March 2020. The Trust has also seen increased turnover in the Board and senior management during the year and

was subject to an independent review of allegations made in relation to bullying and engagement, of medical staff. This identified the need for improvements in the Trust's clinical governance arrangements and management for which actions also remained outstanding during the year ended 31 March 2020.

On 9 January 2020 the CQC published a report on its inspection of the Trust with an overall combined rating of Requires Improvement. The report raised, amongst others, issues relating to the governance of the Trust and its approach to identifying and realising efficiency opportunities. The Trust remains in financial special measures and subject to undertakings to NHS Improvement. This, combined with the prospective nature of the Trust's financial recovery plans, is evidence of weaknesses in the Trust arrangements for the sustainable deployment of resources and informed decision-making.

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 66, 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 December 2019 and updated in April 2020 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

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

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

On 16 April 2020 we made a referral to the Secretary of State under Section 30(1)(a) of the Local Audit and Accountability Act 2014 in respect of the Trust's breach of its "breakeven duty" as set out in paragraph 2(1) of Schedule 5 of the National Health Service Act 2006. At the date of our referral the Trust's estimated financial position for the year ended 31 March 2020 was a deficit of £50.8 million, with a cumulative deficit of £531.6 million.

We have no other matters to report in these respects.

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

This report is made solely to the Board of Directors of 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 for the year ended 31 March 2020 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
Chartered Accountants
15 Canada Square
London
E14 5GL

24 June 2020

SECTION 3 –

FINANCIAL STATEMENTS AND NOTES

Barking, Havering and Redbridge University Hospitals NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 restated * £000
Operating income from patient care activities	3	558,286	505,223
Other operating income	4	82,315	45,228
Operating expenses	7, 9	(629,384)	(588,104)
Operating surplus/(deficit) from continuing operations		**11,217**	**(37,653)**
Finance income	12	161	150
Finance expenses	13	(25,737)	(22,782)
PDC dividends payable		-	-
Net finance costs		**(25,576)**	**(22,632)**
Other gains / (losses)	14	1	(65)
Share of profit / (losses) of associates / joint arrangements	21	-	-
Surplus / (deficit) for the year from continuing operations		**(14,358)**	**(60,350)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	16	**-**	**-**
Surplus / (deficit) for the year		**(14,358)**	**(60,350)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(106)
Revaluations	19	-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-
Total comprehensive income / (expense) for the period		**(14,358)**	**(60,456)**

Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period		(60,350)
Remove prior period adjustments (See Note 1.31)		(2,159)
Surplus / (deficit) for the period (18/19 as originally reported)	(14,358)	(62,509)
Remove net impairments not scoring to the Departmental expenditure limit	(6,151)	(9,741)
Remove (gains) / losses on transfers by absorption	-	-
Remove I&E impact of capital grants and donations	(2,563)	31
Remove impact of 2017/18 Expert determination	-	11,885
Adjusted financial performance surplus / (deficit)	**(23,072)**	**(60,334)**

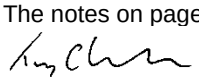
* See Note 1.31

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 restated * £000	1 April 2018 restated * £000
Non-current assets				
Intangible assets	16	5,458	5,552	6,436
Property, plant and equipment	17	345,013	328,486	316,706
Receivables	25	5,991	5,140	4,499
Other assets	26	-	-	-
Total non-current assets		**356,461**	**339,178**	**327,641**
Current assets				
Inventories	24	16,135	15,680	16,895
Receivables	25	62,336	30,813	52,699
Non-current assets for sale and assets in disposal groups	27	-	-	24
Cash and cash equivalents	28	8,544	12,060	3,249
Total current assets		**87,015**	**58,553**	**72,867**
Current liabilities				
Trade and other payables	29	(52,656)	(52,030)	(58,072)
Borrowings	31	(259,301)	(78,517)	(38,862)
Other financial liabilities	32	-	-	-
Provisions	34	(838)	(535)	(309)
Other liabilities	30	(4,589)	(5,190)	(5,251)
Liabilities in disposal groups	27	-	-	-
Total current liabilities		**(317,384)**	**(136,272)**	**(102,494)**
Total assets less current liabilities		**126,093**	**261,458**	**298,014**
Non-current liabilities				
Trade and other payables	29	-	-	-
Borrowings	31	(201,682)	(326,634)	(303,150)
Provisions	34	(6,110)	(5,683)	(6,682)
Other liabilities	30	(3,213)	(3,638)	(3,638)
Total non-current liabilities		**(211,005)**	**(335,955)**	**(313,470)**
Total assets employed		**(84,912)**	**(74,496)**	**(15,456)**
Financed by				
Public dividend capital		486,392	482,450	481,033
Revaluation reserve		1,196	1,196	1,302
Financial assets reserve		-	-	-
Income and expenditure reserve		(572,500)	(558,141)	(497,791)
Total taxpayers' equity		**(84,912)**	**(74,496)**	**(15,456)**

The notes on pages 7 to 69 form part of these accounts.

* See Note 1.31



Name Tony Chambers
Position Chief Executive Officer
Date 17 June 2020

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

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**482,450**	**1,196**	**-**	**-**	**-**	**(558,141)**	**(74,496)**
Surplus/(deficit) for the year	-	-	-	-	-	(14,358)	**(14,358)**
Gain/(loss) arising from transfers by mofieid absorption	-	-	-	-	-	-	**-**
Public dividend capital received	3,942	-	-	-	-	-	**3,942**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2020	**486,392**	**1,196**	**-**	**-**	**-**	**(572,500)**	**(84,912)**

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

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**481,033**	**1,302**	**-**	**-**	**-**	**(522,305)**	**(39,970)**
Prior period adjustment	-	-	-	-	-	24,514	**24,514**
Taxpayers' and others' equity at 1 April 2018 - restated *	**481,033**	**1,302**	**-**	**-**	**-**	**(497,791)**	**(15,456)**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	**-**
Surplus/(deficit) for the year	-	-	-	-	-	(60,350)	**(60,350)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	(106)	-	-	-	-	**(106)**
Revaluations	-	-	-	-	-	-	**-**
Public dividend capital received	1,417	-	-	-	-	-	**1,417**
Taxpayers' and others' equity at 31 March 2019	**482,450**	**1,196**	**-**	**-**	**-**	**(558,141)**	**(74,496)**

* See Note 1.31

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.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

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	2019/20 £000	2018/19 restated * £000
Cash flows from operating activities			
Operating surplus / (deficit)		11,217	(37,653)
Non-cash income and expense:			
Depreciation and amortisation	7.1	16,458	15,380
Net impairments	8	(6,151)	(9,741)
Income recognised in respect of capital donations	4	(2,686)	(80)
Amortisation of PFI deferred credit		-	-
(Increase) / decrease in receivables and other assets		(32,374)	21,077
(Increase) / decrease in inventories		(455)	1,215
Increase / (decrease) in payables and other liabilities		(1,749)	(6,860)
Increase / (decrease) in provisions		703	(792)
Other movements in operating cash flows		-	-
Net cash flows from / (used in) operating activities		**(15,037)**	**(17,454)**
Cash flows from investing activities			
Interest received		161	150
Purchase of intangible assets		-	(1,719)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(20,076)	(5,856)
Sales of PPE and investment property		5	87
Receipt of cash donations to purchase assets		983	-
Net cash flows from / (used in) investing activities		**(18,927)**	**(7,338)**
Cash flows from financing activities			
Public dividend capital received		3,942	1,417
Movement on loans from DHSC		63,319	64,624
Movement on other loans		-	-
Capital element of PFI, LIFT and other service concession payments		(11,576)	(11,172)
Interest on loans		(6,502)	(3,396)
Other interest		(6)	(6)
Interest paid on PFI, LIFT and other service concession obligations		(18,729)	(17,863)
Net cash flows from / (used in) financing activities		**30,448**	**33,604**
Increase / (decrease) in cash and cash equivalents		**(3,516)**	**8,812**
Cash and cash equivalents at 1 April - brought forward		**12,060**	**3,249**
Cash and cash equivalents transferred under absorption accounting	45	-	-
Cash and cash equivalents at 31 March	28.1	**8,544**	**12,060**

* See Note 1.31

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care.

The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

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

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

In normal circumstances the Trust would be starting the new financial year focused on the delivery of a Trust Board approved operating plan and budget, including year two of our Financial Recovery Plan. However given the CoVID-19 pandemic, national guidance has been to suspend the planning round and replace this with short term emergency measures in specific response to the pandemic.

These steps provide income certainty as clinical income has moved to block payment arrangements. A nationally calculated top up is being provided and is designed to fund the Trust to 2019/20 run rate uplifted to 2020/21 prices. Marginal CoVID-19 costs will be reimbursed separately.

These steps focus on simplifying processes and ensuring sufficient and timely cash flows are in place to enable prompt payments to suppliers and staff. The emergency measures as published cover the period 1 April 2020 to 31 July 2020 but will be reviewed by the national team of NHS Improvement and NHS England as the pandemic progresses.

In 2020/21 the Trust will:

- ensure aged creditors are kept to a minimum and maintain the sustained improvements in the better payment practice code (BPPC);
- have its historical NHS debt written off, replaced by Public Dividend Capital (PDC);
- continue to undertake investment in our infrastructure including both Information and Technology (IT) and Estates backlog.
- as we exit the emergency response to CoVID 19, continue to find ways to remove waste from our patient pathways and processes, delivering both improvement and efficiencies as encapsulated in the Financial Recovery Plan.

Although the current period is unprecedented and challenging, it is not perceived as a significant risk. As we exit from the short term response and return to business as usual, we must make sure opportunities that have been catalysed through the necessity of the CoVID-19 situation, such as reductions in transactional activity and changes to outdated models of Outpatient care, act as a foundation for change and are built upon.

For the 2020/21 period there remains materiality uncertainty surrounding the:

- level of planned and contracted patient activity, before the emergency response to CoVID-19 the Trust had identified an forecast outturn of £5M surplus (with underlying deficit position of £35M);
- need to quantify and continue to deliver reduced financial waste across services which will require a continued focused financial recovery plan, including £28.5M of efficiency savings;
- entitlement to continue to receive blocks of non-recurring or performance based income such as PFI support and PSF which in the 2019/20 period totalled £48m.

As with any entity placing reliance on other group entities for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

However, the intention of the Department of Health and Social Care to continue to provide this support is dependent on the continuing need for healthcare and other service to continue to be provided by the public sector for the foreseeable future.

Based on these indications the directors believe that it remains appropriate to prepare the financial statements on a going concern basis. However, these circumstances represent a material uncertainty may cast significant doubt on the company's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £245m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

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

Note 1.3 Interests in other entities

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 £3.43m, an increase in year of £1.31m.

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 2019-20 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% and therefore deemed immaterial, and consolidation was therefore not necessary. The Charity continues to publish a separate set of accounts for 2019/20 in accordance with the Statement of Recommended

Accounting Practice "Accounting and Reporting by Charities"; FRS 102.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it.

The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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

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

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

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

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

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

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales.

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures

for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

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

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

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

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

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

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

The valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020, the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered

to have an infinite life and is not depreciated.

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

Revaluation gains and losses

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

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

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

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

De-recognition

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

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

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

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

Donated and grant funded assets

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

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

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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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, lifecycle 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 Trust to the operator for use in the scheme

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.

Useful lives of property, plant and equipment

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

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

*Note: The Trust Accounts template mandates the exclusion of useful economic lives for those assets where the Trust has recorded nil valuation in the year.

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

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised

Expenditure on development is capitalised 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."

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Information technology	3	5

Development expenditure	3	5
Websites*	-	-
Software licences*		
Licences & trademarks	3	5
Patents*	-	-
Other (purchased)*	-	
Goodwill*	-	-

*Note: The Trust Accounts template mandates the exclusion of useful economic lives for those assets where the Trust has recorded nil valuation in the year.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is usually measured using the average cost price method. This is considered to be reasonable approximation to fair value due to the high turnover of stocks.

Note 1.12 Investment properties

The Trust does not have any investment properties

Note 1.13 Cash and cash equivalents

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

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

Note 1.14 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 will be 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.

Note 1.15 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement

of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

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

The Trust has no assets which are measured at fair value through other comprehensive income

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

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

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Impairment of financial assets

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

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

Impairments are not applied to receivables and assets due from other NHS organisations and government departments, as the government assumes the guarantor for payment of all public expenditure and therefore the risk of non-settlement is deemed low.

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

Derecognition

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

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

Note 1.16 Leases

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

The Trust as a lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

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 34.2 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.

Note 1.18 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 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the
- occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.19 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital

dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

I. donated and grant funded assets,
II. average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
III. any PDC dividend balance receivable or payable.

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

Note 1.20 Value added tax

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

Note 1.21 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.

Note 1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

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

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

Note 1.23 Third party assets

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

Note 1.24 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 its own risks, with insurance premiums then being included as normal revenue expenditure.

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

Note 1.25 Gifts

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

Note 1.26 Transfers of functions to/from other NHS bodies and local government bodies

There was no transfer of functions between the Trust and other organisations in 2019-20.

Note 1.27 Early adoption of standards, amendments and interpretations

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

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2020.

The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury.

Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. [For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition]. No adjustments will be made on 1 April 2021 for existing finance leases.

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

IFRS 16 Leases – The Standard is effective 1 April 2020 as adapted and interpreted by the FReM. The Trust has commenced the assessment of the application of IFRS 16 to its financial statements. This commenced with work to identify leases which are currently operating leases and should be reclassified as finance leases as well as a broader review of recurring expenditure streams where right to use assets may be embedded in contracting arrangements. The work has progressed to March 2020, when the Trust revised it operational priorities and working patterns to deal with the COVID19 pandemic and combined with the decision to defer the implementation of IFRS16 in the NHS to 1 April 2021 means that it has not been practical to complete this work or present it for audit. The work to identify the impact of this standard is expected to recommence in Autumn 2020.

Note 1.29 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.

Note 1.30 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:

Our material estimates and judgements are:

revaluation of Land & Buildings

In addition to these there are other matters which we wish to disclose (not because they are material) but because management have been required to estimate or take a judgement about how they have been treated.

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 r elating 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.

Note 1.31 Prior Period Adjustment

PFI Implicit Interest

In calculating the apportionment between the principal and interest elements of the property related payments made by the Trust under its PFI arrangement since the PFI assets were brought on-balance sheet on 1 April 2009, the Trust had used an interest rate of 7.585%. On review of the methodology used to calculate this rate it was identified that a more appropriate rate would be 3.665%. The impact of this is that the Trust had overstated its PFI liabilities by £26.7 million at

31 March 2019 and had understated its reserves by an equivalent amount.

The table below set out the cumulative impact of this adjustment on the financial statement line items affected at the beginning of the comparative period (1 April 2018), together with the adjustments to the numbers reported in the prior year. This adjustment does not impact the in-year cash amounts that are paid in relation to the PFI.

In addition this impacts on the following associated notes:

- 7.1 Other operating expenditure;
- 13.1 Finance expenditure;
- 25.1 Trade and other payables;
- 29.1 Receivables;
- 31.1 Borrowings;
- 31.3 Reconciliation of liabilities arising from financing activities;
- 39.1 Imputed finance lease obligations;
- 39.2 Total on SoFP PFI, LIFT and other service concession arrangement commitments; and
- 39.3 Analysis of amounts payable to service concession operator.

The impact on the prime financial statement captions is identified below alongside the cumulative impact to the 1st April 2018.

Statement	31/03/2019 £'000	31/03/2019 £'000 restated	Prior Year Adjustment £'000	Cumulative impact to 1st April 2018 £'000
Statement of Comprehensive Income				
Other Income	44,854	44,854	0	0
Operating Expenses	(579,437)	(587,730)	(8,293)	143,038
Finance Costs	(33,234)	(22,782)	10,452	(118,524)
	(567,817)	(565,658)	2,159	24,514
Statement of Financial Position				
Current Liabilities : Trade and Other Payables	(54,034)	(52,030)	2,004	1,956
Current Assets : Receivables (Prepayments)	30,890	30,813	(77)	(81)
Borrowings : Current	(76,725)	(78,517)	(1,792)	(1,920)
Borrowings : Non-Current	(353,172)	(326,634)	26,538	24,559
	(453,041)	(426,368)	26,673	24,514
Income and Expenditure Reserve	(584,814)	(558,141)	26,673	24,514
Statement of Changes in Equity				
Taxpayers' equity at 1 April 2018 - brought forward	(522,305)	(522,305)	0	
Prior Period Adjustment	0	24,514	24,514	
Taxpayers' equity at 1 April 2018 - Restated	(522,305)	(497,791)	24,514	
Surplus/Deficit for the Year	(62,509)	(60,350)	2,159	
Taxpayers' equity at 1 April 2019	(584,814)	(558,141)	26,673	
Statement of Cashflows				
Net cash flows from / (used in) operating activities	(9,162)	(17,455)	(8,293)	
Net cash flows from / (used in) investing activities	(7,338)	(7,338)	0	
Net cash flows from / (used in) financing activities	25,311	33,604	8,293	
Increase / (decrease) in cash and cash equivalents	8,811	8,811	0	
Cash and cash equivalents at 1 April 2018 - restated	3,249	3,249	0	
Cash and cash equivalents at 31 March 2019	12,060	12,060	0	

Note 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.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Elective income	69,398	63,412
Non elective income	202,669	190,281
First outpatient income	37,530	37,475
Follow up outpatient income	39,063	36,837
A & E income	35,902	35,301
High cost drugs income from commissioners (excluding pass-through costs)	36,806	36,337
Other NHS clinical income	115,368	92,709
Mental health services		
Cost and volume contract income	-	-
Block contract income	-	-
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
Ambulance services		
A & E income	-	-
Patient transport services income	-	-
Other income	-	-
Community services		
Community services income from CCGs and NHS England	-	-
Income from other sources (e.g. local authorities)	3,580	3,840
All services		
Private patient income	3,185	2,540
Agenda for Change pay award central funding*		4,827
Additional pension contribution central funding**	14,356	
Other clinical income	429	1,664
Total income from activities	**558,286**	**505,223**

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

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

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	115,247	89,977
Clinical commissioning groups	431,542	400,147
Department of Health and Social Care	20	4,850
Other NHS providers	1,613	783
NHS other	32	36
Local authorities	3,580	3,840
Non-NHS: private patients	518	264
Non-NHS: overseas patients (chargeable to patient)	2,667	2,276
Injury cost recovery scheme	2,825	2,830
Non NHS: other	242	220
Total income from activities	**558,286**	**505,223**
Of which:		
Related to continuing operations	558,286	505,223
Related to discontinued operations	-	-

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

	2019/20	2018/19
	£000	**£000**
Income recognised this year	2,667	2,276
Cash payments received in-year	854	611
Amounts added to provision for impairment of receivables	536	830
Amounts written off in-year	637	4,701

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
					restated	restated
	£000	£000	£000	£000	£000	£000
Research and development	1,182	-	**1,182**	1,329	-	**1,329**
Education and training	16,290	540	**16,830**	16,865	-	**16,865**
Non-patient care services to other bodies	-		**-**	-		**-**
Provider sustainability fund (PSF)	12,869		**12,869**	-		**-**
Financial recovery fund (FRF)	14,807		**14,807**			
Marginal rate emergency tariff funding (MRET)	4,301		**4,301**			
Income in respect of employee benefits accounted on a gross basis	2,453		**2,453**	1,707		**1,707**
Receipt of capital grants and donations		2,686	**2,686**		80	**80**
Charitable and other contributions to expenditure		349	**349**		289	**289**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Rental revenue from finance leases		-	**-**		-	**-**
Rental revenue from operating leases		3,378	**3,378**		4,070	**4,070**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Other income	23,460	-	**23,460**	20,888	-	**20,888**
Total other operating income	**75,362**	**6,953**	**82,315**	**40,415**	**4,813**	**45,228**
Of which:						
Related to continuing operations			**82,315**			**45,228**
Related to discontinued operations			**-**			**-**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	4,947	3,802
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2020 £000	31 March 2019 £000
within one year	6,868	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**6,868**	**-**

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

Note 6.1 Fees and charges

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

	2019/20	**2018/19**
	£000	**£000**
Income	3,578	3,327
Full cost	(2,683)	(2,495)
Surplus / (deficit)	**894**	**832**

Note 7.1 Operating expenses

	2019/20 £000	2018/19 £000 restated
Purchase of healthcare from NHS and DHSC bodies	3,589	3,603
Purchase of healthcare from non-NHS and non-DHSC bodies	4,421	3,600
Purchase of social care	-	-
Staff and executive directors costs	416,847	380,662
Remuneration of non-executive directors	105	109
Supplies and services - clinical (excluding drugs costs)	38,075	38,249
Supplies and services - general	11,524	11,425
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	49,058	46,533
Inventories written down	-	-
Consultancy costs	2,882	4,363
Establishment	5,764	5,159
Premises	19,401	20,885
Transport (including patient travel)	4,330	4,272
Depreciation on property, plant and equipment	14,474	12,777
Amortisation on intangible assets	1,984	2,603
Net impairments	(6,151)	(9,741)
Movement in credit loss allowance: contract receivables / contract assets	1,409	1,201
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	(2)	97
Change in provisions discount rate(s)	214	(155)
Audit fees payable to the external auditor		
audit services- statutory audit	90	90
other auditor remuneration (external auditor only)	1	13
Internal audit costs	217	118
Clinical negligence	25,528	26,088
Legal fees	601	1,762
Insurance	56	345
Research and development	-	-
Education and training	1,242	865
Rentals under operating leases	273	196
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	32,052	30,954
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-
Car parking & security	-	-
Hospitality	95	52
Losses, ex gratia & special payments	-	-
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	1,301	1,979
Total	**629,384**	**588,104**
Of which:		

Related to continuing operations	629,384	588,104
Related to discontinued operations	-	-

In respect of the statutory audit of the financial statements for the year ended 31 March 2020, the Trust's auditor KPMG have been paid £76,012 (excl. VAT)

Note 7.2 Other auditor remuneration

	2019/20 £000	**2018/19 £000**
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	1	13
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	**1**	**13**

Note 7.3 Limitation on auditor's liability

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

Note 8 Impairment of assets

	2019/20	2018/19
	£000	£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	-	(652)
Loss as a result of catastrophe	-	-
Changes in market price	(6,151)	(9,089)
Other	-	-
Total net impairments charged to operating surplus / deficit	**(6,151)**	**(9,741)**
Impairments charged to the revaluation reserve	-	106
Total net impairments	**(6,151)**	**(9,635)**

Note 9 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	305,520	289,331
Social security costs	32,481	29,980
Apprenticeship levy	1,531	1,425
Employer's contributions to NHS pensions	47,316	31,016
Pension cost - other	82	44
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	189	-
Temporary staff (including agency)	29,728	28,946
Total gross staff costs	**416,847**	**380,742**
Recoveries in respect of seconded staff	-	-
Total staff costs	**416,847**	**380,742**
Of which		
Costs capitalised as part of assets	-	80

Note 9.1 Retirements due to ill-health

During 2019/20 there was one early retirement from the Trust agreed on the grounds of ill-health (one in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £114k (£101k in 2018/19).

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

Note 10 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The employer contribution rate for 2019/20 is 20.6%, and the scheme regulations were amended accordingly.

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

In addition to the NHS Pension Scheme the Trust offers the National Employment Savings Scheme (NEST), an additional defined contribution workplace pension scheme.

Note 11 Operating leases

Note 11.1 Barking, Havering and Redbridge University Hospitals NHS 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. The Trust leases ward space at King George Hospital to an NHS Foundation Trust until December 2019.
3. The Trust leases space at both hospitals to Barts Health NHS Trust for renal services
4. The Trust leases space at King George Hospital for GP services.
5. 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.

	2019/20	**2018/19**
	£000	**£000**
Operating lease revenue		
Minimum lease receipts	3,378	4,070
Contingent rent	-	-
Other	-	-
Total	**3,378**	**4,070**

	31 March 2020	**31 March 2019**
	£000	**£000**
Future minimum lease receipts due:		
- not later than one year;	43	43
- later than one year and not later than five years;	174	174
- later than five years.	1,866	1,823
Total	**2,083**	**2,040**

Note 11.2Barking, Havering and Redbridge University Hospitals

NHS 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

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	273	196
Contingent rents	-	-
Less sublease payments received	-	-
Total	**273**	**196**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	777	658
- later than one year and not later than five years;	1,996	1,933
- later than five years.	507	-
Total	**3,280**	**2,591**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	161	150
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**161**	**150**

Note 13.1 Finance expenditure

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

	2019/20	2018/19 restated
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	6,975	4,690
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	6	6
Main finance costs on PFI and LIFT schemes obligations	10,008	10,007
Contingent finance costs on PFI and LIFT scheme obligations	8,721	8,060
Total interest expense	**25,710**	**22,763**
Unwinding of discount on provisions	27	19
Other finance costs	-	-
Total finance costs	**25,737**	**22,782**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	6	6
Amounts included within interest payable arising from claims made under this legislation	6	6
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	3	-
Losses on disposal of assets	(2)	(65)
Total gains / (losses) on disposal of assets	**1**	**(65)**
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 financial assets mandated as fair value through OCI	-	-
Other gains / (losses)	-	-
Total other gains / (losses)	**1**	**(65)**

Note 15 Discontinued operations

	2019/20	2018/19
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**-**	**-**

Note 16.1 Intangible assets - 2019/20

	Licences & trademarks	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**263**	**16,185**	**979**	**-**	**17,427**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	1,372	**1,372**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	518	-	-	**518**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2020	**263**	**16,703**	**979**	**1,372**	**19,317**
Amortisation at 1 April 2019 - brought forward	**263**	**11,329**	**283**	**-**	**11,875**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	-	1,984	-	-	**1,984**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2020	**263**	**13,313**	**283**	**-**	**13,859**
Net book value at 31 March 2020	**-**	**3,390**	**696**	**1,372**	**5,458**
Net book value at 1 April 2019	**-**	**4,856**	**696**	**-**	**5,552**

Note 16.2 Intangible assets - 2018/19

	Licences & trademarks	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**263**	**14,466**	**979**	**-**	**15,708**
Transfers by absorption	-	-	-	-	**-**
Additions	-	1,719	-	-	**1,719**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2019	**263**	**16,185**	**979**	**-**	**17,427**
Amortisation at 1 April 2018 - brought forward	**263**	**8,726**	**283**	**-**	**9,272**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	-	2,603	-	-	**2,603**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2019	**263**	**11,329**	**283**	**-**	**11,875**
Net book value at 31 March 2019	**-**	**4,856**	**696**	**-**	**5,552**
Net book value at 1 April 2018	**-**	**5,740**	**696**	**-**	**6,436**

Note 17.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**32,320**	**243,186**	**9,782**	**1,765**	**97,541**	**-**	**24,442**	**6,583**	**415,620**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	2,300	-	19,206	3,850	-	-	17	**25,373**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	2,758	-	(7,515)	3,531	-	447	261	**(518)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(108)	-	-	-	**(108)**
Valuation/gross cost at 31 March 2020	**32,320**	**248,244**	**9,782**	**13,455**	**104,814**	**-**	**24,889**	**6,861**	**440,366**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**1,274**	**9,772**	**-**	**56,441**	**-**	**16,704**	**2,943**	**87,134**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,471	-	-	6,973	-	1,533	497	**14,474**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	(6,074)	-	-	(77)	-	-	-	**(6,151)**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(104)	-	-	-	**(104)**
Accumulated depreciation at 31 March 2020	**-**	**671**	**9,772**	**-**	**63,233**	**-**	**18,237**	**3,440**	**95,353**
Net book value at 31 March 2020	**32,320**	**247,573**	**10**	**13,455**	**41,581**	**-**	**6,652**	**3,421**	**345,013**
Net book value at 1 April 2019	**32,320**	**241,912**	**10**	**1,765**	**41,100**	**-**	**7,738**	**3,640**	**328,486**

Note 17.2 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**32,320**	**233,439**	**9,782**	**6,434**	**89,470**	**-**	**24,019**	**6,443**	**401,907**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	1,588	-	5,675	7,786	-	-	-	**15,049**
Impairments	-	(202)	-	-	(34)	-	-	-	**(236)**
Reversals of impairments	-	1,373	-	-	702	-	-	-	**2,075**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	6,988	-	(10,344)	2,792	-	424	140	**(0)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(3,175)	-	-	-	**(3,175)**
Valuation/gross cost at 31 March 2019	**32,320**	**243,186**	**9,782**	**1,765**	**97,541**	**-**	**24,442**	**6,583**	**415,620**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**5,376**	**9,772**	**-**	**53,084**	**-**	**14,514**	**2,455**	**85,201**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,709	-	-	6,390	-	2,190	488	**12,777**
Impairments	-	(0)	-	-	-	-	-	-	**(0)**
Reversals of impairments	-	(7,811)	-	-	-	-	-	-	**(7,811)**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(3,033)	-	-	-	**(3,033)**
Accumulated depreciation at 31 March 2019	**-**	**1,274**	**9,772**	**-**	**56,441**	**-**	**16,704**	**2,943**	**87,134**
Net book value at 31 March 2019	**32,320**	**241,912**	**10**	**1,765**	**41,100**	**-**	**7,738**	**3,640**	**328,486**
Net book value at 1 April 2018	**32,320**	**228,063**	**10**	**6,434**	**36,386**	**-**	**9,505**	**3,988**	**316,706**

Note 17.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020									
Owned - purchased	32,320	60,383	10	11,020	16,522	-	6,638	3,390	**130,284**
Finance leased	-	-	-	1,452	-	-	-	-	**1,452**
On-SoFP PFI contracts and other service concession arrangements	-	187,058	-	-	22,785	-	-	-	**209,843**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	983	-	-	-	-	**983**
Owned - donated	-	132	-	-	2,274	-	14	31	**2,451**
NBV total at 31 March 2020	**32,320**	**247,573**	**10**	**13,455**	**41,581**	**-**	**6,652**	**3,421**	**345,013**

Note 17.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019									
Owned - purchased	32,320	61,955	10	1,765	15,231	-	7,738	3,640	**122,660**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts & othr service concession arrangements	-	179,820	-	-	24,872	-	-	-	**204,692**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - Govt granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	137	-	-	997	-	-	-	**1,134**
NBV total at 31 March 2019	**32,320**	**241,912**	**10**	**1,765**	**41,100**	**-**	**7,738**	**3,640**	**328,486**

Note 18 Donations of property, plant and equipment

	£000s
Da Vinci Robot	1,605
KGH-Faxitron Bio vision	64
QH-Relative chairbeds	17
Touch screen PC and RITA for Dementia	18

Note 19 Revaluations of property, plant and equipment

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 31st March 2020 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 (ME*A*) 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 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 in any reduction in the asset value.

In 2019-20, 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.

Note 20.1 Investment Property

	2019/20 £000	2018/19 £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	**-**	**-**

Note 20.2 Investment property income and expenses

	2019/20 £000	2018/19 £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	-	-

Note 21 Investments in associates and joint ventures

	2019/20 £000	2018/19 £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)	-	-
Net impairments	-	-
Transfers to / from assets held for sale	-	-
Disbursements / dividends received	-	-
Disposals	-	-
Share of Other Comprehensive Income	-	-
Other equity movements	-	-
Carrying value at 31 March	**-**	**-**

Note 22 Other investments / financial assets (non-current)

	2019/20 £000	2018/19 £000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments		-
Carrying value at 1 April - restated	**-**	**-**
Impact of implementing IFRS 9 on 1 April 2018		-
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value through income and expenditure	-	-
Movement in fair value through OCI	-	-
Net impairments	-	-
Transfers to / from assets held for sale	-	-
Amortisation at the effective interest rate	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	-	-
Carrying value at 31 March	**-**	**-**

Note 22.1 Other investments / financial assets (current)

	31 March 2020 £000	31 March 2019 £000
Loans receivable within 12 months transferred from non-current financial assets	-	-
Deposits with the National Loans Fund	-	-
Other current financial assets	-	-
Total current investments / financial assets	**-**	**-**

Note 23 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".

Note 24 Inventories

	31 March 2020	31 March 2019
	£000	£000
Drugs	3,484	2,996
Work In progress	-	-
Consumables	12,543	12,556
Energy	108	128
Other	0	(0)
Total inventories	**16,135**	**15,680**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £75,049k (2018/19: £73,346k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Due to the outbreak of the COVID-19 pandemic, the Trust was not able to carry out the planned count and verification of inventories in significant areas of our hospitals. Where this was the case, the Trust has used the previous year's balances as proxy for the stock valuation in the current year.

Note 25.1 Receivables

	31 March 2020 £000	31 March 2019 £000 restated
Current		
Contract receivables	51,642	25,606
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(4,668)	(5,305)
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	10,810	8,381
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	900	900
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	1,856	1,153
Corporation and other taxes receivable	-	-
Other receivables	1,796	78
Total current receivables	**62,336**	**30,813**
Non-current		
Contract receivables	-	-
Contract assets	4,404	4,071
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Allowance for other impaired receivables	(748)	-
Deposits and advances	-	-
Prepayments (non-PFI)	1,151	1,069
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	1,184	-
Total non-current receivables	**5,991**	**5,140**
Of which receivable from NHS and DHSC group bodies:		
Current	41,001	16,614
Non-current	1,184	-

Note 25.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**5,305**	**-**	**-**	**10,405**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			10,405	(10,405)
Transfers by absorption	**-**	**-**	-	-
New allowances arising	1,409	-	1,201	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write offs)	(1,298)	-	(6,301)	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2020	**5,416**	**-**	**5,305**	**-**

Note 25.3 Exposure to credit risk

There is very little exposure to credit risk as the bulk of Trust funds are provided by the Central Government.

Adequate provisions are made for invoices and income raised to overseas patients in line with IFRS 9.

Note 26 Other assets

	31 March 2020 £000	31 March 2019 £000
Current		
EU emissions trading scheme allowance	-	-
Other assets	-	-
Total other current assets	**-**	**-**
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	**-**	**-**

Note 27.1 Non-current assets held for sale and assets in disposal groups

	2019/20 £000	2018/19 £000
NBV of non-current assets for sale and assets in disposal groups at 1st April	**-**	**24**
Transfers by absorption	-	-
Assets classified as available for sale in the year	-	-
Assets sold in year	-	(9)
Impairment of assets held for sale	-	(15)
Reversal of impairment of assets held for sale	-	-
Assets no longer classified as held for sale, for reasons other than sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31st March	**-**	**-**

Note 27.2 Liabilities in disposal groups

	31 March 2020 £000	31 March 2019 £000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

Note 28.1 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.

	2019/20	2018/19
	£000	£000
At 1 April	**12,060**	**3,249**
Prior period adjustments		-
At 1 April (restated)	**12,060**	**3,249**
Transfers by absorption	-	-
Net change in year	(3,516)	8,811
At 31 March	**8,544**	**12,060**
Broken down into:		
Cash at commercial banks and in hand	3	3
Cash with the Government Banking Service	8,541	12,057
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**8,544**	**12,060**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**8,544**	**12,060**

Note 28.2 Third party assets held by the Trust

Barking, Havering and Redbridge University Hospitals NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	-	-
Monies on deposit	2	2
Total third party assets	**2**	**2**

Note 29.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000 restated
Current		
Trade payables	20,562	20,859
Capital payables	5,879	4,530
Accruals	11,607	12,343
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
Social security costs	4,778	4,553
VAT payables	-	-
Other taxes payable	4,426	4,516
PDC dividend payable	-	-
Other payables	5,404	5,229
Total current trade and other payables	**52,656**	**52,030**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,324	5,883
Non-current	-	-

Note 29.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2020 £000	31 March 2020 Number	31 March 2019 £000	31 March 2019 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 30 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	4,589	4,947
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	243
Total other current liabilities	**4,589**	**5,190**
Non-current		
Deferred income: contract liabilities	3,213	3,638
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**3,213**	**3,638**

Note 31.1 Borrowings

	31 March 2020 £000	31 March 2019 restated £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from DHSC	247,779	66,951
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI, LIFT or other service concession contracts	11,522	11,566
Total current borrowings	**259,301**	**78,517**
Non-current		
Loans from DHSC	-	117,036
Other loans	-	-
Obligations under finance leases	1,452	-
Obligations under PFI, LIFT or other service concession contracts	200,230	209,598
Total non-current borrowings	**201,682**	**326,634**

Note 31.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**183,987**	**-**	**-**	**221,164**	**405,151**
Cash movements:					
Financing cash flows - payments and receipts of principal	63,319	-	-	(11,576)	**51,743**
Financing cash flows - payments of interest	(6,502)	-	-	(10,008)	**(16,510)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	1,452	2,163	**3,615**
Application of effective interest rate	6,975	-	-	10,008	**16,983**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2020	**247,779**	**-**	**1,452**	**211,752**	**460,983**

Note 31.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**117,435**	**-**	**-**	**247,216**	**364,651**
Prior period adjustment	**-**	**-**	**-**	**(22,586)**	**(22,586)**
Carrying value at 1 April 2018 - restated	**117,435**	**-**	**-**	**224,630**	**342,065**
Cash movements:					
Financing cash flows - payments and receipts of principal	64,624	-	-	(11,172)	**53,452**
Financing cash flows - payments of interest	(3,396)	-	-	(10,007)	**(13,403)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	634	-	-	-	**634**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	7,706	**7,706**
Application of effective interest rate	4,690	-	-	10,007	**14,697**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2019	**183,987**	**-**	**-**	**221,164**	**405,151**

Note 32 Other financial liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total current other financial liabilities	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total non-current other financial liabilities	**-**	**-**

Note 33 Finance leases

Note 33.1 Barking, Havering and Redbridge University Hospitals NHS Trust as a lessor

Future lease receipts due under finance lease agreements where the Trust is the lessor:

	31 March 2020	31 March 2019
	£000	£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	-	-

Note 33.2 Barking, Havering and Redbridge University Hospitals NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**1,452**	**-**
of which liabilities are due:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	1,452	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**1,452**	**-**
of which payable:		
- not later than one year;	-	-
- later than one year and not later than five years;	1,452	-
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as expense in the period	-	-

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**5,012**	**1,032**	**112**	**62**	**-**	**6,218**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**
Change in the discount rate	**214**	**-**	**-**	**-**	**-**	**214**
Arising during the year	**-**	**200**	**17**	**-**	**1,184**	**1,401**
Utilised during the year	(384)	(258)	(38)	(13)	-	**(693)**
Reclassified to liabilities held in disposal groups	**-**	**-**	**-**	**-**	**-**	**-**
Reversed unused	**(151)**	**-**	**(68)**	**-**	**-**	**(219)**
Unwinding of discount	**22**	**5**	**-**	**-**	**-**	**27**
At 31 March 2020	**4,713**	**979**	**23**	**49**	**1,184**	**6,948**
Expected timing of cash flows:						
- not later than one year;	566	237	22	13	**-**	**838**
- later than one year and not later than five years;	1,440	385	-	36	**-**	**1,861**
- later than five years.	2,707	357	1	-	**1,184**	**4,249**
Total	**4,713**	**979**	**23**	**49**	**1,184**	**6,948**

Note 34.2 Clinical negligence liabilities

At 31 March 2020, £533,422k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barking, Havering and Redbridge University Hospitals NHS Trust (31 March 2019: £515,359k).

Note 35 Contingent assets and liabilities

	31 March 2020	31 March 2019
	£000	£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	**-**	**-**

Note 36 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	1,887	3,320
Intangible assets	1,402	680
Total	**3,289**	**4,000**

Note 37 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2020	31 March 2019
	£000	£000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 38 Defined benefit pension schemes

Not Applicable

Note 38.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2019/20 £000	2018/19 £000
Present value of the defined benefit obligation at 1 April	**-**	**-**
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	**-**	**-**
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	**-**	**-**

Note 38.2 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 2020 £000	31 March 2019 £000

Present value of the defined benefit obligation	-	-
Plan assets at fair value	-	-
Net defined benefit (obligation) / asset recognised in the SoFP	**-**	**-**
Fair value of any reimbursement right	-	-
Net (liability) / asset after the impact of reimbursement rights	**-**	**-**

Note 38.3 Amounts recognised in the SoCI

	2019/20	**2018/19**
	£000	**£000**
Current service cost	-	-
Interest expense / income	-	-
Past service cost	-	-
Gains/(losses) on curtailment and settlement	-	-
Total net (charge) / gain recognised in SOCI	**-**	**-**

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

Note 39.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020	31 March 2019 restated
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**292,254**	**336,047**
Of which liabilities are due		
- not later than one year;	19,723	20,997
- later than one year and not later than five years;	71,395	65,632
- later than five years.	201,136	249,418
Finance charges allocated to future periods	(80,502)	(114,883)
Net PFI, LIFT or other service concession arrangement obligation	**211,752**	**221,164**
- not later than one year;	11,522	11,566
- later than one year and not later than five years;	44,875	48,336
- later than five years.	155,355	161,262

Note 39.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020	31 March 2019 restated
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,257,562**	**1,286,192**
Of which payments are due:		
- not later than one year;	63,674	61,985
- later than one year and not later than five years;	254,696	247,940
- later than five years.	939,192	976,267

Note 39.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000 restated
Unitary payment payable to service concession operator	**63,674**	**61,764**
Consisting of:		
- Interest charge	10,008	10,007
- Repayment of balance sheet obligation	11,576	11,172
- Service element and other charges to operating expenditure	29,560	29,694
- Capital lifecycle maintenance	2,300	1,588
- Revenue lifecycle maintenance	1,509	1,212

- Contingent rent	8,721	8,060
- Addition to lifecycle prepayment	-	31
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	983	48
Total amount paid to service concession operator	**64,657**	**61,812**

Note 40 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 arrangements:

	31 March 2020	31 March 2019
	£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	**-**	**-**

Note 41 Financial instruments

Note 41.1 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 6.0%. 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 2019 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.

Note 41.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	**Held at amortised cost**	**Held at fair value through I&E**	**Held at fair value through OCI**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	53,610	-	-	**53,610**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	8,544	-	-	**8,544**
Total at 31 March 2020	**62,154**	**-**	**-**	**62,154**

Carrying values of financial assets as at 31 March 2019	**Held at amortised cost**	**Held at fair value through I&E**	**Held at fair value through OCI**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	24,450	-	-	**24,450**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	12,060	-	-	**12,060**
Total at 31 March 2019	**36,510**	**-**	**-**	**36,510**

Note 41.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	**Held at amortised cost**	**Held at fair value through I&E**	**Total book value**
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	247,779	-	**247,779**
Obligations under finance leases	1,452	-	**1,452**
Obligations under PFI, LIFT and other service concession contracts	211,752	-	**211,752**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	43,452	-	**43,452**
Other financial liabilities	-	-	**-**
Total at 31 March 2020	**504,435**	**-**	**504,435**

Carrying values of financial liabilities as at 31 March 2019	**Held at amortised cost**	**Held at fair value through I&E**	**Total book value**
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	183,987	-	**183,987**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	221,164	-	**221,164**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	44,965	-	**44,965**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2019	**450,116**	**-**	**450,116**

Note 41.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	302,753	120,154
In more than one year but not more than two years	11,873	125,183
In more than two years but not more than five years	33,003	39,817
In more than five years	156,806	164,962
Total	**504,435**	**450,116**

Note 41.5 Fair values of financial assets and liabilities

Note 42 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	31	7	57	8
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	120	637	1,185	4,701
Stores losses and damage to property	-	-	-	-
Total losses	**151**	**644**	**1,242**	**4,709**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	3	4
Extra-contractual payments	-	-	20	10
Ex-gratia payments	18	10	6	-
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**18**	**10**	**29**	**14**
Total losses and special payments	**169**	**654**	**1,271**	**4,723**
Compensation payments received		-		-

Note 43 Gifts

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Gifts made	-	-	-	-

Note 44 Related parties

During the year none of the Department of Health Ministers have undertaken any transactions with the Trust. Similarly, no Trust Board members undertook transactions with the Trust via their limited liability companies.

	Expenditure **Payments to Related Party**	Income **Receipts from Related Party**	Payables **Amounts owed to Related Party**	Receivables **Amounts due from Related Party**
	£'000s	£'000s	£'000s	£'000s
Queen Mary University of London	1	20		5
The Human Tissue Authority	6			
NHS Confederation			9	

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*	241	376,868	3,408	5,481
Basildon and Brentwood CCG		23,550		439
Barts Health NHS Trust	1,748	1,219	559	2,234
Health Education England		15,990		
Homerton University Hospital NHS Foundation Trust	-22	134	110	82
Imperial College Healthcare NHS Trust	11	12	16	20
NHS Blood and Transplant (NHSBT)	25	32	23	
NHS Business Services Authority	16			
NHS England	14	150,170	2	29,655
NHS Resolution	25,529	323	1	2
NHS Property Services Limited	579	43	82	
North East London NHS Foundation Trust	1,013	1,890	266	378
North Middlesex University Hospitals NHS Trust	12	18	6	11
St George's University Hospitals NHS Foundation Trust	50	144	27	156
University College London NHS Foundation Trust (UCL)	-156	386	199	66
NHS Newham CCG		4,901		31
NHS Thurrock CCG		4,704		
NHS Waltham Forest CCG		2,342		14
NHS West Essex CCG		8,136		341

*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 £3,685k, expenditure of £2,269k, year end receivables of £68k, and payables of £1228k.

Note 45 Transfers by absorption

There has been no transfers by absorption in the year where the Trust has been either the receiving or divesting party.

Note 46 Prior period adjustments

There were no other prior period adjustments other than those already disclosed in Note 1.31.

Note 47 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £245m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 48 Final period of operation as a Trust providing NHS healthcare

Not applicable

Note 49 Better Payment Practice code

Note 49 Better Payment Practice code

	2019/20	2019/20	2018/19	2018/19
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	53,153	256,672	58,822	255,300
Total non-NHS trade invoices paid within target	49,603	244,272	51,757	233,084
Percentage of non-NHS trade invoices paid within target	93.3%	95.2%	88.0%	91.3%
NHS Payables				
Total NHS trade invoices paid in the year	3,439	16,278	4,276	16,806
Total NHS trade invoices paid within target	2,939	13,855	2,658	9,786
Percentage of NHS trade invoices paid within target	85.5%	85.1%	62.2%	58.2%

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

Note 50 External financing limit

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

	2019/20	2018/19
	£000	£000
Cash flow financing	59,201	48,216
Other capital receipts		
External financing requirement	**59,201**	**48,216**
External financing limit (EFL)	68,608	60,899
Under / (over) spend against EFL	**9,407**	**12,683**

Note 51 Capital Resource Limit

	2019/20	2018/19
	£000	£000
Gross capital expenditure	26,745	16,768
Less: Disposals	(4)	(151)
Less: Donated and granted capital additions	(2,686)	(80)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**24,055**	**16,537**
Capital Resource Limit	24,181	16,694
Under / (over) spend against CRL	**126**	**157**

Note 52 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(23,072)
Breakeven duty financial performance surplus / (deficit)	**(23,072)**

Note 53 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(22,281)	(32,986)	(49,913)	(39,492)	(37,754)
Breakeven duty cumulative position	(94,668)	(116,949)	(149,935)	(199,848)	(239,340)	(277,094)
Operating income		397,456	407,107	419,121	438,354	457,495
Cumulative breakeven position as a percentage of operating income		(29.4%)	(36.8%)	(47.7%)	(54.6%)	(60.6%)

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(37,950)	(33,719)	(10,874)	(48,977)	(72,219)	(23,072)
Breakeven duty cumulative position	(315,044)	(348,763)	(359,637)	(408,614)	(480,833)	(503,905)
Operating income	477,993	505,239	557,966	571,774	550,077	640,601
Cumulative breakeven position as a percentage of operating income	(65.9%)	(69.0%)	(64.5%)	(71.5%)	(87.4%)	(78.7%)

Note 54 Staff costs

	Permanent	Other	2019/20 Total	2018/19 Total
	£000	£000	£000	£000
Salaries and wages	273,119	32,401	**305,520**	289,331
Social security costs	27,923	4,558	**32,481**	29,980
Apprenticeship levy	1,499	32	**1,531**	1,425
Employer's contributions to NHS pension scheme	44,980	2,336	**47,316**	31,016
Pension cost – other	70	12	**82**	44
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	189	**189**	-
Temporary staff	-	29,728	**29,728**	28,946
Total gross staff costs	**347,591**	**69,256**	**416,847**	**380,742**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**347,591**	**69,256**	**416,847**	**380,742**
Of which				
Costs capitalised as part of assets	-	-	**-**	80

Average number of employees (WTE basis)

	Permanent	Other	2019/20 Total	2018/19 Total
	Number	Number	Number	Number
Medical and dental	958	196	**1,153**	1,092
Ambulance staff	1	-	**1**	3
Administration and estates	514	47	**561**	587
Healthcare assistants and other support staff	2,026	384	**2,410**	2,175
Nursing, midwifery and health visiting staff	1,984	436	**2,420**	2,327
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	543	56	**598**	570
Healthcare science staff	216	6	**222**	210
Social care staff	-	-	**-**	-
Other	8	-	**8**	14
Total average numbers	**6,250**	**1,124**	**7,374**	**6,979**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	1

Note 55 Reporting of compensation schemes - exit packages 2019/20

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	2	**2**
£10,000 - £25,000	-	5	**5**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	1	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**9**	**9**
Total cost (£)	£0	£189,000	**£189,000**

Reporting of compensation schemes - exit packages 2018/19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	7	**7**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	1	**1**
£100,001 - £150,000	-	1	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**10**	**10**
Total resource cost (£)	£0	£245,000	**£245,000**

Exit packages: other (non-compulsory) departure payments

	2019/20 Payments agreed	Total value of agreements	2018/19 Payments agreed	Total value of agreements
	Number	**£000**	**Number**	**£000**
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	5	122	10	245
Exit payments following Employment Tribunals or court orders	4	67	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**9**	**189**	**10**	**245**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-