Barking, Havering and Redbridge University Hospitals NHS Trust

Annual Report and Accounts 2020/21

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Barking, Havering and Redbridge University Hospitals NHS Trust

TAKING PRIDE IN YOUR CARE

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WELCOME FROM OUR CHAIR

In this, of all years, I have been reminded just how precious and important our staff are as they work, day in day out, providing care for the residents of our three London boroughs and those living in south west Essex. My colleagues have withstood two waves of the pandemic. Our boroughs and our hospitals were amongst the hardest hit in the country. Despite this, our staff carried on looking after patients while also dealing with the impact of the virus on their personal lives. On more than one occasion recently, I have gone onto wards to serve tea and to thank those who worked on the frontline throughout Covid-19.

I have been Chair of our Trust since December 2020 and I am indebted to Joe Fielder, my predecessor, for all the work he and other members of the Board have done which helped to ensure we were in as strong a place as we could have been to respond to the pandemic. And in the year we are reflecting on, our Trust didn't just have to deal with Covid-19. We were determined to try our level best, where we could, to continue to treat those with other illnesses. As the first Covid wave subsided there was no rest for our teams who had to restore the elective (planned) surgery we'd cancelled during the peak. The work we did then put us in a very good position earlier this year when, for a second time, we had an intense focus on our elective programme that continues to this day.

Our Trust's successes have to be balanced against the areas where we have challenges that are deep seated and well documented. In the last financial year, we didn't make the progress necessary on our performance against the four-hour emergency access standard; on our culture; or on our finances. We can do better, and we must as improvements will enhance patient experience and staff retention. When I joined our Trust, I made clear that among my top priorities would be the championing of equality, diversity and inclusion and resetting our ambition to tackle health inequalities.

We have talented staff at all levels of our Trust, but too many feel that the opportunities for career progression are not open to them due to race, faith, sexual orientation, gender or disability. Staff are our greatest asset and we must ensure that we create a culture where all can thrive. We will work with our staff networks over the year ahead and redouble our efforts to ensure that the Trust celebrates diversity and delivers opportunity for all.

Covid has shone a cruel light on the health inequalities that impact so negatively on many of the communities that we serve and so many of our staff live amongst. Over the year ahead we will work with our partners to ensure better access to our services for those most impacted by these health inequalities and transform our services to ensure more equitable clinical outcomes for those we serve.

Good health and well-being doesn't start in hospital, with poor health outcomes driven by many factors from educational opportunity, income and employment status to inadequate housing, poor air quality and discrimination. As one of the largest employers and biggest economic actors in north east London we have a moral obligation to play our part in tackling this. Last year we signed up to ensure that all our staff both in-house and contracted-out staff are paid the London Living Wage. Over the year ahead we will increase our investment in the skills and opportunities for local people, increase the proportion of services we buy from local businesses, and reduce our carbon footprint.

I am also Chair of Croydon Health Services NHS Trust and during eight years there I have had an unrelenting focus on bringing services together so that residents are better served, and staff have fresh and interesting employment opportunities. I have brought my learnings from the collaborative Croydon work to Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT), and it will be this closer working that will help us tackle the challenges I have highlighted.

We will transform the care offered to residents by our closer collaboration with Barts Health and with the Homerton. As well as working with our neighbouring acute providers, we must not lose sight of the critical importance of what we need to do to strengthen our relationships with our local partners. I want us to be a leading player in developing place-based health and care partnerships in each of our three London Boroughs of Barking and Dagenham, Havering and Redbridge.

As I look back, I am saddened by the number of lives lost to Covid-19 and I am humbled by the work of our staff. As I look forward, I am excited by the prospect of a future where we work closely with others to the benefit of all and I am proud to be playing my part.

Mike Bell
Chairman

FROM OUR CHIEF EXECUTIVE

This year has been like no other, with our lives utterly dominated by the Covid-19 pandemic, both professionally and personally.

As always, I have continued to be amazed by the dedication and commitment of our staff. Their resilience, their compassion and their innovative approach in responding to the virus have been nothing short of phenomenal.

I joined the Trust just weeks before the pandemic was declared, and I'd like to thank our previous Chair, Joe Fielder for his support. His leadership and his strengthening of relationships across our health and care system meant we were able to respond in the way that we did.

I would also like to thank system colleagues for their support – it has been a demonstration of collaborative working at its best and highlights what can be achieved when we work together as one team with the patient at the heart of all our decision-making. Our partners are, without a doubt, part of #teamBHRUT.

There are so many examples of how we have responded innovatively to what has been an ever changing situation – these have included developing a unique, multi-disciplinary training programme for redeployed staff to support critical care; increasing our critical care capacity five-fold; and implementing, at speed, an oxygen receiving unit.

Throughout, teamwork has underpinned these successes, with traditional boundaries and ways of working transcended as we focused on keeping our patients and staff safe. Whilst we can never overestimate the scale of the tragedy and the toll it has taken on our staff, there are a multitude of positive learnings to carry forward. Our hospitals have been transformed and in the words of our staff, there is 'no going back'.

I continue to be no less impressed with their achievements as we press ahead with our recovery programme. Our two vaccine centres, one at each site, have been a huge success, with tens of thousands of community, health and social care staff receiving their vaccines in our hospitals.

Flexibility, agility, pace and innovation will remain our constants - our golden threads – throughout recovery and beyond, coupled with the reality that infection, prevention and control guidelines will continue to influence the pace of our recovery.

King George Hospital has been transformed into our elective centre, lending itself well to the necessary zoning to mitigate any spread of infection and very much being front and centre in tackling our waiting list position. I am confident that whilst it will be hard, we will make significant headway. We are helped in this endeavour by our work with our system partners to effectively use our combined capacity and we have held innovative projects, such as our BHRUT Orthopaedic NHS Elective Surgery (BONES) week, which saw 250 patients get the surgery they needed in one seven day period.

It goes without saying that it is not just our residents we need to care for – the recovery and wellbeing of our staff is also paramount. I could not be prouder of my colleagues and alongside a raft of supportive measures implemented during the year - such as seven day a week access to psychologists and wellbeing hubs at both hospitals - my Board colleagues are committed to continuing to improve these resources and the overall staff experience. I'm delighted with new initiatives that have taken place, including a special Thank You Week to celebrate and recognise our staff, and a first ever apprenticeship scheme to further the careers of those working on the frontline who were unable to undertake their nursing degrees early on in their lives.

As we develop our plans for the months ahead, my Executive colleagues and I remain committed to improving our four hour performance against the emergency access standard and our financial

position. We will learn from the transformative ways of working we have seen throughout the year.

Whilst we have a long way to go, I do believe we have a better understanding of where the issues lie and we will use The PRIDE Way methodology (Passion, Responsibility, Innovation, Drive, Empowerment) to help address these. Crucially, it will support a change of mindset from 'quick fix' to one that seeks and encourages sustainable change. In this way we will make a real difference to the lives of the residents we serve.

Tony Chambers
Chief Executive

OUR YEAR IN PICTURES

Staff in our Intensive Therapy Unit working together to treat a Covid-19 patient.

Hundreds of our staff were redeployed from their normal jobs to help on the frontline. Callum Oubridge took up four different roles, including in our supplies team.

During the first peak last April, this recovering Covid-19 patient was taken outside to receive one of the greatest therapies available to us, the sun!

Local companies were very generous in supporting our staff during the first wave, with thousands of pizzas among the meals donated to us.

We started our “tree of life” for patients to add a bee to when they recovered from coronavirus.

Patient Steve Attfield being reunited with his wife Gemma after a 70-day stay in our hospitals. Steve, Gemma, and their dog were featured on ITV London last summer after he returned home.

We recruited more than 100 second- and third-year student nurses to help us on the frontline during the pandemic. Louise Morrison was one of those and said she was grateful for the experience.

This lovely makeshift display was installed outside Queen's Hospital – one of a number of ways the local community showed their support for our staff.

Two members of our staff, Leigh Kaniklides and John Tear, had been due to get married in June 2020 but their wedding was cancelled due to the pandemic and they came into work instead. Their colleagues helped them mark the day anyway with a special lunch.

Covid-19 patient Anil Patel was discharged after spending 149 days in our hospitals. After recovering at a rehabilitation centre, he returned home in time for his daughters' birthdays.

We played our part in the Covid-19 vaccine rollout, with dedicated vaccination hubs at both Queen's and King George hospitals. Radiology support worker Sunny Choudhary was the 5,000th person we inoculated, winning the milestone box of chocolates!

SECTION 1 - PERFORMANCE REPORT

OUR PERFORMANCE REPORT

This section provides an introduction to Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) including an outline of the purpose and activities of the organisation and a brief description of the business model and organisational structure throughout 2020/21. In addition, the Chief Executive's perspective of performance during the year including whether performance has met expectation and an overview of the circumstances where they were not is provided at page 16. Key issues and risks to the delivery of our principal objectives and the steps taken to mitigate those risks are included in the Annual Governance Statement on page 74.

About Us

With a dedicated workforce of more than 7,500 staff and volunteers and an income of £750m, Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) is one of the larger acute trusts in the country.

It provides care for a population of about 750,000 people across north east London (NEL), and that number is predicted to increase by 15 per cent over the next ten years.

The Trust serves three London boroughs with diverse populations, and more than half of its workforce identify as black, Asian and minority ethnic. In addition, eight out of every ten employees are women, and a majority of its workforce live within the host boroughs of Barking and Dagenham, Havering, and Redbridge.

BHRUT also provides healthcare services to people in south west Essex, and specialist neurosciences services to the whole of the county.

The Trust covers all the major specialties of large acute hospitals, operating from two main hospital sites - King George Hospital in Goodmayes and Queen's Hospital in Romford. It also provides a number of outpatient services at Brentwood Community Hospital, Barking Hospital, Loxford Polyclinic and Harold Wood Polyclinic. It has one of the busier emergency departments in London; in 2019/20 emergency and urgent attendances (Type 1 and 2) were 189,518 and it saw nearly 65,000 ambulance arrivals at both sites.

Over recent years, the Trust has made significant improvements to the quality of care it provides patients. It is currently rated 'Requires Improvement' by the Care Quality Commission. In early 2018, the Trust entered Financial Special Measures. A Financial Recovery Plan is in place to deliver the financial savings required over the coming years.

Like other trusts across the country, Covid-19 meant it had to transform, overnight, the way it cared for patients and delivered services. Collaborative working with system colleagues ensured a long Covid clinic was set up that is proving invaluable in supporting the on-going needs of residents. During the vaccine rollout, King George Hospital was designated a vaccination centre and was established and launched in seven days.

The Trust is making good progress as it responds to the needs of those people whose treatment was delayed by the virus. It has much work to do to improve waiting times for urgent and emergency care. Performance against the four-hour emergency access standard remains challenging in comparison to most other London trusts.

BHRUT is proud of its regional Neurosciences Centre; Radiotherapy Centre; Hyper Acute Stroke Unit; and dedicated breast care service at King

George Hospital. It is also pleased to be part of the North East London Cancer Alliance.

As well as having a Hyper Acute Stroke Unit at Queen's Hospital, the stroke service has transformed from being 'D' rated to the highest possible 'A' rating. The improvements that have taken place have included changing stroke consultants' working patterns to match demand; involving the entire team in improvements to give them ownership; and introducing a virtual ward that allows patients, where appropriate, to receive care and support in their own homes. The service was highly commended in the Quality Improvement Initiative of the Year category of the 2020 HSJ Patient Safety Awards.

In 2017, the Trust unveiled one of the UK's first Halcyon radiotherapy machines, which is just one example of the cutting-edge treatment it now offers patients. It also provides Ethos therapy, which uses artificial intelligence to tailor treatment to patients' changing daily anatomy (in terms of their tumour's shape and position).

BHRUT offers staff the opportunity to train to become nurses, while continuing to work full-time in its hospitals. This pioneering Registered Degree Nursing Apprenticeship is transforming lives – and helping to reduce shortages – by supporting staff who wish to progress to become nurses but who were unable to undertake the usual degree route after leaving school. Growing the nursing workforce through this route is just one of the ways the Trust has reduced its nursing vacancies and improved retention rates.

Overview

2020/21 has been a year like no other in living memory, from the first wave of Covid infection which began in March 2020, through a summer and autumn of hope that we had seen the worst of it, on to a winter that many would prefer to forgot whilst at the same time the golden thread of a vaccine that offered a chance for a return to something approaching normal.

Clinical operations at BHRUT were so fundamentally different for the last 12 months that drawing conclusions about the performance of the Trust from a set of national benchmarks misses some of the more salient points. This includes the fact that more than 4,000 of those we treated recovered and went home, which is a considerable achievement for our staff who have had to contend with so much.

This report includes data about performance against previous years which are not comparable due to the extraordinary circumstances of the last 12 months. They are provided as required but come with a caveat that it is not possible to draw conclusions from them in isolation.

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.

Elsewhere in the Annual Report we have referred to a number of initiatives aimed at addressing this challenge including the Whole Hospital Improvement plan, the considerable levels of investment in our ED departments and frailty unit, as well as new investments in critical care and a paediatric assessment unit, all of which will create the correct environment for improving hospital flow and as a consequence the amount of time that patients spend in our Emergency Department.

Our 18-week Referral To Treatment performance declined significantly as elective surgery was halted during the pandemic, falling from 77.6% to 57.6%.

We have started to resume services – in surgery, diagnostics and outpatients – that we had to pause during the height of the second wave. All planned (elective) work at both hospitals stopped at the end of last year so that staff could be redeployed to Covid wards. Face to face outpatient appointments

were limited to urgent ones and 2 week wait cancer appointments.

Endoscopy is now back at Queen's; cancer and urgent diagnostic endoscopies have continued at King George Hospital; and, towards the end of last month, some of our higher priority planned surgeries resumed.

The challenges we face are considerable and we will be helped by the fact our recovery programme will be aligned with others across NEL and we will work with partners including GPs and the North East London NHS Foundation Trust (NELFT). After the first wave, we spent three months reducing our numbers waiting more than 52 weeks. It took just three weeks, during the second wave, for it to return to the level it was at before our remedial work had begun last summer. We now have more than 2,000 patients in this category.

Our initial focus, for the next three months, will be on clearing our backlog of priority patients (known as P2 patients). Our target, for the end of May was to be at 70 per cent of the business-as-usual activity we achieved in the same month, two years ago and this was achieved.

Performance against the cancer standards has been challenging this year. We did not meet the 31 day standard for the full year with 93.9% of our patients receiving a diagnosis and first definitive treatment within 31 days (against a target of 96%). We also did not achieve the urgent referral within two weeks standard (87.0% against a target of 93%), predominantly as a consequence of the first wave of Covid where performance dropped to 59.4% before recovering to meet the standard in the last 2 quarters of the year. The intention is to look to provision of additional capacity to address the backlog of diagnostics to minimise the impact arising from diagnostic delays.

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 as the country begins to recover from the pandemic. 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.

We had three 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 have not achieved our targets for staffing fill rates of nursing staff due to the circumstances of the pandemic and we are still 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.

Tony Chambers, Chief Executive
13 July 2021

OUR 2020/21 OBJECTIVES

HIGHLY RELIABLE HOSPITALS - PROVIDING SAFE & EFFECTIVE SERVICES

- Deliver a GOOD rating in the next CQC assessment and work towards an OUTSTANDING rating in at least one domain.
- Develop a highly reliable performance culture
- Respond to on-going Covid-19 pandemic – minimising excess mortality and morbidity whilst maintaining as near normal elective programme in both Covid-19 peaks and troughs
- Deliver a GOOD rating in the next 'Use of Resources' Assessment

HAPPY AND HEALTHY HOSPITALS - TO BECOME THE HAPPIEST AND HEALTHIEST HOSPITALS IN THE UK

- Develop a consistent environment which enables our staff to be happy and healthy at work
- Improve the inclusivity across the organisation in partnership with our staff networks, focusing on developing our people processes, policies, leadership diversity and talent management to be truly inclusive and supportive of the diverse needs of our people
- We aim to learn and improve our services by ensuring the patient voices are heard and underpin and drive positive service improvement for all patients and their families

PARTNERSHIPS WITH PURPOSE - SUPPORTING OUR PARTNERS & POPULATION

- Accelerating 'Integrated Provider' borough-based partnerships
- Proactive engagement in the North East London Health and Care Partnership
- Working with our partners across health and social care, begin to develop a BHR Health and Social Care Academy to support joint efforts in recruitment and retention, workforce development talent management.

A YEAR LIKE NO OTHER

On 23 March 2020 the World Health Organisation officially declared a Covid-19 global pandemic.

Since then we have witnessed unprecedented tragedy, with this last year having touched the lives of each and every one of us, and seen the NHS face its greatest challenges since inception in 1948.

Yet at the same time, we have witnessed incredible transformation across our hospitals as we learnt to navigate an ever evolving set of circumstances.

Thanks to what was nothing short of phenomenal dedication, commitment and professionalism, teams in all areas of health and care rallied together. Almost overnight, many positive changes and improvements were made in response to the crisis, including increased levels of digitisation, rapid reconfiguration of services, innovative workforce re-design, agile decision-making and increased collaboration to keep our patients and each other safe, and provide the very best care possible.

In April 2020 alone we converted thousands of clinics, holding 5,700 appointments over the phone to ensure only the very sickest of our patients needed to come into our hospitals. Alongside this we have held more than 8,600 video appointments since the launch of 'Attend Anywhere'.

Our cancer and trauma patients were treated in nearby 'Covid-free' sites thanks to the collaborative work undertaken with the Independent Sector, just one example of partnership working at its best. Across the system, organisations responded together, from developing new pathways to improve discharges into the community to addressing capacity to support recovery, rather than as isolated entities.

Working agilely, we were able to flex our ward space as needed; at one point during the first peak, 20 wards were transformed to care for Covid-19 patients. In addition we achieved a five-fold increase in our critical care capacity, an extraordinary achievement; those same teams also succeeded in setting up a critical care renal dialysis unit in just ten days, after emerging evidence showed the impact on patients as a result of the virus.

During the second wave the flow of oxygen became a national issue and our innovative teams converted our frailty unit at King George Hospital into an oxygen receiving unit to enable us to manage such huge demand. The oxygen demand had greatly increased in the second wave because of improved patient ventilation procedures which required much more oxygen. In part this was supported by a previous upgrade to our systems, and a second upgrade has since taken place, offering further resilience against future waves.

Seeing our patients recover from Covid-19 and leave our hospitals has been incredibly motivating for our staff and many videos and images are in circulation of them placing bee stickers on our trees of life, a milestone in their astonishing journey. For those suffering from what we now term as long Covid, we have been collaborating with our partners to set up a dedicated multi-disciplinary clinic to support their on-going needs.

Not only have our patients faced the trauma of their illness, they have often had to do this alone, due to the necessary visitor restrictions in place to minimise footfall in our hospitals. Our staff have done everything they can to support patients and their families during these distressing times, borne out by the success of our Thinking of You service which has seen 3,655 thinking of you messages and 174 get well messages to patients without relatives being shared.

Towards the middle of the year, visitor restrictions started to ease a little, and services that had previously been paused were slowly re-introduced, the pace dictated by rigorous infection, prevention and control guidance that will continue to dominate for many more months to come.

King George Hospital became our centre for elective work, lending itself to the zoning required to protect patients and staff from the spread of infection.

Understandably we saw a dramatic drop in attendances at our Emergency Departments and as planned (elective) surgeries and procedures have restarted, many patients declining to come in. We are continuing to work with partners, and with community leaders and groups, to impress the importance of our local people getting the care they need and the safeguards we have implemented to protect them.

No one has been untouched during the pandemic, not least our staff - the toll this has taken on them, from so many being redeployed to new areas, to facing immeasurable tragedy on a daily basis through to the personal sacrifices they made, cannot in any way be overestimated.

The need for physical and mental support was recognised very early on in the pandemic and a raft of measures were rapidly introduced. Dedicated wellbeing hubs were established across our hospital sites, seven day a week psychological support was made available from a team of psychologists, and 'Let It Out' sessions providing a safe space for teams to process their experiences, were just the beginning.

Over the year this has continued to be one of our key Trust priorities, with a Recovery Champion course piloted and Psychological First Aid courses being rolled out, as well as plans put in motion for a week of thanking, recognising and celebrating our staff in April 2021.

Food and drink offers have been greatly improved, staff rest areas are being refurbished and other tangible ways we show we care for our staff will continue to be placed front and centre during and after our recovery.

The support our staff received from across our boroughs has been 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 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. They also co-ordinated an initiative to bring in extra scrubs for our staff.

We will be living with the impact of the pandemic for some time to come. Our hospitals bear little resemblance to those of a year ago. Our staff are tired and exhausted. Yet the pandemic has given us an

opportunity to see how differently we can do things and we will seek to retain the positive changes. In the words of our staff, there is 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 a considerable proportion 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 considered 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.

HIGHLY RELIABLE HOSPITALS - PROVIDING SAFE & EFFECTIVE SERVICES

Deliver a GOOD rating in the next CQC assessment and work towards an OUTSTANDING rating in at least one domain.

Develop a highly reliable performance culture

Respond to on-going Covid-19 pandemic – minimising excess mortality and morbidity whilst maintaining as near normal elective programme in both Covid-19 peaks and troughs

Deliver a GOOD rating in the next 'Use of Resources' Assessment

A new BHRUT – working in partnership to improve health and care

We need to re-imagine the role of modern acute hospitals and our relationship with the populations we serve.

Covid-19 has had a devastating impact on Barking Havering and Redbridge (BHR), three London boroughs where deprivation and inequality are significant factors. Our hospitals have witnessed unprecedented pressure as we've dealt with two significant surges in demand caused by the virus. The long-term impact on our staff, who have responded phenomenally well, isn't yet fully known. They are exhausted and we are asking for more.

Change, against the backdrop of a pandemic, won't be easy. But change – where we build on recent collaboration – and establish, for example, better children's services across North East London (NEL) is an exciting prospect.

It is our duty to strive to provide improved health and care. The latest reforms planned by the government are designed to ensure health and care services work more closely together and for the NHS, in the words of the Health Secretary, to become "more integrated, more innovative and more responsive".

Closer working with Barts Health

The pandemic brought NHS organisations and partners across north east London more closely together than ever before in responding to Covid, for the benefit of our patients and residents. In particular, the Trust worked closely with the Barts Health group to co-ordinate care for critically ill Covid patients and those with urgent and emergency needs, including transfers between hospitals.

Building on the strong foundation of co-operation between our clinicians, and working closely with our partners at borough level, we are now keen to step up the pace of collaboration to deliver further improvements for our patients, staff and communities. These include the experience of urgent and emergency care, reducing backlogs for planned operations, and tackling the inequalities widened by Covid.

Under the umbrella of our integrated care system (ICS), we are developing a joint view on enabling greater cohesion between the two trusts and talking to as wide a range of staff and stakeholders as possible to inform our discussions. We aim to come to a broad agreement on a model that maximises the strengths of all our hospitals while delivering added benefits for our local communities.

Our closer working relationships are endorsed by national policy, as set out in the recent White Paper proposals for provider collaboratives working in partnership with local government and others within each local ICS.

In the light of this, the Boards of the two trusts will in future be led by the same chair, who will be responsible for taking forward the deeper collaboration and determining the next steps. NHS England is now advertising for a “chair in common” through the normal open public appointments process, which is expected to conclude by August. The two trusts will remain separate statutory bodies.

Staff redeployed to support colleagues:

479

3,655

Thinking of you messages

174

Get well messages

New wellbeing hubs at both our hospitals

250 patients operated on in

7 days

during our 'BONES' perfect week

6,004

donations received from our communities

More than **100**

Let It Out sessions to support our staff's wellbeing

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.

Care Quality Commission (CQC) Report 2020

Throughout the pandemic, the CQC's regulatory role did not change; their core purpose to ensure that the public receive safe, effective, compassionate and high-quality care has remained at the centre of their activities. In March 2020, the CQC paused routine inspections and focused their activity where there was a risk to people's safety. Throughout the year they have continued to only undertake inspection activity where there were serious risks to people's safety or where it supported the health and care system's response to the pandemic.

All Divisional CQC improvement plans are monitored by the Divisional Directors of Nursing with Executive oversight and scrutiny provided by quarterly CQC quality summits. Quality huddles are held weekly (pandemic allowing). During this meeting Ward Leaders report to the Chief Nurse on improvement against their individual ward/department Key Lines Of Enquiry (KLOE's) pertinent to their areas and progress against their CQC improvement plans.

Additionally, the Emergency Division who were inspected by the CQC in January 2020 have undergone a programme of enhanced corporate support, ensuring close monitoring of improvement actions to ensure they are being sustained even during times of surge and throughout the pandemic. Compliance against their improvement plans moved to a monthly Urgent & Emergency Care Governance and CQC Quality Improvement Board, this will be jointly chaired by the Chief Nurse and Divisional Director/Emergency Care.

The Trust has been advised that the CQC's next inspection would be to maternity services, but a formal timeframe was not yet able to be given.

Quality and Safety

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.

Incident reporting rates have returned to pre-pandemic levels with good levels of reporting within the organisation. There were 48.42 incidents reported per 1,000 bed days in March, with 71.42% being recorded as no harm. The Trust met with the CCG to discuss the governance arrangements for the management of the 12-hour breaches and 60 minute off load incidents that have occurred during the Covid pandemic.

All serious incident (SI) investigations are paused until 1 April 2021. The Trust continues to declare SIs and Never Events at the time of identification to ensure that immediate learning and actions were shared with staff in order to prevent reoccurrence of incidents. 14 Serious Incidents were declared in March.

Patient Acuity

A significant increase in patient acuity during the Covid-19 surge resulted in an increase in required care hours for each patient (known as care hours per patient day CHPPD). This gradually reduced during March however, cover for duties was impacted by the rate of staff sickness which included shielding absence. Cover for these duties has been met from redeployment of clinical staff (a key workforce hub function), staff undertaking additional duties via the Trust temporary staffing function and external agency use. There will be a continued focus on staffing across the organisation in line with the recovery programme. The central coordination of international and local recruitment to nursing vacancies is highly successful and will continue.

Never Events

Never Events (NE) are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers (NHS Improvement, 2018). Never Events are incidents that require investigation under the Serious Incident framework (NHS Improvement, 2015).

We aimed to declare zero Never Events within the organisation, however we declared three incidents during the year.

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 2020/21 period we aimed to reduce pressure ulcers by 3% and have zero category 4 acquired pressure ulcers. Due to the nature of Covid we did not achieve these goals. The number of hospital acquired pressure ulcers that occurred were in the following categories:

- 168 category 2 (2019/20: 101)
- 19 category 3 (2019/20: 4)
- 11 deep tissue injuries (2019/20: 3)
- 1 category 4 acquired pressure ulcer (2019/20: zero)

There had been an increase in pressure ulcers firmly related to Covid-19 and work is underway to review this. Local learning has been shared at ward huddles in cases where a hospital acquired pressure ulcer has occurred.

A task and finish group has been formed to undertake thematic analysis of device related incidents which occurred while nursing patients with COVID-19. It is anticipated that the thematic reviews and action plans generated from these will be completed during quarter 2 of the 2021/2022 year.

Tissue Viability training to address common themes for hospital acquired harm will recommence from 1 April 2021, alongside ward based huddles when harm is identified. The Trust will recommence ward and online education programmes to ensure our staff have the skills and knowledge to provide safe and effective care to our patients.

Falls

Falls are a serious problem among older people. As 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 Trust wide. Analysis is undertaken regarding 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.

During the year there were 8 falls resulting in moderate harm (2019/20: 23), 11 falls resulting in severe harm (2019/20: 11) and no falls resulting in catastrophic harm (2019/20: 1).

Staff members are required to complete our Falls e-learning package every 3 years.

Infection prevention and control

The impact of Covid-19 on the Trust's hospitals and the changes necessary to manage and control the spread of the infection have been profound. The Trust Board received regular self-assessment against the Infection Prevention Control Board Assurance framework for Infection Prevention and Control in light of the Covid-19 pandemic.

There were 26 cases of C-Difficile during the year (2019/20: 27) and 7 cases of MRSA (2019/20: 3).

There has been significant work undertaken by the organisation to develop clinical pathways for patients presenting with Covid-19. This has been underpinned by operational agility, education and training and rapid implementation of relevant guidance including that which related to Infection Prevention and Control.

A particular focus has been on the provision of PPE with clear guidance and training for staff in all areas. Through the Gold Command structure daily reporting on procurement and provision of PPE has been made. Potential shortages have been mitigated through collaborative working across the sector.

The self-assessment provided assurance against 10 domains:

- Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks

posed by their environment and other service users.

- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
- Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide or secure adequate isolation facilities.
- Secure adequate access to laboratory support as appropriate.
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Ward Accreditation Programme

During 2019/20, the development of the ward accreditation programme enabled 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 programme was paused during the current year, but the Trust will re-launch it as part of the recovery of hospital services in 2021/22.

61,066

Vaccinations delivered in our hubs

Babies born at our Trust:

6,893

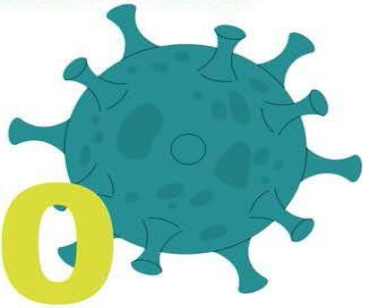
24

Covid wards during the second wave

We increased our critical care capacity by

5 fold

More than



500

Covid-19 inpatients at the peak

210,137

Emergency Department attendances

King George and Queen's Hospitals Charity

King George & Queens Hospital Charity is the official registered charity supporting King George Hospital in Ilford and Queens Hospital in Romford. The Charity has a clear focus - it works alongside and in support of hospital staff, patients and visitors. The Charity raises funds to supply the extras that fall outside NHS budgets, but which are guaranteed to enhance the hospital journey for all.

Funds are usually raised through a platform of events, campaigns and from generous donations made by grateful patients. The Charity is the custodian of all charitable funds. Expenditure and investments are overseen by the enrolled members of the Charitable Funds Committee and the Charity Chair, and all Committee meetings are noted and reported to the Trust Board. The Committee meets bimonthly to discuss requests.

Supporters are encouraged to donate where the need is greatest. However, funds can also be restricted for specific departments, wards or for a project in accordance to the donor's wishes. The Charity is careful not to subsidise NHS budgets but aims to enhance and add to the services already provided.

Expenditure falls into four main areas:

- Innovation in medical equipment
- Information & technology
- Comfort and the hospital environment
- Research & training

In the spring of 2020, the country went into lockdown and everything the Charity had been working on for the year ahead was cancelled.

Overnight the Charity staff became a logistics team with the responsibility of managing and distributing the daily mountain of goodwill gifts that came in from the public in an extraordinary show of support for NHS staff. Everything from pizzas to designer toiletries and clothing were donated and were very gratefully received.

As many charities closed their doors the hospital Charity was on full alert. Phones were ringing off the hook with offers of support. Funds came from different sources and some regular local funding transferred to the NHS Charities Together appeal fund who had also received funds from Sir Captain Tom Moore. Where the planned trajectory was forgotten, funding that came back from NHS Charities Together replaced lost income and happily the Charity was able to report an income of £1.27m which was very close to its original aspirational target.

During the year the Charity provided medical equipment in the form of electrocardiogram machines, LED vein finders, Magnetic Phantom for Radiology, as well funding a new research programme including staff costs and uniform. The main Oncology waiting room was completely refurbished and also one of the complementary therapy rooms. A Peripherally Inserted Central Catheter (PICC) line service was funded for the cancer unit and Neonatal Intensive Care Unit (NICU) received new mother and baby reclining chairs. A young adult's cancer counselling room was created and furnished in retro style and Medical Photography received new photographic equipment. Instalments were also still being paid against the Robotic Arm purchased during 2019/20 and funds are set aside for a Home First project planned for summer 2021.

DEAN'S STORY

One of our cancer patients, who has been given the all clear following a 19-hour operation, has spoken of his gratitude to the staff at our Trust who treated and looked after him.

Dean Watson, 39, of Chigwell, underwent the remarkable, life-saving procedure at Queen's Hospital last month when his cancer recurred and very quickly became quite advanced. Speaking of the first time he noticed symptoms, Dean said: "I had two tumours on my back passage but initially they weren't too big. I kept thinking hopefully in due time it will just disappear but I realised it was only getting worse."

"I went to my GP and they referred me to the hospital. They did some scans and within a week or two I got a phone call saying it was cancer. When I first heard the news, I was really, really upset because I'd had so much time to deal with it. If I'd gone to my GP when I first noticed the symptoms, it wouldn't have got as bad as it did."

Dean was initially cautious about undergoing a major operation and the decision was made to try other treatments first.

"I'd undergone chemotherapy and radiotherapy and the cancer had gone. I was happy about that and I went back to my normal life. I got a phone call about six months down the line asking me to come in. They did another MRI scan and discovered that the cancer had come back. I was devastated."

Dean met with Niroo Rajendran, our Consultant Colorectal Surgeon, who led the complex operation.

"Mr Rajendran always said to me that I'm way too young for this to be happening to me," Dean said. "When he explained the operation to me, I felt sick to my stomach because it was a lot to take in. But I knew I had no other option so I said 'yes, let's do this. I knew it wasn't going to be easy and (the chance of getting the all clear) wasn't 100 per cent. I had to come into the hospital a few weeks before my operation because my symptoms and my pain were so unbearable. I couldn't sit down on my bottom, I couldn't walk around, I couldn't do anything. I was just in unbearable pain."

The procedure started at around 8am on Friday 5 February and it finished at 3am the following day, with many of the staff involved staying the length of the procedure. Dean received the results a couple of weeks

later and was elated to discover that he'd been given the all clear.

"I was delighted, I was so happy when I heard the news. Even having that operation was no guarantee that (the cancer) was going to go. Mr Rajendran and his team, the nurses on the ward, they've been very good to me. I would like to say thank you to everyone who has looked after me."

Niroo said one of the reasons the operation was a success was down to the excellent teamwork by different teams across our Trust. He said: "Other than the operation itself, there was no outside pressure or stress. Some of the theatre team was shuffled around and swapped on the morning of the operation. They would have come to work expecting a normal day and they stayed until the end for the patient so that was fantastic and really kind of them. The juniors were really keen - not just interested from a training point of view but also to see the whole operation through."

"The anaesthetist, Dr Ayad Khalil, stayed the whole day. I rang him before and made sure he was aware and okay with doing a long procedure. You need an anaesthetist who can transfuse you appropriately and keep a level head and Dr Khalil was excellent. The radiologist was phenomenal as well. We used a radiologist from St Mark's Hospital (in west London) so there were quite a few phone calls to them beforehand to plan the operation. There was also a lot of work outside the operating theatre to make it possible. Julie Wright, Interim Divisional Director of Nursing for Surgery, was really helpful in making sure there was going to be an ITU bed for the patient and she also advised the transfusion nurse, drawing on her own experiences."

"I would like to say thanks to Sister Aminat in theatres, who came in very early to make sure there were no delays starting a long case, and to Sister Imelda. The ward staff who have been looking after the patient since have been very good as well, they deserve a lot of credit for their efforts since the operation. There was a great camaraderie and spirit in the theatre. It was phenomenal. It made me feel really happy to work here!"

This operation was one of the longest ever carried out at our Trust but, with advances in the treatment on offer to patients, Niroo believes it is a sign of things to come. He said: "I am used to long, advanced procedures from time working in the Peter MacCallum Cancer Centre, a surgical oncology unit in Melbourne which gave me experience of robotic colorectal surgery, intraoperative radiotherapy, pelvic exenterations and hyperthermic intraoperative chemotherapy (HIPEC).

"These are all services I hope my incredible colleagues and I can start offering to patients in east London and

Essex. There are a lot of patients who would benefit from having these options. It could give them a better quality of life and also a longer life."

Thangadorai Amalesh, Consultant Upper Gastrointestinal and Laparoscopic Surgeon, said: "I would like to thank everyone involved in the operation for going above and beyond their duty in delivering care for the patient. This was one of the biggest and longest cancer operations we have ever carried out in our Trust. It was great to see different teams coming together to help our patient care."

The PRIDE Way

With continuous improvement always at the forefront of its thinking, the Trust was proud to have partnered with the Virginia Mason Institute, along with four other trusts in the country. Now, with the five-year collaboration at an end, BHRUT is continuing to embed The PRIDE Way as its methodology for quality improvement.

We continue to do our best to ensure we implement an evidence-based quality improvement culture and methodology to the benefit of our patients, visitors and staff.

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

We have trained the vast majority of senior managers in the Trust who have actively taken this into their teams to cascade the methodology.

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.

Performance Standards

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

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: 72.8%
Referral To Treatment	92% of our patients to be seen within 18 weeks of referral from their GP for elective care	Not achieved: 57.6%
Cancer: urgent referrals	93% of our patients to be seen in two weeks following an urgent referral from their GP	Not Achieved: 87.0%
Cancer: 31 days	96% of our patients to have a diagnosis and first definitive treatment within 31 days of the decision to treat	Not Achieved: 93.9%
Cancer: 62 days	Target of 85% of patients receiving first treatment from the date of GP referral	Not Achieved: 66.8%
Infection control: C diff	No Target for 20/21	35 cases
Infection control: MRSA	Zero cases of MRSA bacteraemia	Not achieved: 7 cases

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 on the following page:

Standard to achieve		2020/21 Target	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	2020/21 Total	2019/20	2018/19	2017/18	2016/17	2015/16
Infection Control	Number of Clostridium difficile cases	No target set	6	12	10	7	35	29	9	15	29	36
	Number of MRSA blood stream infection cases	0	2	0	2	3	7	3	5	6	7	5
Access to Cancer services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96.00%	89.09%	94.24%	95.20%	95.59%	93.89%	96.50%	98.32%	98.52%	98.67%	96.10%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98.00%	99.24%	100.00%	100.00%	100.00%	99.86%	99.88%	100.00%	100.00%	99.80%	99.70%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94.00%	93.06%	98.25%	93.59%	90.32%	93.33%	97.82%	98.73%	99.56%	99.15%	96.10%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	94.00%	96.62%	100.00%	100.00%	99.51%	98.99%	99.78%	99.66%	99.89%	99.47%	98.70%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment *	85.00%	47.69%	59.45%	76.18%	75.49%	66.83%	78.31%	86.92%	86.21%	74.22%	74.00%
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	90.00%	29.17%	65.38%	79.73%	40.22%	52.92%	88.93%	93.68%	96.78%	95.16%	93.70%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	59.34%	83.61%	96.59%	95.46%	86.98%	88.73%	93.87%	96.79%	95.20%	94.50%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	5.26%	83.33%	100.00%	95.62%	94.08%	97.61%	97.79%	97.89%	93.47%	93.20%
Access to treatment	18 weeks referral to treatment - total incomplete	92.00%	56.48%	48.95%	63.32%	61.49%	57.58%	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%	80.48%	74.74%	67.75%	68.84%	72.78%	75.00%	80.68%	81.84%	85.65%	87.90%
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	64	147	137	72	420	1120	1135	651	974	524
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	14	86	49	29	178	117	205	77	42	38

Four Hour Emergency Access Standard

We owe it to our residents and to those who become our patients to stabilise our performance in our two Emergency Departments (ED) and to reduce variation. We are seeking a week-on-week reliable increase in the numbers of people we admit, discharge or transfer within the required four hours. To help us arrive at this goal, we have a whole hospital improvement plan. It includes work on the culture of our organisation and on improving behaviours such that an ED consultant is empowered to admit a patient to a ward without hurdles being placed in their way.

We also need to address the mismatch that exists – and is evident in our data - between the demand for beds and our current capacity. The status quo adds to delays. Across Barking and Dagenham, Havering and Redbridge (BHR) we are working with partners to review capacity and opportunities to manage the demand. We will look at the workforce that would be required, physical capacity and models of care.

Improved staff wellbeing area and Point of Care Testing 'hot lab' introduced at Queen's Hospital Emergency Department

The Trust opened new facilities in our Emergency Department (ED) at Queen's Hospital, including a larger rest area for our staff with better facilities, training rooms, and a Point of Care Testing (POCT) hot lab, which will speed up treatment times for our patients.

The hot lab in the ED means patients' results are immediately available, speeding up clinical decision making and cutting treatment delays. This reduces time our patients spend in ED while also leading to better overall health outcomes and improved patient experience and will improve our performance against the national four-hour standard.

The works have also given our staff much better facilities, including a large, open plan staff wellbeing room with a kitchen, showers and changing areas. The new area also boasts office space for the ED team and training rooms.

The work was funded through a £4.1m grant from NHS England, part of a £300m funding pot to improve urgent and emergency care across the country. It is another stage in how the Trust is upgrading our ED including the opening of an expanded Rapid Assessment and First Treatment area with eight additional bedded bays and a 'fit to sit' area for up to six patients.

The Whole Hospital Improvement Programme

The Whole Hospital Improvement Programme was established in August under the exceptional circumstances of this year in order to help stabilise our variation against the 4 Hour Performance

Standard for Type 1 patients and then to improve from that steady state as we progress.

The scale of the portfolio of programme activity to support this is significant. In order to aid delivery and begin realising the benefits quickly, the programme has agreed to focus on its top 8 priority schemes. The remaining portfolio of activity will continue to be worked through as there are many additional benefits to be realised in these areas, however it will be the 8 priority schemes which we expect to provide results quickly.

- ED Processes to be unblocked
- Non-Admitted Pathways to be unblocked
- Internal Professional Standards to be rolled out
- Swabbing to help improve flow through the hospital
- Reduction in Length of Stay to help improve flow
- Beech Unit to help reduce 75 + Admissions
- Workforce / Rota to provide a more agile workforce to avoid bed closure
- Reconfiguration of General and Acute Beds to increase bed availability

Red2Green

The Red2Green team focus on making every day spent in hospital count for our patients, as each day should be a 'green day' towards discharge. Working with our wards, they aim to reduce any delays to our patients being able to leave hospital; as we know there is no place like home for recovery.

The Trust's Red2Green team had a fantastic impact during the year to reduce the number of patients in our beds for 21 days or more – known as 'super-stranded' patients – from 199 to 98 during the course of January.

To achieve this great result, the Red2Green team reviewed all discharge pathways out of our hospitals, simplified all pathways to relieve pressure on our staff, and also held daily calls with system partners to speed up patient discharge.

Working together with system partners, including Clinical Commissioning Groups (CCGs), North East London NHS Foundation Trust (NELFT) and local authorities, the Red2Green team beat the national target of 12 per cent of 'super-stranded' patients in our beds and on 4 January achieved 10.6 per cent.

Speaking about the achievement and working with partners, Karen Peters, Head of Operational Transformation, said: "I'm really proud of all involved who helped reduce the number of patients in our beds for 21-days or more to 98 from 199."

"The close collaborative working with our system partners was huge and I must thank each colleague and organisation who worked with us on this. Since the start of the Covid-19 pandemic, I feel we have broken down many barriers, built great relationships and our collaborative working has made each and every system partner feel valued."

Referral To Treatment (RTT) – Elective Care And Outpatient Services

The historical issues around the management of patients waiting for elective care have been well documented. Our waiting list increased from 40,830 at the end of March 2020 to 46,963 at the end of March 2021.

At the height of the first and second Covid peaks, like most other trusts, we had to postpone non urgent outpatient appointments and non-urgent procedures, which resulted in marked increases in waiting list size and patients waiting over 52 weeks.

During both Covid peaks, chemotherapy and radiotherapy treatments continued at Queen's. In parallel, the majority of clinically urgent elective surgery moved to the independent sector, with a very small number of procedures taking place at

Queen's and endoscopies at King George Hospital (KGH).

We are now in the process of resuming that which we have paused. The number of people waiting longer than 52 weeks will, inevitably, take some time to reduce. As of the middle of April, we started a limited number of urgent elective day cases at Queen's and we restarted 'Covid protected' elective work at KGH. We hope to increase the amount of such operations during 2021/22.

The Trust has taken a number of other steps to improve the recovery of elective services including;

- Continuing the use of virtual means for reviewing patients (advice and guidance, triage, telephone / video appointments, clinical reviews) where staff are available
- Certain specialties using SMS texting and triaging to determine if patients need to remain on an active treatment pathway
- Clinically prioritising patients on the admitted waiting list to ensure we have planned sufficient theatre capacity for our most clinically urgent patients
- Continuing to outsource full pathways in Trauma & Orthopaedics and Gynae to Independent Sector providers in 2021/22
- Agree arrangements and funding for outsourcing, insourcing and additional sessions for 2021/22

Cancer services

Cancer performance was heavily impacted by the first 4 months of the pandemic, following this performance strengthened considerably and the Trust was able to meet the target for percentage of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen.

Performance on the 31-day target followed the same profile but fell slightly short of the targets for cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment.

Full details of performance are included in the tables on the Performance report.

Maternity Services and The Ockenden Report

The publication of the Ockenden Report followed an independent maternity review which was undertaken by Donna Ockenden. The report looked at cases of maternal and neonatal harm which occurred at the Shrewsbury and Telford Hospital Trust and included cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new born babies. The total number of families/cases to be included in the final review and report is 1,862. This first report details finding from the 250 cases reviewed to date.

All Trusts were asked to undertake a gap analysis related to its maternity services and the recommendations of the report to identify further improvement actions. There were 7 immediate actions and 12 urgent clinical priorities identified.

NHS England/Improvement (NHSE/I) wrote to all trusts requiring them to implement the 12 urgent clinical priorities. This was completed in December 2020 and the Trust responded and were able to report that 10 priorities were in place designated as green with two amber priorities requiring some more work.

Trusts were also required to take to their Board an Assurance Assessment Tool, which after approval was submitted to NHSE/I in February 2021. The Assurance Assessment Tool was completed by the maternity Division and presented at an extra ordinary Quality Assurance Committee (QAC) convened for this purpose. At this QAC meeting each of the Immediate and Essential Actions and clinical priorities were discussed in detail. Many suggestions and ideas from the Non-Executive Directors were added to the Assurance Tool which was subsequently approved by the QAC.

BONES (BHRUT Orthopaedic NHS Elective Surgery) week

Dedicated weeks are a useful means of clearing backlogs and improving the ways in which we care for our patients. In October, we ran an ambitious project, in collaboration with the Practice Plus Group (an independent provider) to treat as many orthopaedic patients as possible on the waiting list in a seven-day period. Together, we exceeded expectations and delivered 135 joint replacements, 88 day case surgeries and 27 spinal procedures.

Behind the statistics, are the lives that have been improved. Natasha Mercer had a total hip replacement, and she has spoken of how she felt reassured throughout about her safety while undergoing her treatment. Such positive feedback is very helpful as we are still encountering significant numbers of patients who are unwilling to come into hospital during these Covid times.

Our Endoscopy Optimal week

Hot on the heels of our BONES week, where we ensured 250 patients got the care they needed in just seven days, our Endoscopy team completed its own version, which was an Optimal week.

With endoscopy capacity in high demand even before the pandemic, Covid-19 has had a big impact, even more so than in other areas.

So holding a week-long focus on getting as many patients seen as possible was really important, the team aimed to perform 350 procedures across the seven days, however, as previous focused weeks have taught us, we can exceed our own expectations.

In total, 412 patients had endoscopic procedures, a 47 per cent increase on our performance in September.

To help make this happen, the entire team worked extremely hard throughout the week, not to mention all the work that went beforehand, including lots of overtime from our admin team getting patients booked in.

Since the pandemic hit, we're finding we need to put in a lot more work reassuring patients it's safe to come into our hospitals to get the care they need. We could provide this for the hundreds of patients we saw during both our BONES and Optimal weeks. We'd also really appreciate your help among your own networks, encouraging people that our hospitals are safe and open for business, and that people should be coming in to get the care they need.

In this case, patients were kept safe by having their procedures in our Covid-secure green zone, which prevents staff from moving between zones, and requires patients to have a Covid swab test before coming in, and then self-isolating.

Developing integrated frailty services

We've reopened our Frailty Unit at King George Hospital to provide patients with fast access to medical teams specialising in caring for older or frail people.

NHS workers in the community, such as GPs, community nurses and ambulance services can refer a patient directly into the unit which brings together experts from a range of clinical teams including a consultant geriatrician and specialist frailty nurses. This will mean patients no longer having to wait in our busy Emergency Departments.

The unit's environment has been designed to suit the specific needs of frail and older patients, including recliner chairs for those able to sit, which is often easier and more comfortable for patients who are frail and means they can stay in their own clothes.

The aim of the unit is for patients to promptly get the care they need so wherever possible, they can go home the same day, reducing the time spent in hospital.

For older and frail patients, a long stay in hospital can carry additional risks as patient do not move as much and can't follow their usual routine. The team in the Frailty Unit will work in partnership with community teams to arrange any on-going care needed from the patient's home.

However, if a patient is too unwell to go home the same day, the team can arrange a bed for the patient in one of our care of the elderly wards.

Performance Trends and Risks

The risks to the Trust's strategic objectives are set out in the Trust's Board Assurance Framework. These are reviewed through the Board Committees prior to Board. Each Division is responsible for maintaining its own risk register in accordance with the Trust's Risk Management Strategy. The detail of how this operates and the risks during 2020/21 is included in the Annual Governance Statement section of this document.

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

Following the UK's exit from the EU, we continue to monitor any issues cross-organisationally to ensure we are best positioned to face any challenges, through our EU Exit Response team.

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 our energy consumption since 2012/13 by a quarter and this has resulted in just over a £5

million savings (cumulative) inclusive of energy and carbon related costs.

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 Sustainable Development Unit 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 table shows our key sustainability performance highlights for 2020/21:

Carbon		Energy	
42%	10,643 tonnes of CO2 emissions saved 29% EU ETS carbon credit savings in 2019 £0 cost to UK CRC compliance	99%	16% total energy consumption savings 100% live real-time energy display for monitoring CHP
Carbon reduction target 28% by 2020		Electricity used is Renewable	
Waste		**Travel**	
6%	ZERO domestic waste to landfill 29% reduction in high cost incineration clinical waste 20% less plastic waste by implementing reusable Sharps waste containers	Up to 5%	125% increase in the cycle parking facilities Free for Trust staff pool bike scheme Largest community in the country (FAXI car share scheme) 21 Brompton bikes available for subsidised staff hire
Increase in recycling		Staff cycle to work against a target of 3%	
Awareness and Education		**Financial Savings**	
95%	Mandatory Sustainability and Waste Management course Mandatory CPD Waste course accredited by RCN/IEMA Awareness in monthly Corporate Welcome day Green Message Sustainability newsletter publication Intranet and Internet specific pages by target areas	£5.11m	£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
Training on sustainability		Saved	

MANAGING OUR FINANCE

Financial position for the year

The Trust is reporting an adjusted financial performance deficit for the year of £7.4m compared to a deficit in the previous year of £23.1m. The assessment of financial performance by comparison to prior year performance is challenging due to significant changes in the funding streams arising from the need to spend more money to manage and deliver safe patient care during a global pandemic. This issue was identified early by government with additional top up funding available to cover additional costs and also to move the Trust to a break-even position for the year.

The previous year's plan to achieve a £51m recurrent underlying deficit was not achieved, instead the Trust came into 2020/21 at an underlying deficit of £63m, or £5m per month. Operational pressures in the second half of the year resulted in deterioration of the underlying deficit to £6m a month where it ended the year.

Financial plans during the pandemic

In conventional years the Trust Board would be asked to approve the Annual Operating Plan submission to regulators ahead of its final submission towards the end of April. This would be accompanied by detail of internal budgets. Due to Covid, the Operating Plan process was suspended by the national team in March 2020 with temporary arrangements to cover the first six months of the year.

The main points of the temporary guidance included an effective move to income block payment arrangements and top up payments to 2019/20 run rate to take the Trust to a break- even position before the Covid-19 impact and process for Covid-19 marginal cost reclaim.

There were revised financial arrangements for the second half of the year, with the system of underwriting Trust deficits with a retrospective top-up payment being replaced by a regime which requires STPs and its member organisations to live within a fixed financial envelope. The financial envelope encompasses "Business as usual", elective recovery, continued Covid-19 expenditure and a small allowance for growth

Capital Expenditure

The Trust's Capital Resource Limit for 2020/21 was £50.7m (£32.9m from internal sources and the North East London STP capital allocation, £14.4m of national capital funding and £3.4m of PFI capital expenditure funded from the Unitary Payment)

The actual 2020/21 Capital Expenditure was £46.6m. The £3.9m underspend was predominately due to delays in construction projects - Covid pressure over the winter prevented works from progressing at the anticipated rate.

Category	**£m**
Strategic IM&T	11.8
Strategic Estate	7.1
Diagnostic Imaging	5.1
Divisional Projects	13.8
PFI	3.2
Other	5.6
Total	**£46.6m**

Within 3-6 months of Capital Project completion (depending on project complexity) Post Project

Evaluations will be conducted and reported back to the approving Committee so that assurance can be given that the capital investment has delivered value, and the anticipated benefits have been realised.

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 94% against the Better Payment Practice Code and on six months during the year have exceeded 95%. During the financial year £245m of historic NHS debt was converted into Public Dividend Capital and will not therefore be repayable or attract interest.

Delivering a Financial Balance

The evidenced drivers of the Trust underlying deficit show the financial challenge is within the Trust's and local health system's control to fix. Removing waste is key. Three priority areas for financial improvement are managing the size of the workforce, reducing the £20m annual temporary staff premium and reducing the £20m of waste through elective theatres. The Trust plan for 2021/22 requires £20m of waste reduction, with a
£3m cost of delivery fund set aside.

The key areas of focus are Elective waste reduction (£10m) and Temporary Pay Premium reduction (£10m). Daily control and improvement will also be required to ensure the Trust achieve better financial results than 2019/20.

Elective waste reduction is to focus on reducing fallow sessions by 80% and intra session waste by 33%. Workforce numbers remain high.

Development of 3-year service plans, in conjunction with the workforce hubs, will answer the question "what size should the workforce be" to support efficient and effective pathways and processes.

There is also £20m of opportunity to reduce waste through improved use of elective theatres. As elective waiting list numbers grow, there is even greater incentive to improve in this area. It is important financially that the Trust utilises its current theatre capacity, enabling the repatriation of elective work commissioned by NEL from the Independent Sector.

Financial Outlook and the Trusts approach to recovering from the impact of Covid-19

NHS London has required all Integrated Care Systems (ICS) to submit a plan to set out how they intend to recover from the Wave 2 Covid position in the short term, ahead of the longer term National planning round which will begin in quarter 1 2021/22.

In March the Trust set out immediate steps to be taken in order to recover from Wave 2, focussing on Elective Care, Non-Elective Care and Staff Wellbeing. This included agreeing clinical engagement and partnership working, both within BHRUT and across the BHR and NEL systems. A recovery plan was agreed, and governance requirements confirmed by the formation of a Recovery Board.

The Recovery Board will provide monthly reports to Finance and Investment Committee (FIC), via the Trust Executive Committee (TEC) detailing high level milestones and metrics for reviewing the plan as the recommendation.

The recovery plan covers three key domains, as agreed at Recovery Board, recovery of elective services, recovery of non-elective services and supporting the recovery of our staff including the development of the foundations for long-term effective cultural change. In addition, it also has a remit to cover financial recovery.

HAPPY AND HEALTHY HOSPITALS - TO BECOME THE HAPPIEST AND HEALTHIEST HOSPITALS IN THE UK

Develop a consistent environment which enables our staff to be happy and healthy at work

We want to become the happiest and healthiest hospitals in the UK. What would that really look like at BHRUT? We asked ourselves this question through a series of conversations with our people during June-July about what it was like during the pandemic, what they would like to keep, what we need to improve and what their vision for Happy and Healthy Hospitals would be.

Prior to COVID-19, we spent a lot of time understanding and designing changes within our culture with our people. This Culture and Leadership programme was due to launch in April 2020 but was paused due to the pandemic. It was important to understand our new baseline and what staff want to see in the future.

Our learning from COVID-19 is that if we are more compassionate with our leadership, give freedom to the clinical front-line, connect our people with a common purpose and empower others to act, we achieve much more for our people and our patients. Staff valued this autonomy despite the challenges facing them. They also valued that there was one goal – to keep staff and patients safe and the investment made in staff was valued (i.e., free parking, hot drinks and wellbeing support such as the hubs and wobble rooms). Whilst there were lots of positives gained from the changes in the environment, there were also inconsistencies in leadership, behaviour and support which impacted negatively on experience. Ultimately our staff align with the manifesto of 'no going back' but they are concerned it will happen; they have seen change and would like to see more.

Therefore, it is important that we design the future for a Happy and Healthy Hospital. Staff contributed during the pulse check their views on what a Happy and Healthy Hospital looks like to them. Top areas of feedback include consistent and compassionate leadership, breakdown of hierarchy and 'banding boxes', behaviours of respect and trust, learning and evolving, wellbeing and staff experience as a priority. Positive feedback from 'Board to Ward' was in synergy and there was less change apathy due to the learning through Covid-19.

To move to this vision, we need to address the issues which still exist within the culture to be able to develop 'One BHR Team'. Key areas of concern are the consistency of a compassionate leadership, behaviour, wellbeing support, inequalities in the system, hierarchical culture and access to development. These issues continue to impact on

staff recommendation as a place to work and perceptions of treatment. Despite the learning and experiences during Covid- 19, our survey said that 55% of staff would recommend us as a place to work, with 34% believing staff experience is a priority. Establishing a Happy and Healthy Hospitals programme to embed the culture of The PRIDE Way signals staff experience is high on the agenda – however, this must translate into daily management.

A programme of work has been designed in response to what we have heard from staff with the aim of building the foundations of a Happy and Healthy Hospital. Delivery of this programme has begun during the 2020/21 financial year and will continue into 2021/22.

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 8.3% (compared to 10% at the same point in 2020). 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. During the year, our total spend on agency staff was 7.8% 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 and towards the latter months of the year absence has started to decline from the January peak. This trend is expected to continue with a reduction in Covid Diagnoses due to lock down and the introduction of the vaccination.

Recruitment and Retention

Over the past year we have made excellent progress in recruiting permanent staff. We recruited 977 new staff members, including a large number of nursing staff. During the same period, 791 left the Trust and therefore we have increased our permanent workforce by 186 (or just under 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.

During the year the Trust has won an award for its work improving the recruitment experience of international nurses at the prestigious Nursing Times Workforce Awards beating seven other shortlisted trusts from across the country to the top spot. The awards highlight and reward innovation in nursing workforce planning and management.

Beverley Sawer, the Trust's Recruitment Nurse, said: "I'm so pleased we've been recognised with this award. All we wanted to do was make sure our international nurses felt welcome and supported. We are honoured to have these nurses working with us." Beverley works closely with senior nurse Anne Honey, using their wealth of experience to help international nurses settle in. They work hard to

place each nurse on a ward which will suit them, and work together with the nurses to help resolve any issues they may have. They also purchase food and household essentials so that when these nurses arrive they have everything they need after their long flight to the UK.

Inclusive recruitment

Covid-19 shone a light on the disparities of how black, Asian and minority ethnic staff were affected and also provided an opportunity for black, Asian and minority ethnic staff as well as other staff groups with protected characteristics to express how they felt working in our organisation. Supporting improvements in this area is now a major feature of the recruitment and retention strategy. During the year, the Trust carried out a number of actions to create an inclusive environment for recruiting which included;

- For all Senior posts (Band 8a) interviewed and appointed, a report by the recruiting manager is provided to the Trust Executive to ensure there is accountability for the outcomes of these processes
- A Trust wide consultation and review of the Recruitment Policy is undertaken to identify and address any bias in the recruitment process and the inclusion of best practice in this area
- How Positive Action on recruitment can be introduced within the recruitment process
- Diversity targets for senior recruitment introduced
- Mandatory recruitment/Diversity training for all senior leaders within the organisation
- Regular information provided to TEC on recruitment data and metrics

Staff Survey

The Annual NHS Staff Survey is our main source of intelligence on staff experience and provides feedback on us as an organisation to work in and as a care provider. The survey this year was live during the Covid-19 pandemic between October and November 2020. It is an important pulse check on whether we are moving towards our goal of becoming a happy and healthy hospital.

As in previous years we surveyed all staff as recommended by NHS England. Staff were surveyed online. The overall response rate was 46.2%, a reduction of 11.1% compared to the previous year's survey. It is widely evidenced positive staff experience is a key factor in positive patient experience and a key indicator of overall organisational performance including mortality.

This year there has been a deterioration in responses, in contrast to the green shoots of improvement in the 2019 survey results.

It is crucial that there is a proactive and honest response to staff following receipt of these findings, making staff experience a top priority for the organisation. Critical to this is responding to current and post-Covid recovery wellbeing and recognition needs of staff to build engagement and belief in future cultural change and improvement work.

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 who 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.

The Chief Nurse Fellow Programme

The Chief Nurse Fellow programme was initiated as part of the celebrations for the 2020 International Year of the Nurse and Midwife. Over 50 members of clinical staff applied to take part in the programme and have successfully completed the week.

The programme was initially designed to give Nurses, Midwives and Allied Health Professionals an opportunity to shadow the senior nursing team for one week at a time.

Typically, each candidate spent time with the Chief Nurse and her six Deputy Chief Nurses, as well as senior management teams in areas such as Quality and Safety, Clinical Audit, Risk and Compliance, Research and Innovation, Safeguarding, Patient Experience, Procurement and Red2Green. The aim was to give colleagues a really good insight into the workings of the Executive team and the opportunities that are available to them at BHRUT.

The programme has provided a real eye-opener for colleagues from Bands 2 to 9, as well as fostering a hugely beneficial link from board to floor.

The programme has developed over the past year and now includes quarterly updates, attendance at a variety of focus groups and, when opinions are required for a range of topics the group is also contacted.

Whilst the programme was developed for one year, due to its success it has been extended for a further year, the application process has been completed and a further 140 applied to undertake the programme which has been shortlisted down to 50 by members of the current cohort of Chief Nurse Fellows.

Senior Nurse Intern Scheme

Starting 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.

This trailblazing Senior Intern scheme was the subject of a new BBC documentary series – 'Saving our Nurses', first aired in June 2020, with the series examining the success of our initiative to support newly qualified nurses filmed in the weeks leading up to the outbreak of Covid-19.

Senior interns are experienced nurses with a wealth of knowledge to support newly recruited nurses navigate the challenges of hospital life when they are new to the role. Currently over a third of nurses nationally are looking for a new role, so the team's goal is to keep nurses in the NHS at what can be a difficult point in their career.

Our Senior Intern team's efforts so far have slashed the number of nurses leaving our Trust. The team

has even been recognised nationally with a Nursing Times award.

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 on 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.

We are very proud that our Academy of Surgery has been shortlisted for the Healthcare Service Journal (HSJ) Value Awards in the People and Organisational Development Initiative of the Year category for 2021.

Volunteers

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 is at the heart of all we do.

The Trust paused its volunteering in March 2020 as the country went into lockdown and our hospitals needed to care for increasing numbers of patients with Covid-19. As the number of patients, we care for with the virus decreased we restarted some services, and although things were still running differently, the Trust was able to begin welcoming back our volunteers in August.

The second wave began to bite at the start of winter and therefore it was necessary to pause volunteer services again. At the end of March we had 106 active volunteers with the intention of increasing the numbers once lockdown restrictions were relaxed and it was safe to do so.

Our inspirational volunteer helps other stroke survivors by writing a book about her recovery

Louise Hulbert had just returned from three weeks in Spain enjoying the El Camino pilgrimage when she had a stroke. The retired PE teacher woke up on the floor in the middle of the night unable to move, it was only when friends came looking for her the next morning that she was taken to Queen's Hospital.

That was in 2014 and it has been a long road to recovery since following a three month stay at the hospital and a further month on a rehab ward. Now, Louise's confidence and independence has begun to return, so much so that after a throwaway comment during lockdown, she found herself writing a book of her experiences, "Burgos to Bedroom Floor", which was published this December 2020.

Louise, who volunteers on the stroke rehab ward at King George Hospital, to give back for the great care she received following her stroke, said: "I also volunteer for Stroke Rehab Dogs and during lockdown, when we couldn't hold face-to-face sessions, I started a thought of the week on our Facebook page. "Someone said I should turn it into a book. I didn't think I could as it was never something I'd considered, however, I started one chapter and found I couldn't stop. It was really therapeutic for me and I hope that it will encourage and inspire other stroke survivors that you can go on to have a good life after a stroke."

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.

In March 2019 and July 2019 our Nursing Associate pioneers registered with the Nursing and Midwifery Council. 50 completed the programme and 48 remained in the Trust on completion. 20 Nursing Associates completed their registered nurse training in December 2020.

The Trust has also established a Degree Nurse Apprentice 2-year programme.

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 – including the intranet and all staff daily updates – and via social media.

During February and March 2021, we launched a wellbeing survey and included questions about what support staff wanted to see more of to support their wellbeing. Recognition came first, better rest spaces, food and emotional/mental wellbeing support followed. This led to the design of the 'Big Thank You Week' with a cross representation of staff in our wellbeing and recognition group via the Wellbeing Forum, which took place in April 2020.

Our annual PRIDE Awards celebrate achievements and dedication across a range of categories including Hospital Hero, Working Together and Pursuing Excellence. Trust Chair, Mike Bell, Chief Executive, Tony Chambers and Chair of our Hospitals Charity,

George Wood, met individually with our winners to mark their achievement and present them their trophies and vouchers.

Of course, these presentations were different to previous years but no less meaningful and just as welcome to our winners. All our winners and runners up received afternoon tea vouchers for Orsett Hall – our original venue – to enjoy when the time is right, and thank you to our Charity for funding these.

Equality Diversity and Inclusion

Our strategic objective is to improve the inclusivity across the organisation in partnership with our staff networks, focusing on developing our people processes, policies, leadership diversity and talent management to be truly inclusive and supportive of the diverse needs of our people.

Our actions support compliance with the Human Rights Act 1998, Equality Act 2010 and NHS Constitution as well as the NHS Equality Delivery System 2. The "We are the NHS: People Plan 2020/21 - action for us all", published July 2020, mandates us to "take considered, personal and sustained action to improve the working lives of our NHS people and the diverse communities we serve". The new London Workforce Race Equality Strategy also holds us to account for progress. The CQC assess our EDI progress as part of their inspection regime.

Acting on our commitment to EDI demonstrates we value our people and is fundamental to the delivery of our corporate goal to be happy and healthy hospitals. The Trust has heard loud and clear, especially from black, Asian and minority ethnic colleagues, that we need to both commit to radical improvements in promoting equality and take actions to make immediate and longer-term substantial progress.

This is not just what we have heard from black, Asian and minority ethnic colleagues but applies to staff with other protected characteristics, for example the Trust's Ability not Disability Network has also demanded that the pace of improvement be stepped up.

The Black Lives Matter movement and the adverse impact of Covid-19 on black, Asian and minority ethnic people have highlighted the inequalities that still exist within the NHS and locally which need to be addressed.

Our immediate response to this has included: setting up a black, Asian and minority ethnic Task and Finish Group; the completion of risk assessments by all black, Asian and minority ethnic permanent and Bank staff; and regular engagement with our black, Asian and minority ethnic workforce through our Staff Network and an inequality-focused Question Time with the Executives and the appointment of an EDI Board Director. A number of dedicated sessions have been run with black, Asian and minority ethnic colleagues and the Staff Network to evaluate the Workforce Race Equality Standard (WRES) data and produce the new action plan.

We have learnt from all of these and our proposed action plans reflect this. The black, Asian and minority ethnic Task and Finish Group has committed to continue as the Black, Asian and Minority Ethnic Workforce Advisory Group and expanded its membership and refreshed terms of reference to broaden its responsibility for programme managing the WRES action plan and relevant elements of the 2020/21 EDI Action Plan.

We have maintained the same conversation with our disabled colleagues locally and engaged with the national WDES Implementation Team's response to the Covid-19 pandemic.

We have refreshed our approach and our proposed Trust-wide EDI action plan. The overarching goals of this action plan are to:

- Enable our hospitals to be happier and healthier by improving inclusivity in partnership with our staff networks, focusing on developing our

people processes, policies, leadership diversity and talent management to be truly inclusive and supportive of the diverse needs of our people.

- Deliver a further improvement in the annual Staff Survey theme Equality, Diversity and Inclusion (EDI) with a score increase from 8.5 in 2019 to 8.7 in 2020.
- Progress our positive action plans and recruitment standards to improve the representation of black, Asian and minority ethnic and female staff in senior leadership positions.
- Strengthen the vision, voice and impact of our Staff Networks and awareness of EDI and representation in key forums such as the Trust Board.

The Trust recognises that women are under represented both in the higher Agenda for change bandings and very senior manager grade. In addition there are fewer women appointed to Clinical and Divisional lead roles. With respect to the latter, work is being undertaken to better understand what barriers may be in place to prevent women undertaking these roles. This work will be supported by the newly created Women's Reference and Network Group

We aim to learn and improve our services by ensuring the patient voices are heard and underpin and drive positive service improvement for all patients and their families

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.

The target for the Trust is 90% of complaints responded to within the agreed timescales. All formal complaints will be acknowledged in writing or by telephone within 3 working days. Complaints acknowledgement national responsiveness target is 100%.

There has been a continued trend in meeting the Trust target (the target was met for 12 consecutive months). 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 interact with all patients where appropriate, which will continue with expansion into the Emergency Departments on both sites.

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. FFT reporting requirements were paused by NHSE/I in March 2020 with new guidance implemented from January 2021 with no external targets for response rate of overall experience but internal targets remain.

Over the last 12 months, the number of surveys received is low when compared with pre-Covid performance in early 2020. We have also seen that there has been a decrease in responses received for outpatients between February and March 2021. However, the overall experience has improved during the same period.

The Patient Experience Team will be focussing on improving communication in the Trust over the next 12-18 months and a number of actions and projects have been developed to deliver this aim. This includes obtaining real-time feedback from patients in relation to communication they experienced; results will be delivered weekly to the wards to track progress.

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 represented some specific challenges in relation to accessibility when considering the need to manage infection control due to the pandemic.

The Trust has a number of ways we support patients if they have additional communication needs including Accessible Information Standards which aim to ensure that people who have a sensory loss, impairment or disability are given information they can easily read or understand. In cases where a patient's first language isn't English, we have telephone interpreters on hand. If we need extra help communicating with each other, Patients can request a face-to-face interpreter through the service who are caring for them.

One of the most difficult changes we've had to make to keep everyone safe during the pandemic has been severely limiting the number of visitors to our hospital. We do not underestimate the impact this has on our patients, who are missing their family and friends, and those who are left at home, anxious to know how their loved ones are.

Throughout the pandemic we've constantly adapted to find ways to ensure we can keep our patients and their loved ones in touch. We were very lucky early in the pandemic to have several iPads donated, which are used to set up video calls with patients. While lots of our patients have their own mobile devices and are able to independently stay in contact with their loved ones, these iPads have been invaluable for those who don't. Our Chaplaincy team also carried out daily ward visits with their own iPads, helping patients have video calls with their families.

As well as this we launched our 'Thinking of you' service; so patients can now send a letter and some photos just by filling in an online form. Since its launch this initiative has seen well over 3,000 messages sent in from loved ones to patients who couldn't have visitors.

We know the importance of daily contact for families and hearing how their loved one is, so we set up a process to ensure wards call a named relative at least once a day to update them – increasing to two daily calls if a patient's condition changes or there are concerns to be addressed.

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. We do have an identified space on both sites for this and building work will begin in 2021/22.

Virtual Clinics– Service User Feedback

In March 2020, at the start of the Covid-19 pandemic, the Trust expedited the implementation of virtual outpatient clinics across a number of specialities. This resulted in a significant increase in telephone and video consultations taking place.

A small-scale patient experience feedback exercise had previously been undertaken by the Patient Experience Team following the telephone fracture clinic pilot and the report from this was provided to the Outpatient Transformation Board in March 2020. In May 2020, the Patient Experience Team received a request to undertake a further feedback survey in relation to all virtual clinics that had taken place.

The aim was to gain an understanding of how well the virtual clinics had been received by patients, highlight good practice and identify any issues or areas of concern.

The majority of patients (89%) responded positively to the virtual clinics. Due to the situation with

COVID-19, patients understood that we needed to change the way that we provided services to our patients.

The feedback received indicates that patients should be given a choice in how they are seen in outpatient clinics. Each patient is different and has different needs and abilities. There was a lot of feedback from patients who would have preferred a video clinic appointment to a telephone appointment and the Trust is exploring the best way to achieve this outcome.

The availability of the options for outpatient appointments is not adequately understood by all patients and should be communicated clearly at all stages of the appointment process.

PARTNERSHIPS WITH PURPOSE - SUPPORTING OUR PARTNERS & POPULATION

Accelerating 'Integrated Provider' borough-based partnerships

Proactive engagement in the North East London Health and Care Partnership

Working with our partners across health and social care, begin to develop a BHR Health and Social Care Academy to support joint efforts in recruitment and retention, workforce development talent management

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 NEL ICS.

Towards an effective North East London Integrated Care System

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

NHSE/I have confirmed that North East London (NEL) has been designated as an Integrated Care System (ICS).

This followed an application process in November before a plan was submitted to the national team for a decision. NEL had originally been aiming for April 2021 in line with the Long Term Plan, but due to the progress made by mid-year, and the strong history of collaborative working in NEL, the CCG's were in a position to apply earlier generating the momentum to move forward to the next stage of ICS development. The ICS designation will really strengthen the ability to collectively address health inequalities and ultimately improve the health and wellbeing of our local population.

Further development of the structures to support the Integrated Care Partnership at a borough partnership continue and partners are actively

exploring further delegation at this level. Borough Partnerships will be a key element of the BHR Integrated Care Partnership bringing together delivery of health and care services around the needs of local people. This will include input around the wider determinants of health, at a community/place-based level. Borough Partnership development will be led by the respective Local Authority Chief Executives in each area, who will also link them into the work of the Health and Wellbeing Boards to deliver the aspirations of more integrated care, closer to home, supporting local people to remain well for as long as possible, and drawing in support for the wider determinants of health (e.g. housing, debt management, employment) as required.

The BHR ICP has significant and strong clinical and professional leadership with the views of clinicians and professionals represented at every level. Clinical and professional leaders work across the system focussing on what is best for residents, improving outcomes, assimilating evidence and solutions workable for practitioners. Borough members' forums supports the work of the BHR ICP and will be led by each of the borough clinical directors (current BHR CCG Chairs) of the north east London CCG governing body.

Clinical Strategy and the development of Service line plans

In 2019/20, the Trust refreshed its clinical strategy for the next 5 years. Individual Specialties have begun producing Service Line Reports that take the aims and aspirations of the Clinical Strategy and provide the framework and assurance on how these will be delivered at the front line incorporating the elements of the wider healthcare community across NEL. These plans are reviewed by the Trust Executive and then the Finance and Investment Committee and Trust Board.

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.

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 maximised opportunities throughout the pandemic to showcase the innovation of our staff and the care they have been delivering through the pandemic including via national media outlets.

We have continued to provide a responsive and effective press office, whilst following NHS England sign off protocols. 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.

During the pandemic, some of our GPs came to our aid and worked shifts on our wards. Their acts of solidarity are a tangible sign of the benefits of partnership working. And it was the system wide response – in Barking and Dagenham, Havering and Redbridge (BHR) and across north east London (NEL) – with social care, community care and the acute sector coming together, that helped us when the challenges were most acute.

GPs Anil Mehta and Jagan John, who are also respective chairs of the Redbridge and Barking and Dagenham Clinical Commissioning Groups, provided valuable help, not only in looking after both Covid and non-Covid patients, but were also able to see where further improvements could be made between acute frontline care and community services.

Donna Walker, consultant geriatrician at our Trust, who oversaw Anil and Jagan as they supported on two general medical wards at our hospital, was not only grateful for the on-the-ground support they provided, she also saw how the benefits of this closer working will improve patient care in the future.

"What was really useful was their help as generalists, which allowed me to provide more high quality, specialist care to patients. They were also able to see where there are bottlenecks in the local healthcare system, so they can go away and look at community pathways and see where improvements can be made. This will improve care for our patients in the future. It was really good for them to see the pressures we are facing, and for us to have a fresh pair of eyes on the ward."

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. This has never been more important than during the pandemic.

We recognise that we cannot respond alone. We are part of a system – the East London Health and Care Partnership (ELHCP), working with NHS London. The current centralised command, through local 'cells', Integrated Care Systems (ICS) and regions has been effective with organisations accepting a level of control that would have been resisted in the past. It has been judged to be highly effective and is set to continue for some time to come.

The ELHCP 'Acute Care Cell' is provider-led by the CEOs of the three acute hospitals. BHRUT is leading the NEL Elective Care recovery plan. Covid-19 planning and delivery has simplified governance and replaced commissioning and complex assurance arrangements with provider-led leadership. Over time, as power shifts from central command to the ICSs - and providing we continue to play our part with reliable, credible delivery - then our ambition to deliver highly reliable, high quality integrated provider services and to be an anchor organisation for Barking and Dagenham, Havering and Redbridge (BHR) will become increasingly more likely.

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 NHS Act 2006, the Health and Social Care Act 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 NHS Improvement 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 2021 consisted of the Chairman, six non-executive Directors and five executive directors with voting rights:

- Chief Executive
- Deputy Chief Executive
- Chief Medical Officer
- Chief Nurse
- Chief Financial Officer

In addition the five executive directors without voting rights have attended the Board during 2020/21:

- Interim Director of Workforce
- Chief Operating Officer
- Director of Communications and Engagement
- Director of Strategy and Partnerships

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 outgoing Chairman Joe Fielder was considered to be independent on his appointment in November 2017 and the incoming Chairman Mike Bell was considered to be independent on his appointment in December 2020. Five of the Non-Executive Directors are considered to be independent. One Non-Executive Director is considered not to be independent as they are appointed to the Trust Board from Queen Mary University of London.

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 Company 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 England/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 and Leavers

During the year, there has been considerable change in the Board membership.

Appointments in Year:

- Mike Bell joined the Trust on 1 December 2020 as Chairman.
- In order to enhance the Trust's executive leadership capacity and capability given the scale of the challenge and transformation required, two new full time executive director posts were appointed to:
  - Ben Morrin joined the Trust on 4 January 2021 as Deputy Chief Executive on secondment from University College Hospitals London NHS Foundation Trust.
  - Hannah Coffey joined the Trust on 8 February 2021 as Director of Strategy and Partnerships on a fixed term contract until 31 March 2022.
- Alan Wishart joined the Board as Interim Director of Workforce on 1 March 2021 following the departure of David Amos, Interim Director of People and Organisational Development.
- Ruth Crowley has attended our Board since March 2021 as an Associate Non-Executive Director, Ruth is a Havering GP and Clinical Director for Havering Health.

Leavers in Year:

- Joe Fielder, Chairman, left at 30 November 2020.
- Tom Phillips, Non-Executive Director, left at 31 March 2021 at the end of his term of office.
- David Amos, Interim Director of People and Organisational Development, left on 28 February 2021.

- Shelagh Smith, Chief Operating Officer, retired in April 2021.

In addition to the above, toward the end of the last quarter of 2020/2021 a number of appointments were in train which have become effective in the first quarter of 2021/2022:

- Mehboob Khan was appointed Non-Executive Director on 1 April 2021 for a two year term of office (voting).
- George Wood was appointed Associate Non-Executive Director on 1 April 2021 for a one year term of office (non-voting).
- Following Shelagh Smith's retirement as Chief Operating Officer in April 2021, Aleks Hammerton and Richard Pennington joined the Board as Acting Chief Operating Officers for Emergency Care and Elective Care respectively. They are non-voting members of the Board.
- Remi Odejinmi was appointed as our first Director for Equality, Diversity and Inclusion in May 2021 (non-voting).
- Mike Gilham was appointed Director of Finance on 10 May 2021 (non-voting).

The biographies for each of our Trust Board Directors during 2020/2021 are shown below:

Mr Joe Fielder

Chairman (until 30 November 2020)

Chair of the Remuneration and Terms of Service Committee

Joe was appointed as chairman in November 2017 and was 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.

Mike Bell

Mike was appointed as Chairman from 1 December 2020.

His central vision is to lead our Board on its improvement journey towards providing services that are effective, efficient and ethical.

He wants to develop borough-based partnerships that offer the very best joined up care. He is keen to work with our partners across north east London to deliver these services efficiently and ensure there is a relentless focus on tackling the health inequalities that scar our communities.

Mike is also Chair of Croydon Health Services NHS Trust, a position he has held since 2013 where he has championed place-based integration in health and social care and collaborative ventures with other providers across south west London. These alliances have meant services are better able to meet the needs of Croydon's diverse population and have created fresh opportunities for employees.

Mike has more than 20 years of NHS board-level experience and has held many senior roles including Chair of the London Mental Health & Employment Partnership and Vice Chair of NHS London. He is also director of the consultancy firm, MBARC Ltd, which works with central and local government and various NHS bodies on issues relating to both social exclusion and quality assurance.

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 is a senior leader with 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 Vice Chair of the University of Osteopathy and a Trustee of an Academy Trust in East London.

Mehboob Khan

- Independent Non-Executive Director
- Appointed 1 April 2021 for a two year term of office.
- Member of the People and Culture Committee and the Quality Assurance Committee

Mehboob previously served as an Interim Associate Non-Executive Director from 1 January 2021 and prior to that as a Board Advisor to the Trust.

Mehboob is Assistant Director of Policy and Change at the London Borough of Redbridge. He is also Vice Chair at North Middlesex University Hospital Trust.

From 2014 to 2021, he was political adviser to London Councils, the cross-party organisation that represents the city's 32 boroughs and the City of London. Mehboob has held other senior leadership positions in the public sector. He was Kirklees Council Leader (2009 to 2014); Chair of West Yorkshire Fire Authority (2012 to 2014); Vice Chair of the Local Government Association (2012 to 2014); and Vice Chair of the Socialist Group on the Council of Europe (from 2006 to 2008).

Mehboob lives in London and enjoys current affairs, running and cycling. He is a founder member of the Seacole Group which is a forum for NHS Non-Executive directors from the black Asian and minority ethnic community.

He was born in Yorkshire; grew up in Huddersfield; and as Leader of Kirklees Council, Mehboob was the first British Muslim to occupy such a role.

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 and extended for a further one year term in August 2020.
- Chair of the Finance and Investment Committee to 31 March 2021. Member of the Committee from 1 April 2021.
- Chair of the Audit and Risk Assurance Committee from 1 April 2021. Previously a member of the Committee.
- Member of the Remuneration and Terms of Service 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 was previously the Chief Executive of Elevate East London, providing I.T., finance and customer services to local government.

Sue currently provides part time leadership support to Agilisys Ltd, a leading provider in the technology advisory sector.

Tom Phillips

- Independent Non-Executive Director (until 31 March 2021)
- 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 Chairman of Racecourse Technical Services Ltd.

Joan Saddler OBE

- Independent Non-Executive Director
- Appointed in September 2014 for a four year term of office; re-appointed for two further one year terms to October 2020. From 1 January 2021 re-appointed for a further one year term of office.
- Member of the Remuneration and Terms of Service Committee
- Member of the Quality Assurance Committee
- Member of the People and Culture Committee

Joan returned to our Trust in January 2021, after a six-year term with us that ended in the autumn of the previous year.

Joan has considerable NHS experience. She is Director of Partnerships and Equality at the NHS Confederation, which represents organisations across the healthcare sector. She was awarded an OBE for services to health and diversity in 2007.

Joan spent five years as the National Director of Patient and Public Affairs at the Department of Health and she previously served as the Chair of Waltham Forest PCT.

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
- Member of the Audit and Risk Assurance 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.

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.

George Wood

- Appointed Associate Non-Executive Director 1 April 2021.
- Chair of the King George and Queen's Hospitals Charity
- Chair of the Finance and Investment Committee
- Attendee at the Audit and Risk Assurance Committee

George previously served as an Interim Associate Non-Executive Director from 1 January 2021 and prior to that as a Board Advisor to the Trust.

He is also a non-executive director at The Princess Alexandra Hospital NHS Trust.

He worked for the Ford Motor Company for more than 30 years in their financial services division. During his career he spent time in sales, marketing, strategy and operations. He worked for the company in South America as vice president where, for five years, he was responsible for operations in Brazil, Argentina and Venezuela.

George is passionate about the NHS and about delivering a great service for our patients.

Tony Chambers

- Appointed Interim Chief Executive in January 2020
- Member of the Finance and Investment Committee

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 and has also worked at the Northern Care Alliance in Salford.

Kathryn Halford OBE

- Chief Nurse
- 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.

Ben Morrin

- Deputy Chief Executive from 4 January 2021
- Member of the Finance and Investment Committee and People and Culture Committee

Ben joined us as our Deputy Chief Executive in January 2021 from University College London Hospitals NHS Foundation Trust (UCLH). In 2020, he worked as part of the NHS England and Improvement's London executive. From 2014-19, Ben was UCLH's responsible director for workforce, education and communications.

In the preceding decade, he worked across the Department of Health and within the Prime Minister's Delivery Unit. Ben is a Fellow of the Chartered Institute for Personnel and Development.

Dr Magda Smith

- Chief Medical Officer from January 2019 following a period acting up as Chief Medical Officer from September 2018
- Magda's contract as Chief Medical Officer was extended in year for a further two years to 10 January 2023.
- 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 until February 2021
- 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.

Hannah Coffey

- Director of Strategy and Partnerships from 8 February 2021.

Hannah spent ten years as Director of Operations/Chief Operating Officer at Chelsea and Westminster Hospital NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust (GSST).

Hannah has always been a passionate advocate of equality, diversity and inclusion (EDI) and was the Executive sponsor for EDI at GSST. One of her proudest achievements was to oversee the implementation of reverse mentorship and witness the powerful impact it had on all those who took part.

Hannah has recently graduated from the Aspiring CEO programme run by the NHS Leadership Academy and she has trained as a coach.

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.

Shelagh Smith

- Chief Operating Officer from August 2018 until

April 2021
- 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.

Alan Wishart

- Interim Director of Workforce from 1 March 2021
- Member of the Finance and investment Committee and People and Culture Committee

Alan joined the Trust as the Deputy Director of Workforce in December 2015. From March 2021 he has been the Acting Director of Workforce.

Prior to Joining the Trust Alan spent 3 years at Capsticks LLP as the Associate Director for their Human Resources and Organisational Development Advisory Service. Alan started his NHS career in 2003 working at the North West London Strategic Health Authority subsequently moving to work in People and Organisational Development at the West London Mental Health NHS Trust.

In the preceding decade Alan worked as a fulltime officer for both the Banking and Finance Union (now Unite) and spent 10 years at the British Medical Association as an Industrial Relations Officer in London. Alan is a CIPD Chartered Member.

Associate Non-Executive Directors

In addition, three Interim Associate Non-Executive Directors have attended the Board Meetings since January 2021. Previously Board Advisors to the Trust, they provide additional support and capacity to the Chairman and Chief Executive by undertaking the following responsibilities: chairing consultant interview panels and Human Resource hearings and appeals; as members of a number of Board Committees:

- Ms Sandra Malone - People and Culture Committee and Finance and Investment Committee.
- Ms Caroline Roberts – People and Culture Committee and Quality Assurance committee.
- Mr Eric Sorensen – Quality Assurance Committee and People and Culture Committee.

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 2020/21 to improve its corporate governance framework.

In summary during 2020/21 the Trust has undertaken the following:

- Developed and embedded a new Board Assurance Framework structure and associate reporting processes through the Board Committees.

- The Board has undertaken work to set out its risk appetite.

- The Board has undertaken a number of Board Seminar sessions.

- Embedded an improved Board and Committee reporting schedule.

- Developed new and improved committee assurance reports which are submitted to Trust Board following each committee meeting.

- Undertaken a procurement exercise to introduce a Board portal for its governance function.

Further information can be found in the Chief Executive's Annual Governance Statement later in 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 2020/21, there were five Committees of the Board, each Chaired by a Non-Executive Director or Associate 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 and work of each committee during 2020/21 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 7 Board meetings in public between 1 April 2020 and 31 March 2021.

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 the period 1 April 2020 to 31 March 2021.

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.

	Trust Board	Audit & Risk Assurance (ARA)	Finance and Investment (FIC)	Remuneration & Terms of Service	Quality Assurance	People and Culture (PCC)
Non-Executive Directors						

Mike Bell Chairman	2/2	-	-	3/3	-	-

	Trust Board	Audit & Risk Assurance (ARA)	Finance and Investment (FIC)	Remuneration & Terms of Service	Quality Assurance (QAC)	People and Culture (PCC)
(from 01.12.20)						
Joe Fielder Chairman (to 30.11.20)	6/6	-	-	1/1	-	-
Susan Lees Non-executive Director	8/8	6/6	11/11	4/4	-	-
Tom Phillips Senior Independent Director Non-executive Director (to 31.03.21)	8/8	6/6	9/11	4/4	-	-
Joan Saddler Non-executive Director (to 07.10.20) (from 01.01.21)	4.5/6	-	-	2/3	1/4	4/4
Lesley Seary Non-executive Director	8/8	6/6	-	3.5/4	1/1	5/5
Jackie Westaway Vice Chair Non-executive Director	8/8	6/6	-	4/4	8/8	-
Prof Anthony Warrens Non-executive Director	6/8	-	-	0/4	0/8	-
Executive Directors						
Tony Chambers Chief Executive	8/8	-	9/11	-	-	-
David Amos Interim Director of People & Organisational Development	7/7	-	6/10	-	-	5/5
Hannah Coffey Director of Strategy & Partnerships	2/2	-	-	-	-	-
Kathryn Halford Chief Nurse	8/8	-	-	-	8/8	5/5
Peter Hunt Director of Communications & Engagement	8/8	-	-	-	-	-
Ben Morrin Deputy Chief Executive	2/2	-	3/3	-	-	1/1
Dr Magda Smith Chief Medical Officer	8/8	-	-	-	8/8	5/5
Shelagh Smith Chief Operating Officer	8/8	-	10/10	-	7/7	-
Nick Swift Chief Financial Officer	8/8	-	11/11	-	-	-
Alan Wishart Interim Director of Workforce	1/1	-	1/1	-	-	5/5 (as Deputy Director of Workforce)
Associate Non-Executive Directors						

	Trust Board	Audit & Risk Assurance (ARA)	Finance and Investment (FIC)	Remuneration & Terms of Service	Quality Assurance (QAC)	People and Culture (PCC)
Ruth Crowley	1/1	-	-	-	-	-
Mehboob Khan	2/2	-	-	-	8/8	5/5
Sandy Malone	2/2	-	2/2	-	-	1/1
Caroline Roberts	1/ 2	-	-	-	1/2	1/1
Eric Sorensen	2/2	-	-	-	7/8	5/5
George Wood	2/2	-	11/11	-	-	-

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 2020/21 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 and update of the Committee's Terms of Reference.

- Undertook a Committee self-assessment process.

- Completed an Annual Report of its work which will be submitted to the Trust Board meeting in June 2021.

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 met as the Auditor Panel in order to be able to make a recommendation to the Trust Board for the appointment of BDO LLP as external auditors following a procurement exercise.

Members of the Audit Committee in 2020/21 were:

Mr Tom Phillips (Chair)
Ms Jackie Westaway
Ms Susan Lees
Ms Lesley Seary

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/register-of-interests

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 2021 were BDO LLP. BDO 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 they ought to have taken to make themselves 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

13 July 2021

Tony Chambers
Chief Executive

13 July 2021

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: 13 July 2021

ANNUAL GOVERNANCE STATEMENT 2020/21

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 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risks

The Trust has a Risk Management Strategy which sets out the agreed protocol for the management of risk and the individual responsibilities and accountabilities for risk.

Operationally, responsibility for the implementation of risk management has been delegated as follows:

- The Chief Nurse has responsibility for patient safety and patient experience, and joint responsibility with the Chief Medical Officer for Quality. The Chief Nurse also has executive responsibility for the clinical risk management framework.

- The Chief Medical Officer has responsibility for clinical governance and clinical risk, and has joint responsibility with the Chief Nurse for Quality.

- The Chief Financial Officer has responsibility for financial risk and control.

- The Company Secretary has responsibility for maintaining the Board Assurance Framework and its supporting processes.

- All Executive Directors have responsibility for the management of strategic and operational risk within their individual portfolios.

The risk management training programme had been reviewed and brought in-house during 2019/20. A face to face training package was developed which provided staff with access to 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.

During 2020/21 the ability to deliver the training was impacted by the Covid-19 pandemic. Face to face training was paused during the first and second waves. Upon resumption between the pandemic waves the training was delivered remotely and with less regularity.

The Covid-19 pandemic continued to have a significant impact during 2020/21. In order to maintain the Trust's capacity to maintain control over its decision making and governance and handle risks to enable a prompt response to the rapid changes, the measures that had been put in place at the outset of the pandemic in the last quarter of 2019/20 were continued.

These included:

- Establishment of a Gold and Silver Command structure for decisions relating to Covid-19.

- The weekly Trust Executive Committee re-focussed 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.

- The Trust continued to take 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*' in relation to streamlining its Board and Committee meetings which have been held virtually throughout 2020/21.

During 2020/21 further measures were put in place in response to the Covid-19 pandemic:

- The financial impact as a result of the Covid-19 pandemic has been reported and monitored on a monthly basis at the Trust's Finance and Investment Committee.

- During the height of the second wave of the Covid-19 pandemic in January 2021, a weekly telephone briefing was held between the Chief Executive, the Chair, the Chief Medical Officer, the Chief Nurse and Non-Executive Directors. The briefing enabled the Non-Executive Directors to be kept up to date with the changing position on Covid-19 and its impact on the organisation.

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 (KPMG) through the year.

- The results of External Audit's (BDO) 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 Board has put in place governance structures and processes to ensure that the organisation operates effectively and meets its statutory and strategic objectives.

Each year the Trust undertakes a process to provide evidence and self-certify that it has complied with (Condition FT4(8)) as set out in 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 in relation to the validity of its corporate governance structures and processes, having taken into account relevant evidence including any risks and associated mitigations.

Work has been undertaken to review the Trust's compliance for 2020/21 which will be received for approval by the Trust Board at its meeting in June 2021. The work has identified that the Trust remains compliant. The following sections set out the governance structures, processes and work undertaken during the course of the year to support this.

Approach to Risk

The Trust's risk and control framework consists of:

- Risk Management Strategy
- Risk registers and assessment processes
- Board Assurance Framework
- The Trust's governance structure

The Risk Management Strategy sets out an integrated approach to the management of risk across the organisation.

Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities. The strategy seeks to ensure:

- that the Trust's risks in relation to the delivery of services and care to patients are minimised, and that the wellbeing of patients, staff and visitors is optimised;

- that the assets, business systems and income of the Trust are protected;

- the Trust provides services that are best value for money;

- the implementation and on-going management of a comprehensive, integrated Trust-wide approach to risk management based upon the support and leadership offered by the Trust Board.

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. It includes guidance on the risk assessment matrix used to evaluate risks for inclusion on the Trust's risk registers.

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. The Audit and Risk Assurance Committee has responsibility for reviewing the relevance and rigour of the BAF and the arrangements surrounding it.

During the final quarter of 2019/20 a review of the format and content of the BAF had 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 on the

origins of the risk, the impacts that would occur if the risk were to transpire and improved clarity on controls and assurances. Work progressed in the early part of 2020/21 and the new framework was approved by the Trust Board in July 2020.

The framework included the objectives agreed by the Trust Board set out under the three strategic themes of Happy and Healthy Hospitals, Highly Reliable Hospitals and Partnerships with Purpose which were set out in the 'No Going Back' report received by the Board in May 2020.

During the year the processes for regular executive risk lead and Committee and Board review of the BAF have been embedded. The process involves a comprehensive review by the Company Secretary and Executive Risk Leads followed by a collective review by the Executive Team.

The Board Assurance Committees review the risks they are responsible for monitoring. The Committee BAF reports include heat maps which illustrate the current, inherent and residual scores for each risk as drivers for the Committee's focus - whether this needs to be on seeking assurance, or on taking further action to manage the risk. Feedback from the Committees is then incorporated into any further updates prior to Board review. Feedback from the Committees is also included in newly developed Committee Assurance reports to the Board which include a risk section. Throughout 2020/21 the Trust Board has received and reviewed BAF reports outlining changes to the risk position.

The Board Assurance Framework in 2020/21 included the following:

- **Financial Sustainability*:*** "If we do not exit financial year 2020/21 at a maximum £4m deficit per month run rate then we will not be on trajectory to delivery break even by 2023/24 which will inhibit our ability to optimise limited financial resource for the benefit of our population".

- **Capital Expenditure:** "If we fail to invest the increased level of capital on time/cost and deliver benefit from those investments, then this will impact on our ability to provide safe, effective and efficient services".

- **Covid-19:** "If the Trust is unable to manage safely and effectively the care of patients presenting with symptoms of Covid-19, then it could impact on the outcomes of those patients, the safety of our staff and organisational reputation".

- **A&E 4 Hour Standard:** "If there are a lack of robust processes and systems in A&E and the wider hospital, then we will not be able to manage patient flow effectively, resulting in delay in treatment and potential harm to patients and failure to deliver the A&E 4 hour national standard".

- **Access Standards:** "If the volume of demand significantly exceeds the ability of the Trust to manage it, then it could result in a significant, prolonged adverse impact on the quality and productivity of services across multiple divisions, affecting a large number of patients and the achievement of the NHS constitutional access standards".

- **Quality:** "If we do not deliver and demonstrate improvement in the quality of our care and reduction of unwarranted variation, then we will not deliver our regulatory and compliance standards resulting in a failure to improve our CQC rating".

- **Patient Experience:** "If we do not address the variability and inequalities of the patient experience, then we will not meet the needs of our diverse population, resulting in poor patient experience and outcomes".

- **Staff Experience:** "If we fail to have a happy culture, promote staff wellbeing, improve the

experience and representation of our diverse workforce and deliver great leadership, there is a risk to our ability to recruit and retain the best, have financial and operational resilience and deliver outstanding care to our community".

- **Workforce:** "If we fail to recruit, retain, deploy and develop the right staff into the right places with the right skills then we will not run reliable hospitals and provide high quality and accessible patient services".

- **Horizontal Partnerships:** "If we do not move from competition to collaboration with other acute providers in North East London, we will not share best practice and optimise scarce capacity which will worsen patient experience and outcomes".

- **Vertical Partnerships:** "If we do not move from an entity focus to partnership working across our three boroughs, we will not improve whole system pathways and reduce un-necessary spells in hospital for our population".

- **Digital Maturity and Estates:** "If we do not catch up on our investment in estates and digital, we will not be providing the right environment and information for our population and workforce, resulting in financial waste and poor patient care".

- **Reputation:** "If we do not ensure that stakeholders are fully informed about our key issues (including, for example, rapid service change due to Covid-19) then we will lose their support and risk reputational damage and fail to achieve the change that is in the best interests of our service users".

- **Corporate Governance:** "If we do not ensure that we have effective corporate governance in place, then the Board might fail to provide strategic direction and oversight resulting in a failure to deliver its duties set by the Department of Health"

During 2020/21 work has been undertaken with internal auditors to develop the Trust's risk appetite through statements which set out the amount of risk that the Trust is willing to accept, tolerate or justify when delivering healthcare, education, training and research. At the point of writing this statement it is expected that the work will be concluded for Board agreement by the end of the first quarter of 2021/22.

Corporate and divisional objectives are risk assessed as part of the annual business planning and performance management process.

The Trust's risk assessment process covers all of its activities – clinical services, clinical support services and business support functions. Each Division is responsible for maintaining its own risk register in accordance with the Risk Management Strategy. Structured processes are used for the completion of local risk assessments to populate the risk registers.

Best practice is highlighted and shared across divisions through divisional leads, the quality sub committees 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 risk registers are reviewed regularly by divisional forums, and they are required to escalate risks with scores of 15 and above, for inclusion on the Corporate Risk Register.

Our Risk and Compliance Group meets monthly to review the Trust risk register. It receives and reviews a Corporate Risk Report which includes all risks with scores of 15 and above. These risks are reviewed for their link to the Board Assurance Framework.

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 the risk register and the operation of the risk escalation process through the direct engagement of senior operational staff.

Risk management is embedded within the organisation in a variety of ways. All members of staff have a duty to report incidents, hazards, complaints and near misses in accordance with relevant policies. There are structured processes in place for incident reporting, the investigation of Serious Incidents (SIs), complaints and litigation cases.

Many partners support and help us to manage risk. These include our PFI partners; the Local Counter Fraud Specialist; 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.

The risks associated with the Covid-19 pandemic have been closely monitored throughout 2020/21 and added to the Trust's risk register. The BAF includes a separate risk in relation to Covid-19 and in addition the Quality Assurance Committee and Trust Board receive further assurance through an Infection Prevention and Control Covid-19 specific Board Assurance Framework.

The Trust Board and Work of the Board Committees

The Trust Board has overall responsibility for the performance of the Trust. The Board has the following functions:

- To set strategic direction, define objectives and agree plans for the Trust.
- Delegate the achievement of objectives to the Chief Executive.
- Monitor performance and ensure appropriate corrective action is taken.
- Ensure financial probity and stewardship.
- Ensure high standards of corporate and clinical governance.
- Appoint, appraise and remunerate Executive Directors.
- Ensure dialogue with external stakeholders such as statutory bodies and the local community.

In 2020/21 the Board had six committees: Audit and Risk Assurance, Remuneration and Terms of Service, Finance and Performance, Quality Assurance, People and Culture and Trust Executive Committee. These committees exist to support the Board discharge its duties in the following ways:

- Enable the Board to discharge its duties and to govern the Trust effectively, including extending its ability to monitor, review, and revise its strategic direction and the achievement of agreed outcomes.
- Support the Non-Executive Directors in their scrutiny and challenge of Executive management action.
- Maximise the value of Non-Executive Directors' time.
- Support the Board's assessment of evidence so as to enable the Board to make evidence-based unitary decisions.
- Support the more detailed development of background work that might not otherwise be possible at Board meetings alone.

During 2020/21 the Board and Committee meeting schedule which had been developed at the end of the previous financial year has been embedded despite the challenges posed by the Covid-19 pandemic. The new schedule included a move to bi-monthly Board Meetings in Public which have been held virtually during the year, improved phasing of Board Committees to enable them to report in a timely fashion to the Board and Board Seminar sessions.

The Board Seminar sessions have focussed on a number of areas of development including:

- A workshop to ask ourselves what would working in hospitals which put the health and happiness of their staff at the top of the agenda look like? This was the starting point in our journey to a New BHRUT as part of our 'No Going Back' vision. At the workshop a cross- section of staff joined the Board to take part in interactive discussions about this vision and to co-create our happy principles or 'manifesto' for Happy and Healthy Hospitals.

- A workshop on 'Making Data Count' where the Board considered data variation, why it matters and meaningful ways to summarise data charts.

- Proposals for new leadership and operational delivery structures to ensure highly reliable site based daily management and highly effective cross-site clinical leadership together with the development of a Performance and Accountability Framework.

The Chairs of the Board Committees present written reports to the Trust Board after each meeting, highlighting significant issues of interest, including key risks identified, other matters considered and decisions made at their meetings. Work was undertaken during the year with the Non-Executive Director Committee Chairs to enhance the structure and content of these reports.

The practice of having a standing item for the escalation of issues to the Board, on committee agendas has continued. This ensures systematic consideration by all committees about any emerging key risks the Board needs to consider.

The Audit and Risk Assurance Committee meets bi-monthly and exists to oversee the establishment and maintenance of an effective system of internal control throughout the organisation, by means of independent and objective review of financial and corporate governance, and risk management arrangements including compliance with law, guidance and regulations governing the NHS. It ensures there are effective Internal Audit arrangements in place that meet mandatory NHS Internal Audit Standards and provide independent assurance to the Board. KPMG LLP became the Trust's new Internal Auditors at the beginning of 2020/21.

The Committee reviews the work and findings of External Audit and provides a conduit through which the findings can be considered by the Trust Board. The Committee maintains oversight of the Trust's Internal Audit and Counter Fraud arrangements. The Trust's External Audit providers (BDO LLP) were appointed in 2020/21 by the Trust Board following a procurement exercise involving the Trust's Auditor Panel.

The East London NHS Foundation Trust (ELFT) provides the Trust's counter fraud service. The Audit and Risk Assurance Committee has received regular reports from the Trust's Local Counter Fraud Specialist (LCFS) during 2020/21.

The 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 (NHSCFA) 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.

Throughout 2020/2021 the Local Counter Fraud Specialist (LCFS) adapted to remote working due to the pandemic, conducting virtual presentations and producing bite-size videos to maintain awareness of fraud throughout the Trust and how to continue reporting it. Detection and prevention work this year, which usually concentrates on a high risk area, focused on conflicts of interest, off-payroll workers and anti-bribery review to ensure robust measures were in place. When any system weaknesses are identified, recommendations are made and

implemented in relevant departments to ensure processes withstand any occurrences of fraud. Trust policies remain under regular review to ensure best practice and robustness. Throughout the pandemic, alerts and guidance around Covid-19 scams were cascaded. A nominated Fraud Champion is now in place, in line with NHSCFA requirements, with a primary role to support the LCFS in raising concerns at a strategic level at the Trust.

To measure and assess the risk of fraud at the Trust and to ensure that the delivery of services is risk based, the LCFS continued to capture fraud risks from internal audits undertaken within the Trust, with the Fraud Risk Assessment Report regularly updated to reflect this along with updates from the NHSCFA and any other items which could impact controls and measures. The LCFS has continued to attend the Trust Risk and Compliance Group meetings; and there is still some work to be done in this area to ensure the Trust becomes fully compliant against its own Risk Management Policy, in terms of recording these risks on the Trust's risk management system.

Counter Fraud work in 2020/2021 was undertaken to meet the NHS Counter Fraud Authority (NHSCFA) Standards for Providers; however, with the release of the new Government Standards 013 in relation to Fraud in February 2021, compliance against these new standards has been reported instead; with the Trust acquiring an Amber rating – an Action Plan is in place to address the areas of non-compliance.

The Remuneration and Terms of Service Committee is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for the termination of contracts. The Committee ensures that appropriate performance management arrangements are in place for Executive Directors. The Committee has met on four occasions during 2020/21.

Significant areas of interest covered in year have included the establishment of new Board roles: Deputy Chief Executive, Director of Strategy and Partnerships, Director of Finance and the establishment of the Director of Equality, Diversity and Inclusion.

The Finance and Investment Committee meets monthly. Its purpose is to provide assurance to the Board on the effectiveness of the Trust's use of resources. This includes:

- Assurance that the financial performance is delivered in accordance with agreed strategy, plans and trajectories.
- Assurance on the development and delivery of the Trust's Digital and Estates strategies.
- Overview and scrutiny in any areas of financial and performance referred to it by the Trust Board.

During the year the Committee has focussed its work on two key Board Assurance Framework risk areas: financial improvement and investing for value (capital expenditure). Significant areas of interest reported from the Committee to the Trust Board are detailed below.

The financial plan for the year was heavily impacted by Covid-19. Nationally a temporary financial framework was introduced to simplify arrangements and ensure trusts were financed sufficiently to respond to the pandemic. Consequently the Trust reported a small annual surplus and on average across the year 94% of non-NHS suppliers were paid within 30 days.

Whilst it has been critical to ensure finances have been in place to support the response to the pandemic, as an organisation it has remained a priority to manage the underlying position during a very challenging period. The average underlying monthly deficit entering 2020/21 was £5m per month. As operational pressures grew significantly the run rate deteriorated by £1m a month from November. This means entering 2021/22 with a full year underlying annual deficit of £72m delaying our strategic ambition of breaking even by 12 months. At the end of 2021/2022 the Trust will need to be at a monthly deficit of £4m to achieve

breakeven position at the end of 2023/2024. The Committee will monitor the delivery against this throughout 2021/2022.

Consistent with 12 months ago, we continue to be confident that the opportunities to resolve the financial position are well understood. Our corporate priorities will focus efforts on halving the excess premium cost of temporary staff and removing waste in elective pathways so that more patients can be treated which will also improve our finances. Covid-19 has strengthened how we work in partnership and we will continue to harness these to drive out further system waste.

We have significantly grown investment into our infrastructure, spending £45.6m on capital, which is nearly double the investment made in 2019/20. This investment is transforming the Emergency Department Estate on both sites and we are establishing a Children and Young Peoples Assessment Unit at Queen's Hospital. A second Da-Vinci Robot and an Orthopaedic Robot will enable us to expand access to cutting edge surgical procedures, whilst we have also modernised our stock of diagnostic imaging equipment including the addition of a 3T MRI scanner. The Trust's I.T. infrastructure deficit built up over a number of years is significant but we continue to invest and are closing the gap on an ambitious trajectory.

The Trust's Standing Financial Instructions and Scheme of Delegation have been reviewed during 2020/21 and a number of changes made which were endorsed at the Finance and Investment Committee, Audit and Risk Assurance Committee and approved by the Trust Board.

A review of the Committee's responsibilities was undertaken in the final quarter of 2020/21 and into the first quarter of 2021/22. At the time of writing this statement a proposal that the Committee should become a Finance, Investment and Performance Committee is scheduled for Board approval. The proposal is based on the intrinsic link between the delivery of the Constitutional Standards, the Trust's finances and its overarching recovery. The monthly Performance Report would in future be received at the Committee.

The Quality Assurance Committee would in future receive information on the quality impacts of constitutional standards performance within its monthly Integrated Quality and Safety Report. Work is commencing to develop the reporting for this.

The Quality Assurance Committee is responsible for providing the Board with assurance on all aspects of the quality of clinical care, on clinical governance systems, and on standards of quality and safety.

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

The Quality Assurance Committee has changed its reporting schedule in year to meet monthly as the Board committee responsible for scrutinising the following Board Assurance Framework risks:

- A&E Four Hour Standard.
- Access Standards.
- Covid-19.
- Quality.
- Patient Experience.

Significant areas of interest reported from the Committee to the Trust Board are detailed below.

Our A&E Four Hour Standard remains a challenge with all types performance deteriorating in the last two quarters of 2020/21:

BHRUT 4 Hour Access Standard Performance – All Types			
Q1	Q2	Q3	Q4
80.48%	74.74%	67.65%	68.64%

Whilst the pandemic had an impact on this deterioration in performance, the issues are long standing and can be grouped into the following themes:

- Capacity
- Leadership and Culture
- Processes

This has been further supported and confirmed by the recommendations and findings from the Peer Review and Getting It Right First Time (GIRFT) report from 2020/2021.

We have approximately 100 beds shortfall in our capacity to meet the demand at peak times. Whilst some gains are being planned through admission avoidance and length of stay efficiencies, wider system support is required relating to capital investment and local system support relating to the management of patients presenting with mental health issues, rehabilitation capacity in the community and demand management, prevention and discharge facilitation.

During the last quarter of 2020/21 we revised the Internal Professional Standards and have started planning their implementation. The Leadership model in ED is also under review to enable dedicated resource and focused approach to the improvement agenda.

We are aligning our processes with the recommended Urgent and Emergency Care Standards and are focusing our recovery plans on:

- arrival to ready to proceed (including streaming/flow in Emergency Departments and Frailty Receiving Units);
- onwards care (including Same Day Emergency Care, patients spending more than 12 hours in Emergency Departments, Children and Young People Assessment Unit) and
- discharge (including early, pre-5 discharges and reduction in 7+, 14+ and 21+ days length of stay).

Capital support has been provided to both hospital sites to improve the Emergency department facilities. At Queen's Hospital additional Rapid Assessment for Treatment spaces were created adjacent to the existing provision. This has enabled faster ambulance offloads and a space for patients awaiting the outcome of their initial assessments. This is now a light, bright and welcoming clinical space. Staff offices and staff room facilities that were affected by the conversion of this space were then provided in the ground floor "grey" space between the assessment units. Additionally we were able to enhance the staff welfare facilities with showers and changing rooms. A "hot lab" space was also provided in this area to ensure rapid turnaround of laboratory tests for patients in the ED. This has further improved patient experience and enhanced timely clinical decisions.

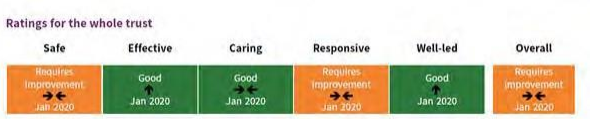
On the King George site significant reconfigurations of the ED have been achieved and continue. The Urgent Treatment Centre has moved out of the ED space in to a purpose designed unit in the outpatient department. This vacated space has facilitated reconfiguration of all aspects of ED, leading to an improved ambulance entrance, doubling of the Resus capacity, increases in the number of majors bays, including specific mental health provision. On- going works due for completing in summer 2021 include a larger children's emergency department, segregated male and female observation ward facilities, rapid assessment for treatment bays and improved staff welfare and wellbeing facilities.

In view of the system challenges and control issues, our trajectory is to reach 75% 4 hour performance for All Types across the Trust by October 2021 and 80% by March 2022. This is based on the confidence and delivery analysis of the improvement opportunities.

Together with its sub-committees, the Quality Assurance Committee oversaw the Trust's on-going compliance with the Care Quality Commission Fundamental Standards of Quality and Safety.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

We are currently rated by the CQC as requiring improvement; however we are pleased that we have achieved our objective and maintained a CQC rating of Good for Effective, Caring and Well Led domains whilst recognising that we have further work to do to improve our ratings for Safe and Responsive, in order to improve our overall rating to Good.



The Trust was last inspected by the CQC in January 2020. This was an unannounced responsive focussed inspection of the Emergency Departments at King George's (KGH) and Queens's Hospital (QH). The inspection was triggered in response to a poor Emergency Department performance. In response to the CQC findings 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. Our overall rating of Requires Improvement was maintained.

Progress against our improvement plans is monitored weekly at quality huddles chaired by the Chief Nurse and via quarterly quality summits attended by all Divisions. Briefing updates are provided to the CQC Inspection Manager by the Director of Nursing – Cross Divisional Programmes at least monthly and the Trust Board is updated on progress and any significant changes.

The CQC changed their approach during the coronavirus pandemic. Inspections were paused in March 2020. Small focused inspections were resumed in some trusts in October 2020 but BHRUT have not undergone inspection since the aforementioned inspection of our Emergency Departments in January 2020.

The new regulatory approach is to assess how Trusts are managing via a telephone call assessment. BHRUT have been undertaking such assessment calls with the CQC fortnightly.

The questions asked during the assessment calls relate to four areas:

- safe care and treatment;
- staffing arrangements;
- protection from abuse;
- assurance processes, monitoring, and risk management.

Nationally the CQC have required trusts to provide assurance related to three topics:

1. Patient First – Keeping our patients safe in Emergency Departments.
2. Infection Prevention and Control – IPC Board Assurance Framework.
3. Ockenden Report – Improving Maternity Services.

The information gathered during the calls is used to form a view about how we are coping. There are two possible outcomes arising from the assessment call - either that the Trust is managing and no support is required, or that the Trust requires support.

The Trust provided assurance to the CQC and has been deemed to be managing and therefore has not required support. Our experience of this focussed approach has been positive. It has involved the submission of a raft of evidence followed by virtual meetings and discussions. We have been commended by the CQC for maintaining a positive open relationship.

At each meeting the Committee reviews an Integrated Quality and Safety report which includes data covering the five CQC domains: Safe, Effective, Caring, Responsive and Well Led.

Quality key performance indicators (KPIs), including the number of never events, serious incidents and explanations of follow-up actions, are monitored by the Committee. There were 122 Serious Incidents reported during the year with four being subsequently de-escalated, and three Never Events. These and other year-end key performance indicators are referenced in the performance report section of the annual report.

Other areas of significant interest covered by the Committee during the year have included:

- An assurance report to each meeting summarising the business of the Quality Governance Steering Group which reports to the Quality Assurance Committee. The report highlights key areas of escalation to the Committee.
- The clinical audit plan for 2020/21.
- Review of the Quality Account for 2019/20.
- Regular updates on the Covid-19 position including the Infection Prevention and Control Board Assurance Framework.
- Focus on the risks related to the Trust's Urgent and Emergency Care Four Hour Access Standard performance. This included review of the Urgent and Emergency Care Priority Plan.
- Review of the Ockenden Report and Trust Action Plan.
- Approval of a number of strategies including:
  - Nursing, Midwifery and Allied Health Professionals Strategy 2021 – 2025.
  - Safeguarding Strategy 2021 – 2025.
  - Patient and Carer Experience Strategy 2021 – 2025.
- A number of reports relating to matters of communication and service user experience and feedback, including:
  - Service User feedback on Virtual Clinics.
  - Communications during the pandemic.
  - Post Discharge Wellbeing Calls.

The Trust has continued its work during 2020/21 to further embed 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 fundamental to 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 People and Culture Committee meets bi-monthly and is responsible for providing the Board with assurance that all aspects of the Trust's people and culture agenda are being met to enable its vision to provide outstanding healthcare to our communities delivered with a determined focus on equality and equity.

The Committee is responsible for monitoring the following Board Assurance Framework risks:

- Workforce.
- Staff Experience.

The Committee has reviewed its remit which will develop further over the next year to add responsibility for developing the role of the Trust in relation to its place in the local community, and in particular its contribution to improving the wider health and well-being of the population with the focus on tacking health inequalities and reshaping service to promote early intervention and the prevention of illness.

In the short term the Committee has kept a very sharp focus and scrutiny on the culture, leadership and equality, diversity and inclusion within the Trust. There is considerable work to do in the Trust to get the culture we need and to ensure that effective leadership is in place with a strong focus on equality, diversity and inclusion.

In order to achieve this focus the Committee has expanded its membership to include representatives of staff networks and trades unions who can add expertise to the work on the committee. The Committee has also added additional Non-Executive Members who bring considerable expertise to aid its work.

Areas of significant interest covered by the Committee during the year have included:

- Review of the Gender Pay Gap Report.
- Quarterly updates from the Freedom to Speak Up Guardian Service.
- Quarterly updates from the Guardian of Safe Working Hours.
- Non-Executive Director deep dive into Equality, Diversity and Inclusion, including executive action plan.
- Progress reports on the recruitment into senior posts of Agenda for Change, Band 8a and above and including Very Senior Managers' posts.
- The Chief Nurse Fellows Programme.
- Review of the Recruitment and Retention Strategy prior to Board approval.
- The 2021/2022 Improving Staff Experience Programme.

The Trust Executive Committee is an executive committee responsible for overseeing the delivery of the strategy and the quality, operational and financial management of the Trust. The Committee is chaired by the Chief Executive and provides a fortnightly forum and mechanism for executive decisions and management. The focus of the Committee for a large part of the year was on the Trust's response to the Covid-19 pandemic. Towards the latter part of the year the focus has been on the key areas of recovery: staff wellbeing, finance, elective and non-elective.

The Trust has constituted a Recovery Board toward the end of the year which reports into the Trust Executive Committee and is chaired by the Deputy Chief Executive. Focus is on four key areas of recovery:

- Non-elective and Emergency Care.
- Elective.
- Finance.
- Culture and Wellbeing.

Workforce Strategies and Staffing Systems

Our Trust Board is required to have oversight of and be accountable for staffing and NHS Improvement's Developing Workforce Safeguards.

Safe Staffing reports are provided to the Trust Board every six months to comply with this requirement. The report provides the Trust Board with information on staffing levels across our wards and departments and assurance of the on-going work to monitor and manage levels of nursing and midwifery staff.

The Trust is committed to the triangulated approach and to ensuring that levels of nursing and midwifery staff, including care support workers, is correct for the acuity and dependency of the patients using the relevant evidence based assessment tool applicable to the clinical area.

Safe staffing levels are viewed taking acuity and dependency into consideration along with skill mix, nurse to patient ratios; staffing numbers per shift, care hours per patient day and professional judgement.

During the year the SafeCare acuity Tool was successfully implemented to support this work.

During 2020/21 the focus was on short term strategies to ensure safe staffing to support the response to the Covid-19 pandemic. This work included joint working across the Integrated Care System, particularly responding to Intensive Treatment Unit shortages, recruitment of volunteers and support staff. Woking with Integrated Care System partners the strategy also included the joint support of managing temporary staffing where possible.

Alongside the above the Trust continued to recruit internationally for both nursing and medical staff who are onboarding during 2021/22.

Equality Diversity and Inclusion

We continued our journey to become more inclusive places to work and receive care in 2020, mindful that we had more to do for our diverse workforce.

The road we were on inevitably changed direction as a result of the Covid-19 pandemic, and in particular the disproportionate impact of this on our black, Asian and minority ethnic colleagues and communities.

Our immediate response was to set up a black, Asian and minority ethnic Task and Finish Group to work collaboratively on completion of timely risk assessments. We engaged regularly with our black, Asian and minority ethnic Network and workforce with focus groups and equality themed Question Time with the Executives. The Task and Finish Group changed its focus to engaging with colleagues to provide information, advice and guidance on vaccinations later in the year.

The People and Culture Committee undertook a Non-Executive-led Equality Diversity and Inclusion Deep Dive in recognition of the importance of improving equity and inclusion as a core strategic aim and enabler of our goals to be happier and healthier hospitals. This was led by Lesley Seary and Mehboob Khan, Non-Executive Directors and PCC members who engaged with Network Chairs, key leads and stakeholders.

Key observations and recommendations have been shared and this welcome contribution has started to shape our approach for 2021/22 with insightful observations and reflections on the key themes of speaking up, ensuring our workforce is representative of its diversity at senior and leadership levels as well as linking equality, diversity and inclusion intrinsically to our culture improvement work.

Other recommendations from this work have been implemented including making all our staff Network Chairs members of the People and Culture Committee and agreeing a budget for the Networks.

In September we launched a Women's Network and Reference Group. Our black, Asian and minority ethnic Network has gone from strength to strength and been a powerful local voice in response to the disproportionate impact of Covid on their communities and families, the death of George Floyd and the resurgence of The Black Lives Matter movement.

Our Ability not Disability Network continues to promote the social model of disability as an asset and has produced a range of guides to support colleagues and enable them in turn to be supported by their managers.

Our LGBT+ Network continue to challenge us to be more welcoming and inclusive of their community and colleagues.

Staff Survey

Our staff survey findings in year showed deterioration in colleagues experience generally, with less than the previous year believing we provide equal opportunities for career progression and promotion. Towards the end of the year we were able to renew our focus on inclusive and fair recruitment and this is now a specific workstream as part of our culture improvement work.

Our overall engagement score in the staff survey also deteriorated to 6.8 compared to 7.0 in 2019. The score covers a range of questions new in 2020 relating to working conditions during the Covid-19 pandemic. Our culture improvement work under the wellbeing workstream is addressing this with pulse check surveys to better understand colleagues experience during the pandemic and the positive legacy they need in place to reverse this trend.

Towards year end it was clear our journey needed to pick up the pace. The year closed with a further commitment to create a Board level Executive Director of Equality, Diversity and Inclusion to commence in post at the earliest opportunity.

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 and Risk Assurance 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 Trust Board 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.

As operational pressures grew significantly during 2020/21 the run rate deteriorated by £1m a month from November. This means entering 2021/22 with a full year underlying annual deficit of £72m

delaying our strategic ambition of breaking even by 12 months.

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 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 June 2021. At the last review, the Trust was compliant in all assertions. The final review of the Data Security Protection Toolkit is scheduled for early June 2021.

Between April 2020 and March 2021 there were 3 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 continues to review policies and procedures to ensure compliance and meet the standards introduced by the Data Protection Act 2018. The Information Governance Team has been expanded and a new Data Protection Impact Assessment process has been implemented which has allowed improved responsiveness to the changing technological landscape and to aid transformational change within the Trust. Further work is underway looking at the Trust's data flows with key partners in the community and wider health landscape with the aim of better supporting working in partnership with other health care providers improving quality of care and patient experience.

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 (Elective). 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 patients 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 in place a strategy, a work plan, validation processes, metrics, key performance indicators and periodical audits which seek 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.

External data quality audits have been completed by 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, Elective Care Delivery and is reviewed and approved by our 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

Elective Care and Covid-19 Impact

Before the Covid-19 pandemic, 40,852 patients were waiting for a consultant-led elective care treatment with 50 patients waiting for more than 1 year and 9,861 patients waiting for more than 18 weeks for treatment. At the time of this statement on 26th May 2021, 50,528 patients are waiting for treatment with 1,745 patients waiting for more than 1 year and 18,227 patients waiting for more than 18 weeks. Our Elective care performance, percentage of patients waiting over 18 weeks, deteriorated from 76% to 64%.

The BHRUT data quality team plays a central role in ensuring that patient pathway status is accurate; the validation team continually corrects data quality errors such as duplicate pathways, overlapping pathways, patients in incorrect waiting list etc. The above corrections ensure that available slots are effectively used for the patients who genuinely require appointments and treatments.

The validation team review patients waiting over 90 weeks every week and operational teams ensure that these patients are prioritised. Weekly long wait week huddles ensure that patients are seen in a timely manner. Harm review processes will be re- aligned to take into account of impact of long waits due to Covid. The Weekly Access Board ensures that constraints to elective care delivery in the order of clinical priority and long waiters are addressed. Quality data is paramount for the successful outcome of all of the above processes.

Patients added to the admitted waiting list are checked and corrected as appropriate by the data quality team, and these patients are clinically prioritised into 5 groups, namely, patients to be seen within 24 hours, within 24-72 hours, within 4 weeks, within 3 months and beyond 3 months. Data quality corrections are crucial for the optimised use of available theatre sites. Patients are booked as per the above prioritisation. Theatre lists are grouped into high activity low complex patients and available theatre slots are optimised.

Diagnostic units have been re-assigned to be within green area and as a result, diagnostic patients are seen without delay. Continuous review and allocation and re-assignment of green theatres ensure that we are responsive to the changing

requirements of Covid-19 patients. Our Organisational Recovery team, theatre transformation board, outpatient transformation boards are effectively monitoring the effective use of space to see patients. Approximately 40% of outpatient appointments are seen virtually, ensuring patients are seen in a timely manner.

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.

Regular reports have been received from the Board Committees and senior managers in relation to key risks. Annual reports have been received by the Trust Board relating to important areas of activity, and ad-hoc reports in-year wherever these were required and as mentioned previously in this statement.

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. For 2020/21 our internal auditors changed to KPMG from RSM.

The Head of Internal Audit has issued the following opinion as at 3 June 2021, based on the work undertaken in 2020/21: **'Significant assurance with minor improvement opportunities'**.

Internal audit reports completed in year assessed as being of significant assurance with minor improvements required included:

- Organisation and Financial Covid Governance.
- I.T. Resilience and Remote Working.
- Infection Prevention Control.
- Core Financial Controls.
- Data Quality – Covid-19.

Two internal audits undertaken in year were assessed as partial assurance with improvements required:

- PFI Management.
- Temporary Staffing

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.

At the end of 2019/20 I reported that inadequate progress had been made in implementing the actions from the internal audit recommendations. During 2020/21 there has been an improvement with management engaged on the prioritisation and de-prioritisation of recommendations as the pressure and commitments required as a result of the Covid-19 pandemic have changed through the year. All changes to recommendation due dates have been reported to and agreed at the Audit and Risk Assurance Committee. At the current time there are 37 live internal audit recommendations with none overdue. Work will continue to monitor delivery to ensure that our progress is maintained.

Conclusion

In conclusion, 2020/2021 was a difficult year impacted by the pressures of the Covid-19 pandemic. I can confirm that there are two significant control issues which have been identified in my Annual Governance Statement:

1. The underlying deficit position deteriorated from £5m to £6m per month during the year, with an underlying annual deficit of £72m and the Trust remains in Financial Special Measures.
2. The performance for urgent and emergency care with our All Types performance deteriorating in the last two quarters of 2020/21.

Signed

Tony Chambers
Chief Executive

Date: 13 July 2021

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. During 2020/21 as a result of the Covid pandemic our usual personal performance review process was halted during the pandemic. Instead Wellbeing conversations were undertaken. These discussions incorporated career development discussions.

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.

Again, as a result of Covid the Remuneration Committee was unable to undertake its normal review process for each director against the responsibilities of the role and objectives set through performance plans. However each director undertook a Performance Planning Review and had objectives set.

The notice period for all substantive executive directors is six months and there are 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.

The following sections of the staff and remuneration report subject to audit;

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

TABLE 1

Salary and Pension entitlements of senior managers
Remuneration

Name and Title	Period (See Note 1)		2020-21						2019-20					
(all figures in £'000)	From	To	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	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
Joe Fielder - Chair	01/04/2020	30/11/2020	25-30	0	0	0	0	25-30	35-40	0	0	0	0	35-40
Mike Bell - Chair	01/12/2020	31/03/2021	10-15	0	0	0	0	10-15		0	0	0	0	-
Tony Chambers - Chief Executive [2]			210-215	0	0	0	0.0 - 2.5	210-215	50-55	0	0	0	780.0-782.5	830-835
Chris Bown - Chief Executive									175-180	0	0	0	0.0-2.5	175-180
Ben Morrin - Deputy Chief Executive [3]	04/01/2021	31/03/2021	35-40	0	0	0	0.0 - 2.5	35-40		0	0	0	0	-
Shelagh Smith - Chief Operating Officer			160-165	0	0	0	27.5 - 30.0	190-195	155-160	0	0	0	72.5-75.0	230-235
Dr Magda Smith - Medical Director [4]			205-210	0	0	0	80.0 - 82.5	285-290	220-225	0	0	0	472.5-475.0	695-700
Nick Swift - Chief Finance Officer			180-185	0	0	0	0.0 - 2.5	180-185	180-185	0	0	0	0.0-2.5	180-185
Kathryn Halford - Chief Nurse			170-175	0	0	0	0.0 - 2.5	170-175	160-165	0	0	0	0.0-2.5	160-165
Peter Hunt - Director of Communications & Engagement			120-125	0	0	0	45.0 - 47.5	165-170	120-125	0	0	0	45.0-47.5	165-170
David Amos - Director of People & Organisational Development			140-145	0	0	0	0.0 - 2.5	140-145	140-145	0	0	0	0.0-2.5	140-145
Hannah Coffey - Director of Strategy and Partnerships [5]	08/02/2021	31/03/2021	0-5	0	0	0	0.0 - 2.5	0-5		0	0	0	0	-
Sue Lees - Non-Executive Director			10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Prof. Anthony Warrens - Non-Executive Director			10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Lesley Seary - Non-Executive Director			10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Jackie Westaway - Non-Executive Director			10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Joan Saddler - Non-Executive Director			5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Tom Phillips - Non-Executive Director			10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Median remuneration of all staff in the Trust (£)			36,706											34,961
Highest paid director of the Trust (£5k band)			210-215											240-245
Ratio of the above two figures			5.8											6.9

NOTES
(1) Unless the period is stated the Directors were here throughout the full financial year (i.e. 1st April 2020 - 31st March 2021).
(2) There were no pension values in current year as individual had left the pension scheme.
(3) Ben Morrin is on secondment from University College London Hospitals Trust (UCLH). His salary costs are being borne by UCLH but recharged to the Trust.
(4) Dr Magda Smith's changes in pension benefits were due to changes in the annual rate of pension entitlement and lump sum. NHS Pensions authorities were unable to provide further information on this.
(5) Hannah Coffey joined the Trust on 08/02/21 on an unpaid basis (Honorary contract). From 05/04/2021 for up to one year, Hannah will be on a fixed term contract with the Trust.

TABLE 2

Salary and Pension entitlements of senior managers (continued)

Pension Benefits

Name and title [1] (all figures in £'000)	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 2021 (bands of £5000) £000	Total related lump sum at age 60 at 31 March 2021 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2020 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real Increase/(decrease) in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Tony Chambers - Chief Executive [2]	0.0-2.5	0.0-2.5	0.0 - 5.0	0.0 - 5.0	1,218	0	0	0
Ben Morrin - Deputy 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 [3]	0.0 - 2.5	0.0-2.5	65.0 - 70.0	90.0 - 95.0	1,265	1,345	59	0
Dr Magda Smith - Medical Director [3]	2.5 - 5.0	0.0-2.5	90.0 - 95.0	245.0 - 250.0	1,925	2,056	99	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 [4]	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	76	114	36	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
Hannah Coffey - Director of Strategy and Partnerships	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0

(1) 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.
(2) There are no pension values in current year as individual had left the pension scheme, and NHS Pension authorities were unable to provide pension values of senior staff who were no longer contributing to the scheme.

(3) Individuals did not witness an increase in lump sum pension values.
(4) There are no pension values in current year as individual had left the pension scheme, and NHS Pension authorities were unable to provide pension values of senior staff who were no longer contributing to the scheme.

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.

Fair Pay Disclosure	2020-21	2019-20
Band of the highest paid director's total remuneration (£000)	210-215	240-245
Median pay remuneration (£)	36,708	34,961
Median pay multiple	5.8	6.9
Range of staff remuneration (£)	20,705-210,000	20,299-231,666

The highest paid director salary was £210,000 (2019/20, £240,792) in the current year against a median salary of £36,708 (2019/20, £34,961), 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 2020/21 was in the band £210k-£215k (2019/20, £240k-£245k). This was 5.8 times (2019/20, 6.9) the median remuneration of the workforce, which was £36,708 (2019/20, £34,961). 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 7 of the accounts. In 2020/21, the Trust spent a total of £774m of which staff costs accounted for £475m (61%).

Expenditure on Consultancy

In 2020/21 the Trust spent £1,319k on Consultancy services

Exit Packages

Details of Staff exit packages are included in Note 32 of the Accounts

Staff Report

Staff Numbers and Costs

Staff costs and numbers of employees are captured in the accounts at note 32.

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	Percentage
White: British	2,683	36.17%
Black or Black British:African	869	11.71%
Asian or Asian British:Indian	623	8.40%
White but not British or Irish	560	7.55%
Filipino	525	7.08%
Asian or Asian British but Unlisted	427	5.76%
Black or Black British but not Caribbean or African	357	4.81%
Asian or Asian British: Pakistani	242	3.26%
Black or Black British: Caribbean	207	2.79%
Not stated or unavailable	186	2.51%
An unlisted ethnic group	185	2.49%
Asian or Asian British: Bangladeshi	168	2.26%
White: Irish	123	1.66%
Mixed: Other Mixed Background	87	1.17%
Chinese	55	0.74%
Mixed: White & Black Caribbean	51	0.69%
Mixed: White & Asian	36	0.49%
Mixed: White & Black African	34	0.46%

The table below gives the gender breakdown within the Trust at 31 March 2021:

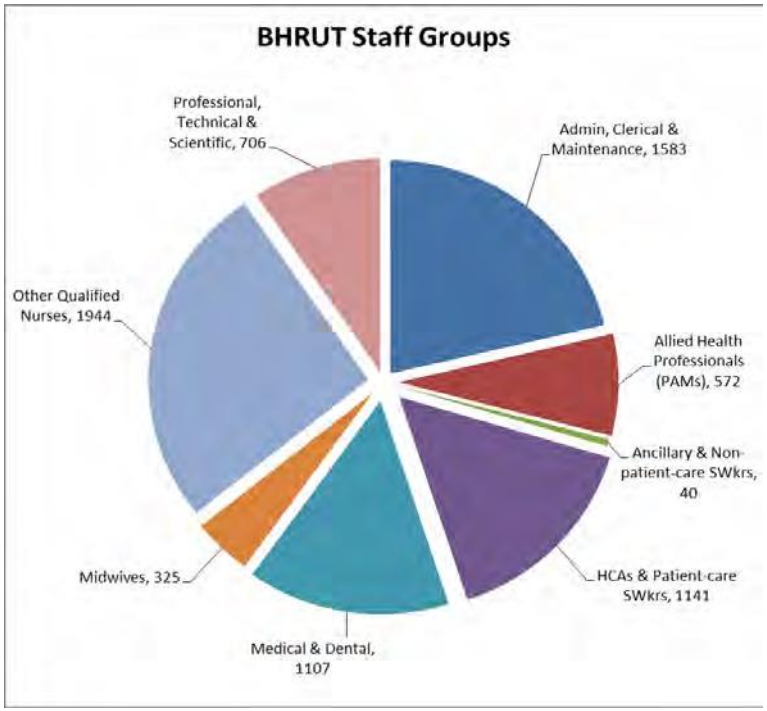
	Female	Male
Board Level Director	3	4
Non Exec / Chair	4	5
Senior Manager	350	165
All other employees	5,281	1,606
Total	5,638	1,780

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

Pay Band	Headcount
Band 8a	277
Band 8b	117
Band 8c	53
Band 8d	28
Band 9	31
VSM	9

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

Staff Group	Headcount	Ratio
Admin, Clerical and Maintenance	1,583	21.34%
Allied Health Professionals (PAMs)	572	7.71%
Ancillary & Non-patient-care SWkrs	40	0.54%
HCAs & Patient-care SWkrs	1,141	15.38%
Medical & Dental	1,107	14.92%
Midwives	325	4.38%
Other Qualified Nurses	1,944	26.21%
Professional, Technical & Scientific	706	9.52%



Of our 7,418 staff, 78% are in direct clinical care roles.

We have 424 more staff in post than last year.
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

Staff sickness absence rate at 31 March 2021 was 3.22%, although during both surges of the pandemic sickness rates significantly increased.

Staff Turnover

Staff turnover rate at 28 February 2021 was 12.77%. Due to the pandemic, as with most NHS Trusts, there has been little staff mobility therefore the turnover rate has been stable throughout the year.

Staff Engagement Percentage (for NHS Staff Survey)

The Survey ran from October to December 2020. As in previous years we surveyed all staff as recommended by NHS England. Staff were surveyed online. The overall response rate for the survey was 46.2% with 3,226 responses compare to 57% and 3,630 responses in 2019. These reflect the increase in staff headcount between years.

Our overall engagement score in the NHS Staff Survey deteriorated to 6.8 compared to 7.0 in 2019. The score covers a range of questions new in 2020 relating to working conditions during the Covid-19 pandemic. Our culture improvement work under the wellbeing workstream is addressing this with pulse check surveys to better understand colleagues experience during the pandemic and the positive legacy they need in place to reverse this trend.

Staff Policies applied during the year

We continue to support the Equality and Diversity agenda and have an Equality, Diversity and Inclusion policy including supporting the employment of people with protected characteristics. We are undertaking significant changes relating to our recruitment and selection policy to ensure this reflects our EDI agenda. Similarly we are reviewing our other ER policies to ensure they reflect the 'Just Culture' approach.

Trade Union Facility Reporting

Number of employees who were relevant union officials during the relevant period (full-time equivalent) 27**.**

Full-time equivalent employee number – 6957**.**

Percentage of time spent on facility time

Percentage of time and number of employees:

0% - 0

1-50% - 26

51%-99% - 1

100% - 0

Percentage of pay bill spent on facility time

The total cost of facility time was £55,000

The total pay bill was £416,847,000

Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100 – 0.01%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 – 0.02%

Table 1: Off-payroll engagements longer than 6 months For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months:	
	Number
Number of existing engagements as of 31 March 2021	-
Of which, the number that have existed:	
for less than one year at the time of reporting	-
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 2020 and March 2021, 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 2020 and 31 March 2021	**-**
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	-
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 2020 and 31 March 2021.	
	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	-
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.(2)	**16**

SECTION 3 - FINANCIAL STATEMENT AND NOTES

INDEPENDENT AUDITOR'S REPORT

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

Qualified opinion on financial statements

We have audited the financial statements of Barking, Havering and Redbridge University Hospitals NHS Trust (the Trust) for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs), and as interpreted and adapted by the 2020-21 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2020-21.

In our opinion, except for the possible effects of the matters described in the basis for qualified opinion on financial statements section of our report, the financial statements:

- give a true and fair view of the financial position of Barking, Havering and Redbridge University Hospitals NHS Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2020-21; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for qualified opinion on financial statements

As a consequence of the Covid-19 pandemic we were unable to attend management's counting of physical inventories held within the Trust at the end of the financial year, and we were also unable to attend counting of Personal Protective Equipment held on the Trust's behalf by a third party. As a result, we were unable to observe procedures used to ascertain existence and condition of inventories. In addition, we were also unable to obtain a report from the Trust's system detailing the volume and value of inventory items held as at 31 March 2021 as this report can only be generated at a specific point in time. It was not generated on 31 March 2021 and could not then be recreated retrospectively. We were unable to obtain sufficient appropriate evidence concerning the inventory quantities held at 31 March 2021, which are included in the Statement of Financial Position at £12.317 million, by using other audit procedures. Consequently, we were unable to determine whether any adjustment to this amount was necessary.

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

Material uncertainty related to going concern

We draw attention to note 1.2 to the financial statements, which concludes that that there is a material uncertainty in respect of going concern, and details the factors which have led to this uncertainty. As stated in note 1.2 these events or conditions, along with other matters as set out in note 1.2, indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion on the financial statements is not modified in respect of this matter.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

As described in the basis for qualified opinion on financial statements section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £12.317m held at 31 March 2021. We have concluded that where the other information refers to the inventory balance or related matters such as expenditure, it may be materially misstated for the same reason.

Opinion on information in the Remuneration and Staff Report

Qualified opinion on information in the Remuneration and Staff Report

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

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

Except for the matter referred to in the Basis for qualified opinion on information paragraph in the Remuneration and Staff Report paragraph of our report, in our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the the Department of Health and Social Care's Group Accounting Manual 2020-21.

Basis for qualified opinion on information in the Remuneration and Staff Report

The Remuneration and Staff Report does not include the required pension benefit disclosures for two senior managers who are deferred members of the NHS pension scheme and for whom no contributions in 2020/21 were made. The Trust has been unable to obtain the required information in respect of these individuals from NHS Pensions, the administrator of the scheme, and is unable to obtain the information from other sources. This matter results in the information included in all the columns of the Pensions table and the pension information included in the remuneration table for 2020/21 being incomplete for the senior managers in question.

The Remuneration and Staff Report also does not include the required explanation for a material year-on-year decrease in pension benefit disclosures for one senior manager. The Trust has been unable to obtain the required explanation in respect of this individual from NHS Pensions, the administrator of the scheme, and is unable to obtain the explanation from other sources. This matter results in the information included in all the columns of the Pensions table and the pension information included in the remuneration table for 2020/21 being potentially inaccurate for the senior manager in question.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have identified a significant weakness in arrangements in respect of financial sustainability, on which further audit work will be performed. We have not identified any other significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements, and any recommendations we have, in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities as the Accounting Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

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

Our work will be undertaken in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Other matters on which we are required to report by exception

Report to the Secretary of State

On 25 June 2021 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust has forecast a pathway to breakeven, which would see it continue to report deficits in each reporting period until 2024/25. The Trust has an obligation under the Local Audit and Accountability Act 2014 to ensure that they do not breach their rolling breakeven duty. We consider therefore that the Trust is about to take, or has begun to take a course of action that would be unlawful and likely to cause a loss or deficiency.

Other matters

We have nothing to report in respect of the following other matters which the Local Audit and Accountability Act 2014 requires us to report to you if:

- in our opinion the Annual Governance statement does not comply with the guidance issued by NHS Improvement; or
- except as reported above 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.

Responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of Directors' reponsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and 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.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

As explained in the Statement of the Chief Executive's responsibilities as the accountable officer of the Trust, the Chief Executive is responsible for ensuring that value for money is achieved from the resources available to the Trust.

Auditor's responsibilities for the audit of the financial statements

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

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Our procedures included the following:

- inquiring of management, and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Trust's controls relating to Managing Public Money requirements;
- discussing among the engagement team and involving relevant internal specialists, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, posting of unusual journals and cut off of expenditure around the year-end;

- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. The key laws and regulations we considered in this context included the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, which requires that each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account. On 25 June 2021 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust has forecast a pathway to breakeven, which would see it continue to report deficits in each reporting period until 2024/25. The Trust has an obligation under the Local Audit and Accountability Act 2014 to ensure that they do not breach their rolling breakeven duty. Other relevant laws and regulations identified include VAT legislation, PAYE legislation and the NHS Group Accounting Manual.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit and Risk Assurance Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantively testing an increased sample of expenditure around the year-end.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

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

Auditor's other responsibilities

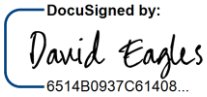
As set out in the Other matters on which we report by exception section of our report there are certain other matters which we are required to report by exception.

Certificate - delay in completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the Barking Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.



David Eagles, Key Audit Partner
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK

20 July 2021

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

Audit Completion Certificate issued to the Directors of Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2021

In our auditor's report dated 20 July 2021 we explained that the audit could not be formally concluded until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

This work has now been completed and we have reported the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report.

No matters have come to our attention since 20 July 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

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

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have identified the following significant weaknesses in the Trust's arrangements for the year ended 31 March 2021:

Area	Significant weakness in arrangements	Recommendation
Financial Sustainability	The Trust has an underlying month deficit of £6 million prior to the receipt of control total or COVID-19 related funding. The Trust plans to reduce this to £5 million by the end of 2021/22 and £0 by the end of 2024/25. Historical performance against savings targets suggest this plan is ambitious and may not be achievable. If the Trust does not achieve financial balance, this will require the Trust to identify additional sources of finance going forward, which may not be forthcoming. It will also be difficult to exit financial special measures (System Oversight Framework Segment 4).	Savings which eliminate the full £72 million underlying deficit are identified and a realistic timeline is put in place for when these will be achieved. Focus should continue to be applied to the £40m of inefficiencies in respect of temporary staffing and elective services, in order to identify measures to eliminate them.
Management of private finance initiative (PFI) contract	Internal audit undertook a review of the management of the PFI contract in 2020/21, and gave a partial assurance opinion. In addition to the concerns raised by internal audit, BDO identified a number of issues with the management of the PFI during the financial statements audit. In particular, there was a lack of process documentation in respect of the PFI in general and in relation to the managed equipment services (MES). It was also identified that there was a material error in respect of the refresh of clinical equipment under the MES, which dated back to 2016. As a result of the above, the Trust may potentially have to write off £14.1 million in relation to asset refreshes which did not happen.	The Trust should take action to recover the £14.1 million. The Trust should also implement actions to ensure that a similar scenario does not re-occur. Specific focus should be given to the segregation of duties within the contract management, the documentation of the transactions undertaken and the governance structure in place for this contract.
Temporary staffing	A number of deficiencies were identified in respect of temporary staffing following a review by internal audit. In particular, it was noted that compliance with rostering policies was 30%. This is a contributing factor to a £20 million cost inefficiency within temporary staffing.	The Trust has a detailed action plan in place to address the issues raised. The implementation of this action plan needs to be monitored, in order to ensure that all actions are implemented in a timely manner.

Area	Significant weakness in arrangements	Recommendation
Performance against 4 hour wait target	As at August 2021, the Trust is achieving performance of 63.44% against the national target of 95% of patients being admitted, transferred or discharged within 4 hours of arrival in the emergency department. Actions to improve performance are being taken, but these only aim to improve the performance to 80%. Further actions need to be identified to achieve the targeted 95%.	Identify additional actions which could be undertake in order to achieve the national target of 95%.
Procurement	Internal audit raised a number of recommendations regarding potential failure to follow documented processes in respect of procurement during their review in 2019/20. Limited action was observed to have been taken in response to these recommendations. It was also noted that current procedures are easy to override. The main implication of the above is that contracts entered into may not provide value for money. If processes are easy to override, then it is also easy not to follow them. If processes are not followed, then this creates a significant value for money risk as contracts which do not represent value for money could be entered into, and suppliers who are not providing value for money services could be retained beyond the necessary period. The recommendations raised in this area by internal audit have correctly been raised as high priority. There is, however, limited evidence to suggest that the Trust has treated them as high priority.	Actions in response to the recommendations raised by internal audit need to be considered as high priority. In particular there needs to be a focus on documenting all procurement activity in order to evidence that the processes in place are being followed. A revision to the governance structure in procurement should also be considered.

Certificate

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

David Eagles, Key Audit Partner
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK

20 September 2021

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2021

Barking, Havering and Redbridge University Hospitals NHS Trust

Annual accounts for the year ended 31 March 2021

Statement of Comprehensive Income for year ended 31 March 2021

	Note	2020/21 £000	2019/20 Restated £000
Operating income from patient care activities	2	654,396	558,286
Other operating income	3	114,565	82,315
Operating expenses	5, 7	(752,931)	(631,837)
Operating surplus from continuing operations		**16,030**	**8,764**
Finance income		7	161
Finance expenses	10	(17,794)	(24,812)
PDC dividends payable		(4,376)	-
Net finance costs		**(22,163)**	**(24,651)**
Other gains		-	1
Deficit for the year		**(6,133)**	**(15,886)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments of Property Plant and Equipment (PPE)	6	(270)	-
Total comprehensive expense for the period		**(6,403)**	**(15,886)**
Adjusted financial performance (control total basis):			
Deficit for the period		(6,133)	(14,358)
Remove net impairments not scoring to the Departmental expenditure limit		12,393	(6,151)
Remove I&E impact of capital grants and donations		(3,582)	(2,563)
Prior period adjustments		(5,940)	-
Remove net impact of inventories received from DHSC group bodies for COVID response		(4,165)	-
Adjusted financial performance surplus / (deficit)		**(7,427)**	**(23,072)**

Statement of Financial Position for the year ended 31 March 2021

	Note	31 March 2021 £000	31 March 2020 Restated £000	1 April 2019 Restated £000
Non-current assets				
Intangible assets	11	10,195	5,458	5,552
Property, plant and equipment	12	362,815	345,245	328,718
Receivables	16	5,801	5,991	5,140
Total non-current assets		**378,811**	**356,694**	**339,410**
Current assets				
Inventories	15	12,317	16,135	15,680
Receivables	16	32,693	62,336	30,813
Cash and cash equivalents	17	70,323	8,544	12,060
Total current assets		**115,333**	**87,015**	**58,553**
Current liabilities				
Trade and other payables	18	(78,898)	(52,656)	(52,030)
Borrowings	19	(13,895)	(261,466)	(79,937)
Provisions	20	(843)	(838)	(535)
Other liabilities	19	(1,493)	(4,589)	(5,190)
Total current liabilities		**(95,129)**	**(319,549)**	**(137,692)**
Total assets less current liabilities		**399,015**	**124,160**	**260,271**
Non-current liabilities				
Borrowings	19	(197,220)	(205,689)	(329,858)
Provisions	20	(5,976)	(6,110)	(5,683)
Other liabilities	19	(3,000)	(3,213)	(3,638)
Total non-current liabilities		**(206,196)**	**(215,012)**	**(339,179)**
Total assets employed		**192,819**	**(90,852)**	**(78,908)**
Financed by				
Public dividend capital		776,466	486,392	482,454
Revaluation reserve		926	1,196	1,196
Income and expenditure reserve		(584,573)	(578,440)	(562,558)
Total taxpayers' equity		**192,819**	**(90,852)**	**(78,908)**

The notes on pages 122 to 169 form part of these accounts.

Name	Tony Chambers
Position	Chief Executive
Date	13/07/2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**486,392**	**1,196**	**(578,440)**	**(90,852)**
Deficit for the year	-	-	(6,133)	**(6,133)**
Impairments	-	(270)	-	**(270)**
Public dividend capital received	290,074	-	-	**290,074**
Taxpayers' and others' equity at 31 March 2021	**776,466**	**926**	**(584,573)**	**192,819**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**482,450**	**1,196**	**(558,142)**	**(74,496)**
Prior period adjustment	-	-	(4,412)	**(4,412)**
Taxpayers' and others' equity at 1 April 2019 - restated	**482,450**	**1,196**	**(562,554)**	**(78,908)**
Deficit for the year	-	-	(15,886)	**(15,886)**
Public dividend capital received	3,942	-	-	**3,942**
Taxpayers' and others' equity at 31 March 2020	**486,392**	**1,196**	**(578,440)**	**(90,852)**

Information on reserves

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

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

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

Statement of Cash Flows for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 Restated £000
Cash flows from operating activities			
Operating surplus		16,030	8,764
Non-cash income and expense:			
Depreciation and amortisation	5.1	16,492	16,458
Net impairments	6	12,393	(6,151)
Income recognised in respect of capital donations	3	(3,877)	(2,686)
(Increase) / decrease in receivables and other assets		31,783	(29,921)
(Increase) / decrease in inventories		3,818	(455)
Increase / (decrease) in payables and other liabilities		3,840	(1,749)
Increase / (decrease) in provisions		(176)	703
Net cash flows from / (used in) operating activities		**80,303**	**(15,037)**
Cash flows from investing activities			
Interest received		7	161
Purchase of intangible assets		(5,054)	-
Purchase of PPE		(21,305)	(20,076)
Sales of PPE		-	5
Receipt of cash donations to purchase assets		-	983
Net cash flows used in investing activities		**(26,352)**	**(18,927)**
Cash flows from financing activities			
Public dividend capital received		290,074	3,942
Reduction in loans from DHSC		(245,378)	63,319
Capital element of finance lease rental payments		(94)	-
Capital element of Private Finance Initiative (PFI)		(11,557)	(11,576)
Interest on loans		(2,401)	(6,502)
Other interest		(4)	(6)
Interest paid on Private Finance Initiative (PFI)		(18,678)	(18,729)
PDC dividend paid		(4,134)	-
Net cash flows from financing activities		**7,828**	**30,448**
Increase / (decrease) in cash and cash equivalents		**61,779**	**(3,516)**
Cash and cash equivalents at 1 April - brought forward		**8,544**	**12,060**
Cash and cash equivalents at 31 March	17	**70,323**	**8,544**

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.2 Going concern

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.

The Trust will be starting the new financial year focused on the delivery of a Trust Board approved operating plan and budget, including our Financial Recovery Plan. The 2021/22 financial framework is yet to be published, however a letter from NHSI dated 23/12/20 advises systems to plan income on underlying 2019/20 outturn contract values, and in particular, to assume block payment arrangements in at least the first quarter of 2021/22. In addition, the letter advises the following assumptions to be taken into the planning considerations:

1. Cost inflation of 3% for Pay, 1% Non pay (as per 2020/21 guidance)
2. Clinical income to be set at 2019/20 plus inflation
3. Growth at 2% with corresponding costs

The 2020/21 NHSI Financial planning framework, when finalised, will continue to focus on simplifying processes and ensuring sufficient and timely cash flows are in place to enable prompt payments to suppliers and staff. In 2021/22 the Trust will continue operate as part of the North East London Integrated Care System (ICS), and continue to enhance and strengthen the collaborations and partnerships already built in the past year.

The Trust has a strategic plan to be financially balanced by 2024/25.
□ In 2021/22, the Trust will work to stabilise current adverse trends and non-recurring spend in 2021/22 through effective daily management and enhanced accountability;
□ In 2022/23 and 2023/24, the Trust will seek to deliver a vast majority of temporary staffing and elective theatre waste reduction opportunities. It will also work on the development of further cash releasing waste reduction initiatives through highly effective partnerships;
□ In later years (2023/24 +), there will be the optimisation of patient pathways through the use of advanced population health informatics and patient level costing;
□ as we exit the emergency response to CoVID 19, we will 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 2021/22 period there remains material uncertainty in respect of Going Concern with resolution being focussed through:
•Trust planning a financial deficit of £60m in line with the current underlying run rate of expenditure expected to be financed through Provider Sustainability Fund (PSF) funding support and efficiency savings;
•Trust continuing to quantify and to deliver reduced financial waste across services which will require a continued focused financial recovery plan, including £17m of efficiency savings;
• Trust expects an entitlement to continue to receive blocks of non-recurring or performance based income such as PFI support and Provider Sustainability Fund (PSF) which is expected to be £45m in 2021/22.

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 and may cast significant doubt on the Trust'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.

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 "King George and Queen's Hospital Charity" is a 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 £4.31m, an increase in year of £1.00m.

Under the provisions of IFRS 10 Consolidated 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 2020-21 income and total funds are viewed below materiality.
The Trust determined this by comparing the total Charity's 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 2020/21 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.

Education and Training Income

The main source of Education income for the Trust is contract with Health Education England for education and training of staff engaged in the administration of patient services . A performance obligation relating to delivery of education and training is generally satisfied over time as training is received by staff. The customer in such a contract is Health Education England, but the customer benefits as services are provided to the staff for which the contract was signed for. The Trust invoices and receives the income quarterly in advance. This is deferred and apportioned, with revenue recognised, over the quarter as the staff stay in training and education. 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.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020-21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer.

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

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds was accounted for as variable consideration.

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 and this portion of revenue is deferred as a contract liability.

Grants and donations income
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 recognised in the statement of comprehensive income once any conditions have been met. Where the grant is used to fund capital expenditure, it is credited to the statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

This year the Trust received significant items of consumables for the management of the Covid 19 pandemic.The items received by the Trust are considered as a transfer of resources akin to a 'government grant relating to income' in IAS 20. This treatment is supported with reference to the Conceptual Framework explaining where a transfer of assets not on market terms should be recognised at a 'deemed cost'. The deemed cost for the Trust is what it would have cost the Trust to acquire those items at that point in time. This deemed cost on receipt (price x quantity) is a debit to inventory with an equivalent non-cash credit recorded within the other operating income note for the value of the 'grant' realised.

Note 1.5 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 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 a 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 (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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.

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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) transactions

PFI 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	Max life
	Years	Years
Buildings, excluding dwellings	15	69
Dwellings	15	50
Plant & machinery	7	40
Information technology	4	11
Furniture & fittings	7	15

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. Land is expected to have an indefinite life and so it is not depreciated.

Note 1.8 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.

Internally generated intangible assets

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

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

Software

Software which is integral to the operation of hardware, 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
Licences & trademarks	3	5
Other (purchased)	3	5

Note 1.9 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.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 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.

In the Statement of Cash Flows, cash and cash equivalents shown form an integral part of the Trust's cash management. Cash and bank balances are recorded at current values.

Note 1.11 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 are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

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 1.12 Leases

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

The Trust as 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 as 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

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 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation, 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 2021:

		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 2021:

	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 0.95% 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 20.2 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 1.14 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 only where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed, 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 1.15 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 1.16 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 1.17 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.18 Losses and special payments

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

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

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.20 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 2022. 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 2022, 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 defined by HM Treasury. Currently this rate is 0.91% 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. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Note 1.21 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.

The valuation of the Trust's Land and Buildings asset base assumes that the modern equivalent re-provision of the existing service would be from fewer locations. Therefore, the functional obsolescence attributed to the buildings and the size and location of the 'alternative' site required for the modern equivalent asset takes this into account. It is assumed that the existing services at King George Hospital and Queen's Hospital would be incorporated onto a single site.

The Depreciated Replacement Cost has been applied in the valuation, which assumes the current cost of replacing an asset with its modern equivalent less deductions for physical deterioration and all relevant forms of obsolescence and optimisation, and not a building of identical design, with the same service potential as the existing asset. The modern equivalent may well be smaller than the existing asset, for example due to technological advances in plant and machinery.

The modern equivalent asset may be located on a new site out of town, or be on a smaller site due to changes in the way services are provided. The site is valued based on the size of the modern equivalent, and not the actual site area occupied at current.

Note 1.22 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 in relation to the revaluation of Land & Buildings. The key assumptions underlying these estimates and judgements are explained in Note 14.

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 8). The Trust carries provisions in certain instances relating to early retirement, based on latest actuarial information provided by the NHS Pensions Agency. This is therefore subject to change which is recognised in the period to which it arises.

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

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

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

Land and building assets are valued on the basis explained in Notes 1.7 and 14. 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 1.23 Prior Period Adjustment

Finance Leases – Managed Equipment Services

As part of its arrangements for the PFI, the Trust has a contracted Managed Equipment Service (MES) for a number of pieces of clinical equipment. In accordance with the guidance provided to the Trust during transition to International Financial Reporting Standards in 2010, these arrangements have always been reflected as Finance Leases with assets and liabilities being recognised as the assets reached their estimated useful lives.

There is an obligation on the provider to replace equipment in accordance with an Equipment Replacement Plan. The obligation to replace equipment is not based on the condition of the equipment; time is the only trigger for the obligation to replace.

Previously, the Trust had accounted for delayed equipment refreshes by de-recognising the asset and the associated liability, however no adjustment was made for the element of repayment of the principle sums or the associated interest.

To correct this, the Trust has recognised the element of repayment of the finance lease principle and interest for assets not refreshed in accordance with the Equipment Replacement Plan as a prepayment and a corresponding adjustment to the Finance Lease liability and charge for Finance Lease interest.

The total impact of this is that Property Plant and Equipment was understated by £0.2m, prepayments had been understated by £9.4m, Finance Lease Liabilities understated by £6.2m and PFI Interest charges overstated by £3.4m as at 31 March 2020.

The Trust has also made a provision against the prepayment to reflect uncertainty around the recoverability.

In addition, this impacts on the following associated notes:

- 5.1 Other operating expenditure;
- 10. Finance expenditure;
- 12. Property Plant and Equipment;
- 19 Other liabilities;
- 16.1 Receivables;

The impact on the prime financial statement captions is identified below alongside the cumulative impact to the 1st April 2019.

Statement	Original 31/03/2020 £m	Restated 31/03/2020 £m	Prior Period Adjustment £m	Original Balance at 1 April 2019 £m	Restated Balance at 1 April 2019 £m	Cumulative Impact to 1st April 2019 £m
Statement of Comprehensive Income						
Operating Expenses	(629.39)	(631.84)	(2.45)	(558.10)	(565.01)	(6.91)
Finance expenses	(25.74)	(24.81)	0.93	(22.78)	(20.29)	2.49
	(655.13)	(656.65)	(1.52)	(580.88)	(585.30)	(4.42)
Statement of Financial Position						
Non Current Assets - Property Plant and Equipment	**345.01**	**345.25**	**0.24**	**328.49**	**328.72**	**0.23**
Current Assets : Receivables - PFI prepayments - capital contributions	0.00	9.36	9.36	0.00	6.90	6.90
Current Assets : Receivables - Allowance for impaired contract receivables / assets	(4.67)	(14.03)	(9.36)	(5.31)	(12.21)	(6.90)
Current Assets : Receivables - Other	67.01	67.01	0.00	36.12	36.12	0.00
Total Current Asset : Receivables	**62.34**	**62.34**	**0.00**	**30.81**	**30.81**	**0.00**
Borrowings: Current	(259.30)	(261.47)	(2.17)	(78.52)	(79.94)	(1.63)
Borrowings: Non-Current	(201.68)	(205.69)	(4.01)	(326.63)	(329.86)	(3.01)
	(460.98)	**(467.16)**	**(6.18)**	**(405.15)**	**(409.80)**	**(4.64)**
Income and Expenditure Reserve	**(572.50)**	**(578.44)**	**(5.94)**	**(558.14)**	**(562.56)**	**(4.42)**
Statement of Changes in Equity						
Taxpayers' equity at 1 April 2019 - brought forward	**(558.14)**	**(558.14)**	**0.00**			
Prior Period Adjustment	0.00	(4.42)	(4.42)			
Taxpayers' equity at 1 April 2019 - restated	**(558.14)**	**(562.56)**	**(4.42)**			
Deficit for the year	(14.36)	(15.88)	(1.52)			
Taxpayers' equity at 31 March 2020 - restated	**(572.50)**	**(578.44)**	**(5.94)**			

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	628,975	384,562
High cost drugs income from commissioners (excluding pass-through costs)	1,978	36,806
Other NHS clinical income	249	115,368
Community services		
Income from other sources (e.g. local authorities)	4,800	3,580
All services		
Private patient income	1,769	3,185
Additional pension contribution central funding**	15,740	14,356
Other clinical income	885	429
Total income from activities	**654,396**	**558,286**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	126,945	115,247
Clinical commissioning groups	519,997	431,542
Department of Health and Social Care	20	20
Other NHS providers	759	1,613
NHS other	42	32
Local authorities	2,781	3,580
Non-NHS: private patients	132	518
Non-NHS: overseas patients (chargeable to patient)	1,636	2,667
Injury cost recovery scheme	1,998	2,825
Non NHS: other	86	242
Total income from activities	**654,396**	**558,286**
Of which:		
Related to continuing operations	654,396	558,286

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	£000
Income recognised this year	1,636	2,667
Cash payments received in-year	492	854
Amounts added to provision for impairment of receivables	523	536
Amounts written off in-year	460	637

Note 3 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	867	-	**867**	1,182	-	**1,182**
Education and training	17,969	754	**18,723**	16,290	540	**16,830**
Provider sustainability fund (2019/20 only)	-	-	**-**	12,869	-	**12,869**
Financial recovery fund (2019/20 only)	-	-	**-**	14,807	-	**14,807**
Marginal rate emergency tariff funding (2019/20 only)	-	-	**-**	4,301	-	**4,301**
Reimbursement and top up funding	62,208	-	**62,208**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	2,361	-	**2,361**	2,453	-	**2,453**
Receipt of capital grants and donations	-	3,877	**3,877**	-	2,686	**2,686**
Charitable and other contributions to expenditure	-	19,109	**19,109**	-	349	**349**
Rental revenue from operating leases	-	1,727	**1,727**	-	3,378	**3,378**
Other income	5,693	-	**5,693**	23,460	-	**23,460**
Total other operating income	**89,098**	**25,467**	**114,565**	**75,362**	**6,953**	**82,315**
Of which:						
Related to continuing operations			114,565			82,315

Note 4 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.

	2020/21	2019/20
	£000	£000
Income	2,311	3,578
Full cost	(1,618)	(2,683)
Surplus	**693**	**895**

Income relates to the Trust's Pharmacy production unit's sales of drug products and car park income. The pharmacy production unit had an income of £1,888k in current year and £1,890k in previous year.

Note 5.1 Operating expenses

	2020/21	2019/20 Restated
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,916	3,589
Purchase of healthcare from non-NHS and non-DHSC bodies	3,772	4,421
Staff and executive directors costs	474,525	416,847
Remuneration of non-executive directors	145	105
Supplies and services - clinical (excluding drugs costs)	65,638	38,075
Supplies and services - general	14,570	11,524
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	44,983	49,058
Inventories written down	2,803	-
Consultancy costs	1,319	2,882
Establishment	6,202	5,764
Premises	18,465	16,625
Transport (including patient travel)	4,455	4,330
Depreciation on property, plant and equipment	14,941	14,474
Amortisation on intangible assets	1,551	1,984
Net impairments	12,394	(6,151)
Movement in credit loss allowance: contract receivables / contract assets	4,025	3,862 Decrease
in other provisions	-	(2)
Change in provisions discount rate(s)	348	214
Audit fees payable to the external auditor		
audit services- statutory audit*	97	90
other auditor remuneration (external auditor only)	-	1
Internal audit costs**	211	217
Clinical negligence	29,628	25,528
Legal fees	484	601
Insurance	37	56
Education and training	1,514	1,242
Rentals under operating leases	950	273
Redundancy	181	-
Charges to operating expenditure for on-SoFP PFI arrangements	42,522	34,828
Hospitality	53	95
Other	4,202	1,305
Total	**752,931**	**631,837**
Of which:		
Related to continuing operations	752,931	631,837

*In respect of the statutory audit of the financial statements for the year ended 31 March 2021, the Trust's auditor BDO have been paid £80,500 (excl. VAT). The prior year equivalent was £76,012 paid to KPMG, the Trust's then external auditors.

**All internal audit costs relate to non-staffing.

Note 5.2 Limitation on auditor's liability
The limitation on auditor's liability for external audit work is £1 million (2019/20: £2 million).

Note 6 Impairment of assets

	2020/21	2019/20
	£000	£000
Impairments charged to operating surplus / deficit resulting from:		
Changes in market price	12,393	(6,151)
Total impairments charged to operating surplus / deficit	**12,393**	**(6,151)**
Impairments charged to the revaluation reserve	270	-
Total impairments	**12,663**	**(6,151)**

The total value of the impairments relate to the Trust's Buildings (excluding Dwellings). This is as a result of changes in market price following an independent valuation undertaken by a qualified valuer, having considered the future use of the building space and the ongoing renovations and improvements.

Note 7 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages*	347,182	305,520
Social security costs	36,851	32,481
Apprenticeship levy	1,707	1,531
Employer's contributions to NHS pensions	51,780	47,316
Pension cost - other	94	82
Termination benefits	-	189
Temporary staff (including agency)	37,154	29,728
Total staff costs	**474,768**	**416,847**
Of which		
Costs capitalised as part of assets	62	-

* Total includes redudancy costs of £181k compared to salaries and wages disclosure in note 5.1.

Note 7.1 Retirements due to ill-health

During 2020/21 there were 2 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £74k (£114k in 2019/20).

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

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 9 Operating leases

Note 9.1 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.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,727	3,378
Total	**1,727**	**3,378**

	31 March 2021	31 March 2020
	£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.	1,736	1,866
Total	**1,953**	**2,083**

Note 9.2 Barking, 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.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	950	273
Total	**950**	**273**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	794	777
- later than one year and not later than five years;	1,914	1,996
- later than five years.	791	507
Total	**3,499**	**3,280**

Note 10 Finance expenditure

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

	2020/21	2019/20 Restated
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	6,975
Interest on late payment of commercial debt	4	6
Main finance costs on PFI scheme obligations	8,607	9,083
Contingent finance costs on PFI scheme obligations	9,134	8,721
Total interest expense	**17,745**	**24,785**
Unwinding of discount on provisions	49	27
Total finance costs	**17,794**	**24,812**

Note 11.1 Intangible assets - 2020/21

	Licences & trademarks	IT (Internally generated and third party)	Development expenditure	Intangible assets under construction	Computer Software: Purchased	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**263**	**16,703**	**979**	**1,372**	**-**	**19,317**
Additions	-	-	-	4,837	-	**4,837**
Reclassifications	-	4,659	-	(4,659)	1,451	**1,451**
Valuation / gross cost at 31 March 2021	**263**	**21,362**	**979**	**1,550**	**1,451**	**25,605**
Amortisation at 1 April 2020 - brought forward	**263**	**13,313**	**283**	**-**	**-**	**13,859**
Provided during the year	-	1,390	-	-	161	**1,551**
Amortisation at 31 March 2021	**263**	**14,703**	**283**	**-**	**161**	**15,410**
Net book value at 31 March 2021	**-**	**6,659**	**696**	**1,550**	**1,290**	**10,195**
Net book value at 1 April 2020	**-**	**3,390**	**696**	**1,372**	**-**	**5,458**

Note 11.2 Intangible assets - 2019/20

	Licences & trademarks	IT (Internally generated and third party)	Development expenditure	Intangible assets under construction	Computer Software: Purchased	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**263**	**16,185**	**979**	**-**	**-**	**17,427**
Additions	-	-	-	1,372	-	**1,372**
Reclassifications	-	518	-	-	-	**518**
Valuation / gross cost at 31 March 2020	**263**	**16,703**	**979**	**1,372**	**-**	**19,317**
Amortisation at 1 April 2019	**263**	**11,329**	**283**	**-**	**-**	**11,875**
Provided during the year	-	1,984	-	-	-	**1,984**
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 12.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**32,320**	**248,244**	**9,782**	**13,456**	**105,046**	**24,889**	**6,861**	**440,598**
Additions	-	2,609	-	38,239	5,778	-	-	**46,626**
Impairments	-	(12,965)	-	-	-	-	-	**(12,965)**
Revaluations	-	(5,990)	-	-	-	-	-	**(5,990)**
Reclassifications	-	4,624	-	(37,002)	20,454	9,794	679	**(1,451)**
Valuation/gross cost at 31 March 2021	**32,320**	**236,522**	**9,782**	**14,693**	**131,278**	**34,683**	**7,540**	**466,818**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**671**	**9,772**	**-**	**63,233**	**18,237**	**3,440**	**95,353**
Provided during the year	-	5,768	-	-	6,874	1,766	533	**14,941**
Reversals of impairments	-	(44)	-	-	(257)	-	-	**(301)**
Revaluations	-	(5,990)	-	-	-	-	-	**(5,990)**
Accumulated depreciation at 31 March 2021	**-**	**405**	**9,772**	**-**	**69,850**	**20,003**	**3,973**	**104,003**
Net book value at 31 March 2021	**32,320**	**236,117**	**10**	**14,693**	**61,428**	**14,680**	**3,567**	**362,815**
Net book value at 1 April 2020	**32,320**	**247,573**	**10**	**13,456**	**41,813**	**6,652**	**3,421**	**345,245**

Note 12.2 Property, plant and equipment - 2019/20 Restated

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**32,320**	**243,186**	**9,782**	**1,765**	**97,541**	**24,442**	**6,583**	**415,619**
Additions	-	2,300	-	19,206	4,082	-	17	**25,605**
Reclassifications	-	2,758	-	(7,515)	3,531	447	261	**(518)**
Disposals / derecognition	-	-	-	-	(108)	-	-	**(108)**
Valuation/gross cost at 31 March 2020	**32,320**	**248,244**	**9,782**	**13,456**	**105,046**	**24,889**	**6,861**	**440,598**
Accumulated depreciation at 1 April 2019	**-**	**1,274**	**9,772**	**-**	**56,441**	**16,704**	**2,943**	**87,134**
Provided during the year	-	5,471	-	-	6,973	1,533	497	**14,474**
Reversals of impairments	-	(6,074)	-	-	(77)	-	-	**(6,151)**
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**	**13,456**	**41,813**	**6,652**	**3,421**	**345,245**
Net book value at 1 April 2019	**32,320**	**241,912**	**10**	**1,765**	**41,100**	**7,738**	**3,640**	**328,485**

Note 12.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	32,320	54,097	10	14,693	34,539	14,680	3,547	**153,886**
On-SoFP PFI contract arrangements	-	181,891	-	-	20,780	-	-	**202,671**
Owned - donated/granted	-	129	-	-	6,109	-	20	**6,258**
NBV total at 31 March 2021	**32,320**	**236,117**	**10**	**14,693**	**61,428**	**14,680**	**3,567**	**362,815**

Note 12.4 Property, plant and equipment financing - 2019/20 Restated

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	32,320	60,383	10	11,020	16,522	6,638	3,392	**130,285**
Finance leased	-	-	-	1,452	-	-	-	**1,452**
On-SoFP PFI contract arrangements	-	187,058	-	-	23,017	-	-	**210,075**
Owned - donated/granted	-	132	-	983	2,274	14	31	**3,434**
NBV total at 31 March 2020	**32,320**	**247,573**	**10**	**13,455**	**41,813**	**6,652**	**3,423**	**345,246**

Note 13 Donations of property, plant and equipment

As part of the management of the Covid-19 pandemic, the Trust received property, plant and equipment donation worth £3.8m from the Department of Health and Social Care.

Note 14 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 during September 2017) and are normally revalued annually, by professional valuers, using indices, with the only exception being donated assets which have been valued at historical depreciated costs.

In view of property price changes in the London region Land and Buildings were revalued as at 31st March 2021 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 is assessed at EUV. For non-operational land including surplus land, the valuations are carried out at Market Value.

The Department of Health has adopted the Modern Equivalent Asset (MEA) approach for its DRC valuations. 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 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 2020-21, 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.

Valuation of specialised properties

The Trust values specialised properties on a depreciated replacement cost (DRC) basis. Property, Plant and Equipment on the Statement of Financial Position (SoFP) has a carrying amount of £362m, within this £215m is considered to be specialised property. These are the Queens and King George Hospital buildings excluding land and external areas.

The DRC basis of valuation seeks to determine the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

The key assumptions that are most likely to affect the valuations are:

Cost data: The valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 2% higher this would have an impact on the value of specialised properties recorded on the SoFP of £5m.

Adjustments for obsolescence: Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the valuer based on his knowledge and experience, it takes into account physical deterioration, functional obsolescence and economic obsolescence. Had the adjustment for obsolescence been 2% higher than the valuer assumed, this would have an impact on the value of specialised properties recorded on the SoFP of £4.9m.

Adjustments for modern equivalent asset (MEA): the assets have been valued at MEA basis with deductions for physical deterioration and important forms of obsolescence taken into consideration for optimisation. The key assumption underlying the valuation is that the size of the new asset would be less than the existing total square footage representing economies gained through increased efficiencies in occupation based on the valuer's knowledge and experience. Had the adjustment for MEA been 2% higher than the valuer assumed, this would have an impact on the value of specialised properties recorded on the SoFP of £5.3m.

Note 15 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	3,270	3,484
Consumables	8,915	12,543
Energy	132	108
Total inventories	**12,317**	**16,135**
of which:		

Inventories recognised in expenses for the year were £69,817k (2019/20: £75,049k). Write-down of inventories recognised as expenses for the year were £2,803k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £18,438k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 16.1 Receivables

	31 March 2021 £000	31 March 2020 Restated £000
Current		
Contract receivables	28,049	51,642
Allowance for impaired contract receivables / assets	(16,725)	(14,026)
Prepayments	6,066	10,810
PFI prepayments - capital contributions	11,867	9,358
PFI lifecycle prepayments	300	900
VAT receivable	1,481	1,856
Other receivables	1,655	1,796
Total current receivables	**32,693**	**62,336**
Non-current		
Prepayments (PFI)	1,223	1,151
Other receivables	5,124	5,588
Allowance for other impaired receivables	(546)	(748)
Total non-current receivables	**5,801**	**5,991**
Of which receivable from NHS and DHSC group bodies:		
Current	18,828	41,001
Non-current	1,184	1,184

Note 16.2 Allowances for credit losses

	2020/21	2019/20
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**14,774**	**5,305**
New allowances arising	4,025	10,767
Utilisation of allowances (write offs)	(1,527)	(1,298)
Allowances as at 31 Mar 2021	**17,272**	**14,774**

Note 16.3 Exposure to credit risk

Although there is no significant exposure to credit risk, as the bulk of Trust funds are provided by Central Government, the Trust has some exposure to credit risk concerning overseas debt. A significant proportion of the £5.4m recognised for allowances for credit losses is related to overseas patient debt.

Adequate provisions are made for invoices and income raised to overseas patients in line with IFRS 9 (expected credit loss).

Note 17 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.

	2020/21	2019/20
	£000	£000
At 1 April	**8,544**	**12,060**
Net change in year	61,779	(3,516)
At 31 March	**70,323**	**8,544**
Broken down into:		
Cash at commercial banks and in hand	3	3
Cash with the Government Banking Service	70,320	8,541
Total cash and cash equivalents as in SoFP and SoCF	**70,323**	**8,544**

Note 18 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	27,633	20,562
Capital payables	24,729	5,879
Accruals	9,741	11,607
Social security costs	5,193	4,778
Other taxes payable	5,197	4,426
PDC dividend payable	242	-
Other payables	6,163	5,404
Total current trade and other payables	**78,898**	**52,656**
Of which payables from NHS and DHSC group bodies:		
Current	2,127	2,324

Note 19.1 Other liabilities

	31 March 2021 £000	31 March 2020 Restated £000
Current		
Deferred income: contract liabilities	1,493	4,589
Total other current liabilities	**1,493**	**4,589**
Non-current		
Deferred income: contract liabilities	3,000	3,213
Total other non-current liabilities	**3,000**	**3,213**

Note 19.2 Borrowings

	31 March 2021 £000	31 March 2020 Restated £000
Current		
Loans from DHSC	-	247,779
Obligations under PFI contracts	13,895	13,687
Total current borrowings	**13,895**	**261,466**
Non-current		
Obligations under finance leases	1,358	1,452
Obligations under PFI contracts	195,862	204,237
Total non-current borrowings	**197,220**	**205,689**

Note 19.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI scheme	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**247,779**	**1,452**	**217,923**	**467,154**
Cash movements:				
Financing cash flows - payments and receipts of principal	(245,378)	(94)	(11,557)	**(257,029)**
Financing cash flows - payments of interest	(2,401)	-	(9,503)	**(11,904)**
Non-cash movements:				
Additions	-	-	1,777	**1,777**
Application of effective interest rate	-	-	9,503	**9,503**
Other changes	-	-	1,614	**1,614**
Carrying value at 31 March 2021	**-**	**1,358**	**209,757**	**211,115**

Note 19.4 Reconciliation of liabilities arising from financing activities - 2019/20 Restated

	Loans from DHSC	Finance leases	PFI scheme	Total
	£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:				
Additions	-	1,452	2,395	**3,847**
Application of effective interest rate	6,975	-	10,008	**16,983**
Other changes	-	-	5,940	**5,940**
Carrying value at 31 March 2020	**247,779**	**1,452**	**217,923**	**467,154**

Note 20.1 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 2020	**4,713**	**979**	**23**	**49**	**1,184**	**6,948**
Change in the discount rate	348	-	-	-	-	**348**
Arising during the year	-	-	44	-	-	**44**
Utilised during the year	(405)	(108)	(45)	(11)	-	**(569)**
Reversed unused	-	-	(1)	-	-	**(1)**
Unwinding of discount	41	8	-	-	-	**49**
At 31 March 2021	**4,697**	**879**	**21**	**38**	**1,184**	**6,819**
Expected timing of cash flows:						
- not later than one year;	584	240	20	-	**-**	**844**
- later than one year and not later than five years;	1,325	341	-	-	**-**	**1,666**
- later than five years.	2,788	298	1	38	**1,184**	**4,309**
Total	**4,697**	**879**	**21**	**38**	**1,184**	**6,819**

Note 20.2 Clinical negligence liabilities

At 31 March 2021, £569,274k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barking, Havering and Redbridge University Hospitals NHS Trust (31 March 2020: £533,422k).

Note 21 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	6,769	1,887
Intangible assets	1,345	1,402
Total	**8,114**	**3,289**

Note 22 On-SoFP PFI arrangements

Note 22.1 On-SoFP PFI arrangement obligations

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2021	31 March 2020
	£000	£000
Gross PFI liabilities	**283,577**	**299,221**
Of which liabilities are due		
- not later than one year;	22,125	22,276
- later than one year and not later than five years;	73,952	75,808
- later than five years.	187,500	201,137
Finance charges allocated to future periods	(73,820)	(81,297)
Net PFI arrangement obligation	**209,757**	**217,924**
- not later than one year;	13,895	13,687
- later than one year and not later than five years;	48,635	48,882
- later than five years.	147,227	155,355

Note 22.2 Total on-SoFP PFI arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI arrangements	**1,284,038**	**1,257,562**
Of which payments are due:		
- not later than one year;	68,482	63,674
- later than one year and not later than five years;	273,928	254,696
- later than five years.	941,628	939,192

Note 22.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**68,482**	**66,450**
Consisting of:		
- Interest charge	8,607	10,008
- Repayment of balance sheet obligation	11,557	11,576
- Service element and other charges to operating expenditure	35,311	32,336
- Capital lifecycle maintenance	2,000	2,300
- Revenue lifecycle maintenance	1,873	1,509
- Contingent rent	9,134	8,721
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	6,234	983
Total amount paid to service concession operator	**74,716**	**67,433**

Note 23 Financial instruments

Note 23.1 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 following 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 and Social Care. The borrowings are for 1 – 25 years and interest rates are confirmed by the Department of Health and Social Care. 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.

All Department of Health loans were paid off in full by the end of the financial year (31/03/2021)

The Trust is also exposed to the rate of interest chargeable on the outstanding liability for Private Finance Initiative (PFI) transactions which recognise the underlying assets as property, plant and equipment, together with an equivalent liability.

The annual contract payments are apportioned between the repayment of the liability, a finance cost (interest), the charges for services and lifecycle replacement of components of the asset.

The interests rates, although relatively stable, are subject to change over the life of the outstanding liability and with it, the changes to the finance costs.

Credit risk

Although there is no significant exposure to credit risk, as the bulk of Trust funds are provided by Central Government, the Trust has some exposure to credit risk concerning overseas debt. A significant proportion of the £5.4m recognised for allowances for credit losses is related to overseas patient debt.

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 capital resource limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 23.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March	Held at amortised cost 31 March 2021	Held at amortised cost 31 March 2020
	£000	£000
Trade and other receivables excluding non financial assets	29,424	53,610
Cash and cash equivalents	70,323	8,544
Total at 31 March	**99,747**	**62,154**
Of which assets with other NHS organisations	20,012	42,185

Note 23.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March Restated	Held at amortised cost 31 March 2021	Held at amortised cost 31 March 2020
	£000	£000
Loans from the Department of Health and Social Care	-	247,779
Obligations under finance leases	1,358	1,452
Obligations under PFI concession contracts	209,757	217,924
Trade and other payables excluding non financial liabilities	68,266	43,452
Total at 31 March	**279,381**	**510,607**
Of which liabilities with other NHS organisations	2,127	250,103

IFRS 7 requires the Trust to disclose the fair value of financial liabilities. The PFI scheme is a non-current financial liabilty where the fair value is likely to differ from the carrying value. The Trust has used the discount rate of 0.7%+RPI 5 in the GAM in order to calculate the fair value of the liability. The fair value of the liability on the building at 31 March 2021 is £239,862k (£239,872k 19/20). The fair value of the liability on the Managed Equipment service will not be materially different from the carrying value of the underlying assets. £20,779k (£22,785k 19/20). The Trust has reviewed all fully depreciated underlying asset values which remain in operation to assess whether they have any material fair value and concluded that, based on asset type and age, this would increase the total Fair value by £639k to £21,418k.

Note 23.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	90,391	313,507
In more than one year but not more than five years	73,951	75,808
In more than five years	188,858	202,589
Total	**353,200**	**591,904**

* In the prior year, this disclosure was prepared using discounted cash flows in error. This comparative has been restated on an undiscounted basis

Note 24 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	22	5	31	7
Fruitless payments and constructive losses	1	2,084	-	-
Bad debts and claims abandoned	108	460	120	637
Total losses	**131**	**2,549**	**151**	**644**
Special payments				
Ex-gratia payments	17	9	18	10
Total special payments	**17**	**9**	**18**	**10**
Total losses and special payments	**148**	**2,558**	**169**	**654**

Details of cases individually over £300k

This relates to one case of fruitless payment of £2.1m made for the setting up and use of premier modular units wards to manage the COVID-19 pandemic, which the Trust did not subsequently proceed with, after a further review of its requirements.

Note 25 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.

In respect of entities within government control, the Trust has undertaken a single transaction with the Cabinet Office, resulting in accounts payable of £1k at the end of the reporting period.

	Expenditure		Income		Payables		Receivables	
	Payments to Related Party		**Receipts from Related Party**		**Amounts owed to Related Party**		**Amounts due from Related Party**	
	2020-21	2019-20	2020-21	2019-20	2020-21	2019-20	2020-21	2019-20
	£'000s		£'000s		£'000s		£'000s	
Queen Mary University of London	3	1	106	20	-	-	7	5
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 transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The Trust has a threshold disclosure of £1,000k. These are:

Barking and Dagenham CCG, Havering CCG and Redbridge CCG	-	-	401,183	376,868	-	3,408	-	5,481
Basildon and Brentwood CCG	-	-	23,101	23,550	-	-	-	-
Barts Health NHS Trust	1,117	1,748	2,191	1,219	-	-	-	2,234
Health Education England	-	-	18,045	15,990	-	-	-	-
NHS Blood and Transplant (NHSBT)	1,824	-	-	-	-	-	-	-
NHS England	-	-	173,446	150,170	-	-	7,439	29,655
NHS Resolution	29,627	25,529	-	-	-	-	-	-
NHS Property Services Limited	1,280	-	-	-	-	-	-	-
NHS Tower Hamlets CCG	-	-	67,403	1,377	-	-	8,565	-
North East London NHS Foundation Trust	1,716	1,013	-	1,890	-	-	-	-
NHS Newham CCG	-	-	5,317	4,901	-	-	-	-
NHS Thurrock CCG	-	-	4,726	4,704	-	-	-	-
NHS Waltham Forest CCG	-	-	2,576	2,342	-	-	-	-
NHS West Essex CCG	-	-	8,577	8,136	-	-	-	-
Royal Free London NHS FT	2,619	-	-	-	-	-	-	-
NHS Castle Point and Rochford CCG	-	-	1,102	-	-	-	-	-
NHS Mid Essex CCG	-	-	1,649	-	-	-	-	-
NHS North Central London CCG	-	-	1,025	-	-	-	-	-
NHS North East Essex CCG			1,075					

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 £1,544k, expenditure of £429k, year end receivables of £8k, and payables of £893k.

Note 26 Events after the reporting date

There were no events after the reporting date

Note 27 Better Payment Practice code

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	42,755	269,421	53,153	256,672
Total non-NHS trade invoices paid within target	40,815	263,019	49,603	244,272
Percentage of non-NHS trade invoices paid within target	95.5%	97.6%	93.3%	95.2%
NHS Payables				
Total NHS trade invoices paid in the year	3,508	12,960	3,439	16,278
Total NHS trade invoices paid within target	3,042	11,542	2,939	13,855
Percentage of NHS trade invoices paid within target	86.7%	89.1%	85.5%	85.1%

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.

The number of Non-NHS invoices paid in current period reduced significantly compared to the previous year but not necessarily the amounts, as a result of the consolidation of some supplier invoices including agency invoices.

Note 28 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2020/21 £000	2019/20 £000
Cash flow financing	(28,734)	59,201
External financing requirement	**(28,734)**	**59,201**
External financing limit (EFL)	(856)	68,608
Under spend against EFL	**27,878**	**9,407**

Note 29 Capital Resource Limit

	2020/21 £000	2019/20 Restated £000
Gross capital expenditure	51,463	26,977
Less: Disposals	-	(4)
Less: Donated and granted capital additions	(3,877)	(2,686)
Charge against Capital Resource Limit	**47,586**	**24,287**
Capital Resource Limit	50,697	24,181
Under / (over) spend against CRL	**3,111**	**(106)**

Note 30 Breakeven duty financial performance

	2020/21 £000	2019/20 £000
Adjusted financial performance surplus	(7,427)	(23,072)
Breakeven duty financial performance surplus/(deficit)	**(7,427)**	**(23,072)**

Note 31 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(22,281)	(32,986)	(49,913)	(39,492)	(37,754)	(37,950)
Breakeven duty cumulative position	(94,668)	(116,949)	(149,935)	(199,848)	(239,340)	(277,094)	(315,044)
Operating income		397,456	407,107	419,121	438,354	457,495	477,993
Cumulative breakeven position as a percentage of operating income		(29.4%)	(36.8%)	(47.7%)	(54.6%)	(60.6%)	(65.9%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(33,719)	(10,874)	(48,977)	(72,219)	(23,072)	(7,427)
Breakeven duty cumulative position	(348,763)	(359,637)	(408,614)	(480,833)	(503,905)	(511,332)
Operating income	505,239	557,966	571,774	550,077	640,601	768,960
Cumulative breakeven position as a percentage of operating income	(69.0%)	(64.5%)	(71.5%)	(87.4%)	(78.7%)	(66.5%)

Note 32 Staff Costs

			2020/21	2019/20
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	311,463	35,719	**347,182**	305,520
Social security costs	31,126	5,725	**36,851**	32,481
Apprenticeship levy	1,664	43	**1,707**	1,531
Employer's contributions to NHS pension scheme	48,730	3,050	**51,780**	47,316
Pension cost - other	70	24	**94**	82
Termination benefits	-	-	**-**	189
Temporary staff	-	37,154	**37,154**	29,728
Total gross staff costs	**393,053**	**81,715**	**474,768**	**416,847**
Of which				
Costs capitalised as part of assets	-	62	**62**	-

Average number of employees (WTE basis)

			2020/21	2019/20
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,016.5	276.8	**1,293.3**	1,153.2
Ambulance staff	1.0	-	**1.0**	1.2
Administration and estates	534.1	94.7	**628.8**	560.0
Healthcare assistants and other support staff	2,213.9	344.9	**2,558.8**	2,410.3
Nursing, midwifery and health visiting staff	2,071.0	366.7	**2,437.7**	2,418.8
Scientific, therapeutic and technical staff	585.5	54.5	**640.0**	598.4
Healthcare science staff	226.5	4.2	**230.7**	221.7
Other	10.7	-	**10.7**	8.5
Total average numbers	**6,659.2**	**1,141.8**	**7,801.0**	**7,372.1**
Of which:				
Number of employees (WTE) engaged on capital projects	-	1	**1**	-

Reporting of compensation schemes - exit packages 2020/21

	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	1	1	**2**
£10,000 - £25,000	-	1	**1**
£50,001 - £100,000	2	-	**2**
Total number of exit packages by type	**3**	**2**	**5**
Total cost (£)	£178,000	£30,000	**£208,000**

Reporting of compensation schemes - exit packages 2019/20

	Number of other departures agreed	Total number of exit packages
	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**
Total number of exit packages by type	**9**	**9**
Total resource cost (£)	£189,000	**£189,000**

Exit packages: other (non-compulsory) departure payments

	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Mutually agreed resignations (MARS) contractual costs	1	5	-	-
Contractual payments in lieu of notice	-	-	5	122
Exit payments following Employment Tribunals or court orders	1	25	4	67
Total	**2**	**30**	**9**	**189**