Barking, Havering and Redbridge University Hospitals NHS Trust

ANNUAL REPORT

2018/19

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A MESSAGE FROM OUR CHAIR

Welcome to our annual report for 2018/19 – my second as Chair of our Trust.

It's been an eventful year, but one I think we can look back on with no small amount of satisfaction. My overall reflection is that this has been a strong year, albeit one which started in a difficult place.

As I have reported regularly, both in this report last year, and to the Board, there were and are significant challenges, particularly around our financial situation. There has also been continued change particularly in the executive team, with Matthew Hopkins leaving us as Chief Executive, and Chris Bown joining in an interim capacity. I'd like to thank Matthew for his contribution.

I am very pleased that we have taken a grip on our finances this year. Agreeing and hitting our revised budget was a positive step forward. Our regulators have expressed increased confidence in us, which is good news.

However, I am clear that while we must continue to work constructively and productively to reduce our deficit, we must do so without compromising the quality and scope of patient care which must and will continue to be our priority.

We cannot do what we do in isolation, so we continue to work hard on how we engage with others. These relationships are internal – our Patient Partners for example – who are an increasingly invaluable asset to our Trust (and I was pleased to create a place for a Patient Partner to join our Board).

They are also our partners in the local and national health economy – NELFT, our Clinical Commissioning Groups, GPs, the BHR Provider Alliance, NHS England and NHS Improvement to name a few, or internationally, the Virginia Mason Institute, which continues to shape our approach (The PRIDE Way) to driving quality improvements in our hospitals.

On the subject of The PRIDE Way, we are absolutely seeing the benefits of a renewed focus in recent months.

As I write this, a few weeks on from the close of the year, it was fantastic to recently attend our first ever PRIDE Way 3P event – a week long workshop which created some visionary ideas about how we might redesign our outpatients (in this case, our fracture clinic).

I was inspired by the energy and enthusiasm in the room, and the testimony of staff at all levels who were involved was a fantastic endorsement of our quality improvement approach.

One of the big priorities we need to tackle in the coming months and years will be around the availability of capital resource to invest in our future. This is something we face across the NHS but chairing both our Trust and North East London Foundation Trust (NELFT), I see this all too acutely. We need to make the case loud and clear and I will be doing my best to do just that.

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

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

Joe Fielder
Chair

A MESSAGE FROM OUR CHIEF EXECUTIVE

I would like to give huge thanks to every one of our staff, volunteers and partners for their tremendous support, effort and hard work.

When I came to the Trust in August last year, it was clear to me that there were a number of key priorities, which included: bringing our finances under control; focusing on our constitutional standards to ensure we are providing the right care for local people; improving our relationships with key partners; and improving our medical and staff engagement.

I am very pleased that we have made real demonstrable progress on each of these areas.

As the financial report shows, I am pleased to report that we have delivered our revised agreed budget for 2018/19, although we recognise the major challenges we still face as we enter 2019/20 in implementing our Financial Recovery Plan.

On our constitutional standards, it has been a mixed picture. The four-hour access target for emergency care has remained a stubborn challenge which we have not overcome. However, there have been very positive signs in recent weeks and I am optimistic about the positive impact of a renewed focus on patient flow. Our performance for cancer patients has been excellent, but our referral to treatment (18-week wait) performance has again been patchy.

Our relationships with both the Clinical Commissioning Groups (CCGs) and NHSI/E are in a far stronger position and I am pleased that our delivery of the control total will demonstrate we did what we said we would and I hope will instil further confidence. There is still a long way to go, but this marks a significant achievement. Our local partnerships and movement towards becoming an Integrated Care System (ICS) have been a really positive step.

2019/20 will bring with it a major piece of work as we review our clinical strategy in the context of the developing plans of the ICS.

Staff engagement was another key priority. It was evident to me that there was much to be done to improve in this area. At the end of the year, I would observe that there are pockets of excellence and good engagement throughout the Trust, but the picture is not consistent. We must ensure in the year ahead that we continue to focus relentlessly on improving this. We should set and expect high standards from us all in the way we work and treat each other.

The issues extend beyond the medical and clinical workforce. Our staff survey results showed that our hospitals have become increasingly difficult places to work over the past two years and morale is low. While we have faced many challenges, it is clear not enough of our focus has been on supporting our staff. This will be one of my top priorities into 2019/20.

Finally, it was a huge pleasure at the end of the financial year to publish a firm position statement confirming the future of the accident and emergency department at King George Hospital. There has been significant uncertainty in recent years, so it was extremely gratifying to confirm along with partners from local Councils and our CCGs, that the department will remain, recognising the continuing need for acute and emergency services to serve our community.

Chris Bown
Interim Chief Executive

OUR YEAR IN PICTURES

April 2018

Our 'Sound of PRIDE' choir released a single to raise money for our charity- its own version of the single Proud by Heather Small.

May 2018

A dedicated family room was opened at Queen's Hospital in memory of grandfather Dennis Sullivan. His family raised around £6,000 for the room which is a place for families and loved ones to spent private time together during a terminal diagnosis.

June 2018

Our Chief Nurse, Kathryn Halford, received an OBE in the Queen's Birthday Honours in recognition of her services to nursing.

July 2018

We marked 70 years of the NHS with celebrations across our hospitals including a birthday breakfast, visits from some of our local MPs, and a picnic at King George Hospital. We also hosted Channel 4 News who filmed in Maternity and held a live panel debate on the future of the NHS with Chief Executive, Matthew Hopkins and Chief Nurse, Kathryn Halford.

August 2018

We marked 12 months of delivering the NHS constitutional standard for cancer treatment times, ensuring that 85 per cent of patients were starting treatment within 62 days of referral from their GP.

September 2018

We spoke to one of our consultant neurosurgeons, Nick Haliasos, about the £57,000 grant he secured to bring Artificial Intelligence (AI) to our Trust. The tool will help emergency department clinicians to identify patients with serious conditions like stroke or sepsis.

October 2018

We were named Preceptorship of the Year at the Nursing Times Workforce Awards after developing a senior intern team to provide a successful mentoring and coaching programme for new nurses – the first of its kind in the country.

November 2018

Our Sustainability team picked up two awards at the Sustainable Health and Care Awards. Both awards recognised our Trust's commitment to carbon reduction.

December 2018

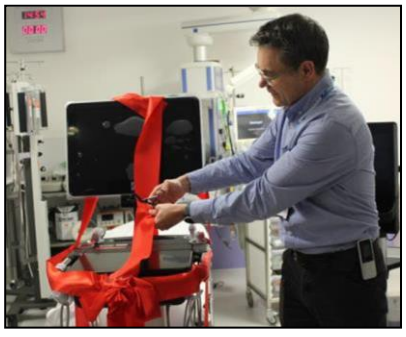
It was one of the busiest Christmases ever for new arrivals at Queen' s Hospital – with 25 babies born on Tuesday 25 December. First to make an entrance was Harriet Lindsay, who arrived by c-section just 47 minutes after midnight.

January 2019

Speech and Language Therapists from our Trust travelled to Cambodia to teach healthcare workers there how to help patients with tracheostomies including how to manage swallowing difficulties.

February 2019

We had a record-breaking Nursing and Midwife Recruitment Day thanks to the tremendous efforts of teams across our organisation who put on a fabulous show promoting our Trust as a place to work.
We welcomed more than 150 potential new colleagues to Queen's Hospital, offering 119 of them jobs on the day, with new recruits coming from far and wide to join us – we saw applicants from 12 universities from across the UK and three European ones too.



March 2019

Our Emergency Department colleagues were delighted to get a whole new batch of point of care ultrasound machines up and running after investing around £170,000 in this terrific new kit to help us make better, faster decisions about caring for patients.

SECTION 1 – PERFORMANCE REPORT

OUR 2018/19 OBJECTIVES

DELIVERING HIGH QUALITY CARE

- Ensure we are systematic in responding to quality and safety concerns and reducing harm
- Establish the principles of daily management, standard work and continuous improvement across the organisation, as part of embedding The PRIDE Way

RUNNING OUR HOSPITALS EFFICIENTLY

- Continue to improve delivery of our constitutional standards
- Continue to reduce variations and inefficiencies in practice, through the use of external benchmarking

BECOMING AN EMPLOYER OF CHOICE

- Establish outstanding leadership at all levels of the organisation
- Recruit and retain a flexible and diverse workforce and reduce our reliance on agency staff

WORKING IN PARTNERSHIP

- Work with our local partners to integrate our clinical pathways and maximise our use of resources

- **Embed strong engagement and involve our patients and the public in our work**

MANAGING OUR FINANCES

- **Deliver our ambitious Quality and Cost Improvement Plan**
- **Embed clear processes, roles and responsibilities to ensure strong financial governance and budgetary control**

DELIVERING HIGH QUALITY CARE

Ensure we are systematic in responding to quality and safety concerns and reducing harm

Establish the principles of daily management, standard work and continuous improvement across the organisation, as part of embedding The PRIDE Way

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.

Comprehensive detail on our performance this year is found in our Quality Account, but the following gives an overview.

CQC report 2018

We welcomed the CQC to the Trust at the start of 2018 to undertake a review, including one of the 'Well Led' domain. We received the formal report in June 2018.

Four core services were reviewed, which were: Urgent and Emergency Care; Medical Care (including older peoples care), Surgery; and Maternity Services, under the five domains.

This was the first time that the Use of Resources element was assessed. This assessment is undertaken by NHS Improvement and was completed on 5 April 2018. It was published by CQC alongside the other Trust level ratings.

The report was positive about the quality of our care, and found that just over a year since the last inspection by the CQC (which found transformational change at our Trust resulting in our leaving special measures for quality), we had made further improvements.

Three services – Surgery, Maternity and Medical Care (including older peoples' care) were given improved ratings and are now rated 'Good' overall.

The inspection team found that every one of the four core services being assessed as part of the 'focused inspection' had shown improvement across the five 'domains' it measures (Safe, Effective, Caring, Responsive and Well-Led). These were seen across both our hospitals.

Our Maternity department is now rated 'Good' overall, with Good ratings across four of the five domains. It's one of the largest maternity units in the country, with more than 8,000 babies a year born at Queen's Hospital. Inspectors highlighted "strong leadership throughout" and said that "a determination for ongoing improvement was evident."

There was further praise for our community team particularly, and their offering of flexible evening and weekend appointments and better continuity of care for expectant mothers.

Medical Care (including nine of our specialties, such as stroke, respiratory medicine and neuroscience) is also now rated 'Good' overall. The inspectors said there was "a demonstrable,

palpable drive to improve the working culture of the hospital through engagement strategies and open and honest communication about how to meet increasingly challenging demand."

Some outstanding practice was identified in how our nurses were being supported to tackle staffing capacity issues, and the teams' commitment to using research to improve care.

In the 'Well Led' assessment we fared less well, returning a rating of 'Requires Improvement'.

The new 'Use of Resources' element of the report, based on an assessment undertaken by NHS Improvement, which considers how productively trusts are using their resources (financial and otherwise) returned an 'Inadequate' rating – a reflection of the financial difficulties which ultimately led to our Trust being placed in financial special measures at the beginning of 2018.

We retain the overall 'Requires Improvement' rating from the CQC, as the targeted inspection was of only four services, so an overall rating change was not possible as a result of the inspection.

Four "must do" actions were identified and 55 "should do" actions recommended, to avoid breaching any legal requirement in the future, and to improve the quality of the care and services.

Points raised by the CQC during the inspection are addressed within a separate Trust action plan. The action plan outlines a timeframe for achievement and actions required.

Delivery against the four "must dos" have been completed, and these actions are being monitored by the divisions.

Ratings for Queen's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Requires improvement ➔➔ Jun 2018	Requires improvement ➔➔ Jun 2018	Requires improvement ➔➔ Jun 2018
Medical care (including older people's care)	Good ↑ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ↑ Jun 2018	Good ➔➔ Jun 2018	Good ↑ Jun 2018
Surgery	Good ↑ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Requires improvement ➔➔ Jun 2018	Good ↑ Jun 2018
Critical care	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015
Maternity	Requires improvement ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018
Services for children and young people	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
End of life care	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Outpatients and diagnostic imaging	Good Mar 2017	N/A	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017
Overall*	Requires improvement ➔➔ Jun 2018	Good ↑ Jun 2018	Good ➔➔ Jun 2018	Requires improvement ➔➔ Jun 2018	Requires improvement ➔➔ Jun 2018	Requires improvement ➔➔ Jun 2018

Ratings for King George Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
Medical care (including older people's care)	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018
Surgery	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Requires improvement ↓ Jun 2018	Good ↑ Jun 2018
Critical care	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015
Services for children and young people	Requires improvement Jul 2015	Requires improvement Jul 2015	Good Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015	Requires improvement Jul 2015
End of life care	Good Jul 2015	Requires improvement Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
Outpatients and Diagnostic Imaging	Requires improvement Mar 2017	N/A	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Requires improvement Mar 2017
Overall*	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Queen's Hospital	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Requires improvement ↑ Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
King George Hospital	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
Overall trust	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good ↑ Jun 2018	Requires improvement ↑ Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018

Patient Safety Summits

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

These gatherings, which are for all the clinical divisions, continue to be extremely valuable opportunities for learning and reflection, and are well attended at both King George and Queen's hospitals.

Quality and safety

Our quality and safety team continue with their efforts to help all our frontline staff deliver high quality, safe care to our patients. For 2018/19 we had a number of priority areas which are addressed below.

Incident reporting

We aimed to increase the 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 learning and improve safety. The result of this improvement work shows that we have significantly improved reporting levels and sustained them throughout the year.

We achieved better than our targets throughout the year, and our figures overall (55 per 1,000 bed days) put us in the top 20% nationally against peer acute Trusts. From where we were just two years ago, this represents a dramatic improvement.

We had also aimed to increase the number of incidents not resulting in harm to more than 75% (national average 74.3%) but came up just short with 73.9%.

Monitoring patient deterioration

We have seen significant improvement since introducing electronic observations within the organisation via Vitalpac.

This is due to the correct calculation of the National Early Warning Score (a tool to detect sick patents) and prompt response by medical and nursing staff.

We are taking this further by developing this system to further benefit patients by including automated alerts on patient deterioration.

Never Events

We aimed to declare zero Never Events within the organisation, however we saw three incidents occur. Two related to the unintentional connection of a patient requiring oxygen to an air flowmeter. The other elated to the retaining of a Naso Gastric tube guidewire (retained foreign object).

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 2018/19 we aimed to have fewer than 122 Category 2 hospital-acquired pressure ulcers; fewer than 51 Category 3; and zero Category 4 (the most severe). We reported 104, 30 and two respectively. We have reviewed and will continue to investigate all incidents of Category 2 and above, sharing the learning, and will be continuing to progress changes to pressure ulcer prevention and management training in line with guidance from NHS Improvement in 2018 which will take a comprehensive and structured approach.

Falls

Falls are a serious problem among older people. A major cause of disability and mortality, falls also have a significant psychological impact on confidence and independence. We want to avoid falls in our hospitals to avoid patients having to stay in hospital any longer than they need. It is therefore imperative that we both understand and minimise the risk of falling.

For 2018/19 we sought a 3% reduction in the overall number of falls per 1,000 bed days. We were very pleased that we achieved this part of our target. However, we also wanted to have fewer than 33 falls where there was 'harm' – moderate, severe or catastrophic. We actually reported 49, which was disappointing.

In the next year we intend to push ahead with our training, including launching our e-learning package, which is in the final stages of review.

We have also been trialling falls sensors to help provide warning for staff about at risk patients who are attempting to leave their bed or chair, which we hope to bring forward in the coming year.

Infection prevention and control

For Clostridium difficile infection (CDI), our maximum allowed number of cases in 2018/19 was 29. Our total number of cases for the year was nine, which is below the annual target and shows an improvement from last year.

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

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

We intend to undertake a project aimed at reducing blood culture contamination rates which are a contributory factor to some cases of MRSA and can result in a delay in prompt treatment of patients. This project will be undertaken with our Emergency Department where the majority of blood cultures are taken in order to promptly identify cases of sepsis.

Stroke service transformation

A fantastic year for our stroke team was capped off with them being crowned the Stroke and Cardiovascular Team of the Year at the prestigious British Medical Journal (BMJ) Awards, in recognition of huge improvements and innovation in the service.

In the past 18 months, the service's rating according to the national Sentinel Stroke National Audit Programme, has improved from a D to an A rating, with recognition given to the Trust for increasing consultant cover across the department, helping quicker decisions to be made.

The team's consultants restructured their job plans to provide better out-of-hours cover for the emergency department so clinicians can identify patients who are (or who aren't) stroke patients more quickly and care for them appropriately.

Patients are now being admitted to the Hyper Acute Stroke Unit (HASU) much more quickly, but overall admissions have been reduced by 26% because of better, faster diagnosis. Increased bed availability means that stroke patients who need the specialist care at HASU can now get access. Previously, many patients had to be admitted to wards around the hospital which was not ideal for their care.

Patients are also recovering and going home more quickly due to innovative improvements in treatment, like the mechanical thombectomy, a revolutionary method of treating patients with stroke, whereby blood clots on the brain are physically removed via an operation going up through a patient's groin, reducing the need for blood-thinning drugs. Patients undergoing the procedure have a hugely improved chance of making a total or near total recovery.

Improving Patient Experience

Patient experience

The views of our patients are vital as we strive to make improvements that will make a real difference to their experience. We want to ensure that every patient has the best possible experience of care, and that we listen to every

patient so we can understand what we are doing well and where we can improve.

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

Friends and Family Test

We continue to work with external partner "I Want Great Care" to help us gather and analyse data relating to our Friends and Family Test (FFT) scores. We received more than 95,000 this year – a significant evidence base from which we can further refine and improve in coming years. We review the comments and the data every month to see how we are performing and to focus our improvement work. We were particularly pleased that 88% of our A&E patients gave positive responses, hitting our target of 85%.

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

We also use the FFT scores and other examples of teams' commitment to improving services for patients to help identify and reward our Team of the Week. This is valuable recognition to our staff for a job well done and motivates them to continue encouraging patients to participate. The comments and feedback we receive from patients continues to help us improve our services.

Patient Experience Collaborative

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

A year on and although the collaborative has concluded, we continue to see huge benefits from this programme. We have continued the collection of feedback through real-time conversations with our patients that was part of the collaborative.

At the annual PENNA awards, we were successful for the third year in a row – we scooped two awards and a runner-up recognition.

Nursing associate Alina Stevens was among our winners. She was named Patient Advocate of the Year. Alina works in our Dementia team and was nominated for her work to support vulnerable patients.

When one patient, Betty, was anxious about what to do with her sensory aids during surgery, Alina found a place to keep them. Realising it would be an issue for many more people, Alina designed and made her own box out of materials within the hospital to keep items like glasses and hearing aids in, for the benefit of all patients.

Sara Turle, our patient partner, also won in the Outstanding Contribution category.

And our Specialist Palliative Care team was also runner-up in the Integration and Continuation of Care category, in recognition of their collaborative work with nursing homes, which is helping to get elderly patients out of hospital quicker and improving the coordination of care.

King George and Queen's Hospitals Charity

Our charity continues to provide invaluable support, raising funds to enhance the hospital journey for all.

Requests and ideas are put forward to the Charity by both staff and patients. Charity funds are used to supply goods or services that fall outside of the current NHS core essential budget.

This could be anything from a piece of innovative medical equipment, extra training or research, technology and information or a refurbishment to enhance the comfort of both patients and their families.

The charity team is thriving and over the course of the last year has raised around £823,000, an increase of around 29% on the previous year.

The charity organises several public charity events throughout the year, including sportive events such as Pedal4Patients – a home grown sponsored cycle ride which was launched in May 2018.

The event saw 56 riders sponsored to clock up between 45 – 69 miles. Riders collectively cycled over 3,000 miles and raised over £8,000 to support charity projects.

The most popular and successful of these events remains the annual Christmas Ball – tickets from the 2018 Masquerade-themed event sold out several weeks in advance and the 360 guests enjoyed live entertainment from opera singing waiters Contempo and delicious Italian themed menu from top class caterers Milsoms of Dedham. The event raised a fantastic £58,500.

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

All the money the charity receives is reinvested in our hospitals, via the Charitable Funds Committee, which meets regularly to discuss applications. Last year the charity supported the hospital by £100k more than the previous year which can only be good news for anyone using our hospitals now or in the future.

Case Study – Mobile Heart Monitors

We were able to invest in a batch of mobile heart monitors for patients thanks to support from the charity, along with the Zippers' Bowling Association – an 'exclusive' club which you can only join if you've had open heart surgery (the name 'Zipper' relates to their surgery scar!) – and the King George League of Friends.

These nifty devices allow patients to monitor their own heart rhythms, by attaching to their smart phones. They're really helpful to enable patients to stay on top of their condition, and they're invaluable for our clinicians in terms of monitoring and keeping an eye on patients' progress.

Case Study – The Snowdrop Suite

Our Trust delivers thousands of babies every year but sadly not every pregnancy has the hoped-for happy ending.

One bereaved Dad had the strength to talk about his experience and pledged to help raise funds to refurbish Queen's Hospital's Snowdrop Bereavement Suite.

Funds raised from Pedal4Patients ride were used to refurbish the room. The suite is now more of a bright 'home from home' environment where a bereaved family can say their farewells in private and in comfortable surroundings.

The room has been much appreciated by both staff and families alike. The Charity expanded the project and also gave a floral update to all the birthing rooms on the labour ward.

Learning from patient feedback

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

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

We acknowledged 100% of complaints within three days, but came just short of our target to hit 90% of complaint responses within the agreed timescales.

We also wanted to reduce the numbers of reactivated complaints and hit a target of 15% reactivations, which we achieved.

We had hoped to develop an online satisfaction survey, to seek feedback from patients on how we handled their case, but this is still in development and will be brought forward this year.

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

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

"PATRICIA"'S STORY

As is described elsewhere in this report, one of the biggest operational priorities of the final quarter of our year was the reintroduction and embedding of Red2Green to improve our care for patients, how we progress their treatment, and their safe and appropriate discharge home or to a place where their needs can be met, working with partners in the community.

At the heart of this campaign was a patient, "Patricia" (whose name we have changed).

Patricia died after spending 118 days in our hospital. The last 100 days of her life were spent waiting.

In October last year Patricia, a 68 year old lady, arrived at our emergency department (ED) after a fall. Although she had a history of vascular dementia she lived independently with no carers. She spent over 18 hours in our ED before she was admitted to a ward.

During this time multiple efforts were made to try and discharge her home yet to no avail. Patricia was eventually admitted with vertigo, dehydration and chronic anaemia. In total she spent 118 days in our hospital – only 16 of these were 'green' days, days that added value to her stay. 102 days were 'red'; these were days that Patricia spent in a bay with little stimulation and waiting for something to happen. Overall there were 39 entries in her notes stating she was medically fit for discharge. There were eight entries where it was noted that Patricia's wish was to go home.

Patricia saw six different consultants and was under two different social workers. Just six days after admission she was declared medically fit and a package of care was arranged.

At this point her next of kin (who didn't live locally) expressed concerns about Patricia's ability to cope at home and felt that she didn't have capacity to make this decision. Numerous mental capacity assessments were undertaken causing further delays. Patricia was assessed to not have capacity to make the decision regarding her discharge and it was decided that the best option was a care home. Four care homes came to assess Patricia over a period of time; all four declined due to her deteriorating 'challenging' behaviour.

In December, two months after her admission, Patricia became unwell.

She was treated for a urinary infection and responded well to treatment however a week later had a fall on the ward due to her reduced mobility and general decline from being in hospital. Once deemed medically fit again, discharge planning recommenced.

Two weeks later Patricia deteriorated again and was treated for hospital-acquired pneumonia. She didn't respond well to treatment and required input from the critical outreach team and a ceiling of care decision was made that Patricia was no longer for resuscitation but for active treatment. Patricia failed to respond and at this point it was decided that she was in the last three months of her life and the best option would be to try and get her into a care home for comfort. One was finally identified that would take care of her, but there was delays in funding because the home was 'out of our area'. One week later Patricia was reviewed by our Palliative Care team. She was too unwell to move.

She died at the beginning of February.

Her story is tragic, sad, instructive and highlights the challenges facing the NHS every day. We need there to be no more stories like Patricia's.

THE PRIDE WAY

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

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

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

We are now in our penultimate year of partnership with VMI. While overall we've made good progress, we are probably not as far forward as we would want to be. So, at the beginning of 2019, we made a conscious effort to inject new momentum into this work.

Significantly (and as is mentioned later in this report), this has involved repositioning The PRIDE Way so it means more to our staff than being an improvement 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.

The actions taken included making the PRIDE Way for Leaders training course compulsory for all top leaders in the organisation.

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.

A group of executives and divisional directors went to Seattle to see first-hand just what Virginia Mason is all about, and how they operate. It was an inspiring trip which brought home just what the potential opportunities are if we can get The PRIDE Way right.

3P Event – Outpatient Fracture Clinic

In March, we ran our first ever The PRIDE Way 3P event.

3P stands for Production, Preparation and Process. It's about developing what we want the future of a service to look like for our patients.

For this first event we focused on our fracture clinic outpatient pathway and in true system-working style, it involved our nurses, doctors, therapists, and administrators joining forces with our GP and CCG colleagues.

It was a really fascinating week, with great engagement, and colleagues were enthusiastic about the prospect of taking a 'blank sheet of paper' approach and being creative about how we could do things in future.

Shawn Bacchus, one of our clinic prep clerks described the experience as "mind-blowing" and said she was "inspired" – which is exactly how we want people to feel about working here.

This was a really positive first step – we have bold ambitions to revolutionise how we approach outpatients and clinics, so the lessons learned will be invaluable across our Trust.

RUNNING OUR HOSPITALS EFFICIENTLY

Continue to improve delivery of our constitutional standards

Continue to reduce variations and inefficiencies in practice, through the use of external benchmarking

Constitutional Standards

Four Hour Target and Emergency Department performance

Again this year, performance against the four hour access target has been one of the greatest challenges, as it has across the NHS.

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

It was an extremely busy winter particularly, with very high attendances throughout and continuing to the end of March. We frequently saw 1,000 attendees a day at our Emergency Departments.

We continued to see very high numbers of patients transferred via ambulance from both London Ambulance Service and East of England Ambulance Service – once more Queen's Hospital saw more ambulances than almost any other hospital in London, and numbers were up at King George Hospital too.

Staffing, particularly in our Emergency Departments, was and remains a significant issue. We are routinely in a position where we have to turn to agency staff to fill rota gaps. We know that this impacts upon our ability to see and treat patients. The fill rates here are still among the worst in the trust.

As a result, we have not hit the constitutional standard of treating, admitting, or discharging 95% of patients within four hours this year. Our year end figure was 81%.

We received regular visits from the CQC, NHS England and NHS Improvement (NHSI), particularly over the busy winter period, and we worked closely with NHSI's Emergency Care Intensive Support Team (ECIST).

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

Red2Green

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

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

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

means we are able to quickly identify where patients need to have decisions made about their care.

We last attempted to introduce this visual and engaging method of managing patients a couple of years ago, but with limited lasting engagement. The signs this time are far more encouraging.

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

'The 12 Green Days of Christmas' was a triumph both musically and operationally – the memory of the trust's senior team at Team Brief singing the carol with such gusto will live long. We also achieved the main ambition, which was to get more patients discharged home for Christmas.

And, as the financial year came to a close, we took on the challenge to run our Perfect Week. Perfect Week was our way of adapting a national initiative to clearly and unambiguously focus on doing whatever was necessary to prioritise getting patients' care progressed with the overall goal of getting them discharged safely and appropriately.

One of our main aims was to reduce length of stay for our patients. We got 40 patients home who had stayed more than seven days; the equivalent of more than an entire ward which was a fantastic achievement, and 22 people here for more than 21 days, were able to leave our hospitals. This was a particular achievement as they were complex patients.

All of our divisions made a difference and it was achieved with very little additional resource. For the first time we really crossed boundaries with clinical and non-clinical staff working together to make things happen; which was fantastic.

There was no drop in pressure, no reduction in the number of patients, however, with everyone focused and working together, we were able to achieve a huge amount.

Things that made the biggest differences were senior support and challenge for our decision-making, and the positive response from our ward staff. There was better communication and problems were being solved earlier in the day, which meant things were happening quicker for our patients. There were lots of learnings we can take forward in the months ahead.

Referral To Treatment (RTT) – Elective Care

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

We anticipated that the year would be challenging as we continue to balance activity with our commissioners, and so it was proved. We did not hit the constitutional target of 92% of patients being treated within 18 weeks of referral, returning a performance of 84% and a decline compared with last year.

In October 2018, we agreed a revised recovery plan with our commissioners and regulators.

Since then, we have reduced the overall number of patients waiting from over 41,000 in September 2018 to just above 39,000 in January 2019.

Whilst we have not met the overall improvement trajectory, we have delivered significant improvements in the performance in a number of specialties, including oral / maxillo-facial surgery, neurology and endocrinology. We have extended available capacity in-house and through outsourcing contracts for orthopaedics, ENT and neurosurgery to the independent sector, which will continue.

As a health system, we have been working jointly to agree common pathways between primary care and secondary care as part of our 'Improving Referrals Together' (IRT) programme. Working with commissioners, we have put in Advice and Guidance arrangements to enable GPs to request

input on patients from our clinicians, without having to refer, although there is work to be done to improve this service across all specialties. In the year ahead, one of our top priorities is a transformation of how our outpatients work. This will involve working with our commissioners and GPs to deliver new models of care which are so needed.

Outpatients

It has been another busy year for outpatients, with some challenges.

We continue to see the benefit overall from employing the Envoy text messaging system, and we appointed a third party company last year to assist with our mailings. However, these processes have not been without issue.

There have been several Serious Incidents raised in the latter half of the year relating to administration and correspondence affecting large numbers of patients who haven't received documents. This has highlighted continued challenges around the systems that we use and how we use them. Full investigations are underway to identify and tackle the root causes of these issues.

One of our priorities for 2019/20 will be to reduce the numbers of outpatients we see in our hospitals. As previously described, we have been employing The PRIDE Way to work with internal and external partners to find ways to transform the way we approach outpatients appointments and clinics.

Cancer services

Our cancer performance has again been extremely positive this year. For 2018/19, our objective was to meet all the national standards for cancer pathways (these are detailed in the Performance Analysis section); whether a two-week wait, the 31 day standard, or the 62 day target; which stipulates that 85% of patients should have received treatment within 62 days of urgent referral.

We have met all standards for 2018/19, including the 62 day target, with more than a year having passed since we missed a monthly benchmark. This level of performance puts us in the top bracket of trusts across the country.

This is the most challenging of all the cancer standards so it is a significant achievement to have met this and all the others during such busy periods in our hospitals.

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

This success has been built on a solid foundation of work delivered last year and this, particularly in the form of implementing a comprehensive and robust recovery trajectory and cancer action plan, developed with support from the CCGs and other colleagues across London-wide networks.

Radiotherapy advances

In October 2017 we were delighted to become the first trust in Britain to install a cutting edge new radiotherapy machine – the Varian Halcyon. The Halcyon offers more precise, more comfortable treatment at twice the speed of more traditional machines, ensuring that we can offer better treatment to our patients than ever before.

This year we have added a second Halcyon, becoming the only hospital in the world to have two, and we also added a third new machine – the Edge – as part of our planned replacement cycle. The mainstay of funding came from the Department of Health for this project, but we added additional features by investing to upgrade it.

Again, we took the opportunity to refurbish the rooms too, including redecorating and installing sky panels to help provide the most welcoming and calming environment possible.

We are now one of the most advanced non-specialist radiotherapy centres in the NHS, offering cutting edge treatment to patients, and able to offer fantastic career and development opportunities to our staff.

Chemotherapy centralisation/Living With and Beyond Cancer Hub

In November 2018 we had to bring forward a plan to centralise our chemotherapy services at Queen's Hospital.

We had for some time been intending to make this move, as we believe it offers the best, safest service for patients. Our chemotherapy options at King George Hospital were extremely limited, and the staffing challenges across two sites made it very difficult.

We also wanted to use the space at King George to develop a 'living beyond cancer hub' where we could support patients and their families.

Cancer patients and their families are going through an intensely difficult time. They tell us how much they value the broader support outside of their treatment, such as psychological support, having someone to speak with, or alternative therapies.

We want to develop the Cedar Centre to provide those options as they're often as important as the medical care.

However, we were forced to move more quickly than would have liked due to acute short-term staffing pressures which meant we were unable to staff both sites safely, so the decision was made on operational and safety grounds, and with a very short lead in time.

While we are very pleased with how the move was handled, the response from patients, and with the fantastic feedback about the Cedar Centre, we have taken on board subsequent points made by stakeholders about engagement and consultation around service changes.

Securing the Emergency Department at King George Hospital

One of the most significant developments this year (coming in the final months) was the substantial step forward of being able to produce a definitive statement, along with partners from local Councils and our CCGs, confirming the future of the Emergency Department at King George Hospital (KGH).

After years of uncertainty, being able to articulate our collective commitment was a notable moment.

The statement was co-signed by Councillors Jas Athwal, Damian White and Darren Rodwell – the respective Leaders of Redbridge, Havering and Barking & Dagenham Councils – as well as our chief executive, Chris Bown and Ceri Jacob, Managing Director of the BHR CCGs.

For some time there has been a recognition that the anticipated growth in our local population was going to put increasing pressure on acute and emergency care in our community.

It was therefore really positive to be able to confirm that the threat of closure of the Accident and Emergency unit arising from decisions in 2011 has been removed and that there will continue to be an Accident and Emergency unit at KGH.

New CT scanner up and running

And in further good news at KGH, we were delighted to be able to end the financial year by bringing online our new state-of-the-art CT scanner at King George.

The new scanner uses a reduced dose of radiation, without impacting the quality of images. It also works faster than the previous model, which allows our Radiology staff to scan patients more quickly. As this means more people can be scanned in less time, anxious patients will get their tests completed faster, in many cases allowing them to start their treatment earlier.

The room in our Radiology department where the scanner is located has also been completely refurbished to create a calming and relaxed atmosphere for our patients, complete with decorated ceiling panels to make them feel as if they are looking up at the sky during their scan.

And the scanner has special cardiac capabilities which will allow patients to be scanned closer to home rather than needing to travel further afield.

BECOMING AN EMPLOYER OF CHOICE

- **Establish outstanding leadership at all levels of the organisation**
- **Recruit and retain a flexible and diverse workforce and reduce our reliance on agency staff**

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 14%. This is higher than we would like. However we have increased the number of staff we employ and increased our establishment.

We are still spending too much money on agency staff however – during the year, our total spend on agency staff was 8% of our entire pay bill. We continue to consider ways that we can reduce this level. One improvement which made a difference was that we introduced weekly pay runs, so that staff on Trust Temps (our bank) can get a similar experience to those working for agencies.

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 2.8%, and although during certain months during the year we have achieved that figure, our average absence rate was 3.8% - marginally up on last year.

Recruitment and Retention

Over the past year we recruited 907 new staff members, including a record number of nursing staff. However, during the same period, a similar number left the Trust – many of which were from clinical posts; nurses, allied health professionals and doctors.

Recruitment takes time and resources, and a constant turnover of staff impacts on the delivery of patient care, staff morale and the ability to build teams. Our focus was therefore on improving staff retention.

By the end of the year, we were beginning to see some positive results. At the start of the year, we were losing 26% of staff within their first year. By the end, this was down to 20%. We had also got our staff turnover to just over 14%, but it's still above the NHS average of 10%.

One avenue of success in recruitment terms was our special recruitment days throughout the year. In February 2019 we had a record-breaking Nursing and Midwife recruitment day thanks to the tremendous efforts of teams across our organisation who put on a fabulous show promoting our Trust as a place to work.

We welcomed more than 150 potential new colleagues to Queen's Hospital, offering 119 of them jobs on the day, with new recruits coming from far and wide to join us – we saw applicants from 12 universities from across the UK and three European ones too.

Staff Survey

Our 2018 Staff Survey was in places a difficult read. The results show that for some staff our hospitals have become increasingly difficult places to work over the past two years and morale is not high.

Since 2017 the number of our employees who would recommend our Trust as a place to work has gone down. A third of staff who responded said they had thought about leaving.

The survey also strongly reinforced the feedback we receive on an ongoing basis that we need to improve the experience of coming to work. In response to this feedback and through The PRIDE Way we have already started to take steps towards improving our organisational culture to ensure we have compassionate and inclusive leadership, a key indicator of staff satisfaction.

There is much more we need to do. Our challenge is to ensure we have consistently good staff experience across our hospitals.

When we published the results, our chief executive made clear they would be a catalyst for change – in the year ahead we will be embarking on a major programme of improvement activity to tackle issues such as staff's health and wellbeing, transparent and inclusive recruitment, supporting them to progress in their careers and aspirations, while providing a supportive environment.

Deloitte report into medical culture

In September/October 2018 we published a report by independent consultants, Deloitte, which we had commissioned to explore allegations of bullying and poor engagement of medical staff at our Trust.

Deloitte carried out a series of interviews, held focus groups and studied the relevant Trust papers to inform their report.

Deloitte found no evidence of bullying and intimidation against our consultants by our senior leaders. However, the report did highlight allegations were made at the focus groups about the inappropriate behaviours and culture of a pocket of medical consultants.

We took these views very seriously, sharing the report internally and making it accessible to our teams and stakeholders.

It was made extremely clear that the behaviours identified would not be accepted, and that the doors of the chair, chief executive and executive colleagues were open to anyone who wanted to raise concerns.

The PRIDE Way/Culture change

As mentioned earlier, and in the context of the challenges identified above, one of the big programmes of work this year has been in how we reposition The PRIDE Way, so that everyone understands this is the way we lead, behave and make improvements.

In the final months of the financial year we made good progress with rolling out a major programme of work (which will continue through 2019) to identify and tackle our cultural challenges. This is being led by a Cultural Change team comprising colleagues from across the organisation.

This included a confidential survey as part of a tried and tested NHS Improvement/the King's Fund toolkit which was rolled out, asking staff for their views on our current position and our leadership behaviours.

Our next steps are to focus on cultural improvement, looking at our own behaviours, how we treat each other, and our leadership style.

Another phase (being delivered as this report was being written) will be a series of focus groups for staff to share their views on our culture, with randomly selected colleagues being asked to attend these sessions to help us capture a representative view of our Trust.

This is the first time we've ever undertaken something like this, identifying the root causes of our cultural issues so we can make meaningful change. The year ahead will be key in seeing whether and how we can make meaningful progress.

Nurse Intern scheme

Just one example of how we are working hard to retain our nurses is our innovative Nurse Intern scheme.

We started this programme late in 2017, in which our small, dedicated team of more experienced nurses work to support less experienced nurses, or those new to our Trust, providing them with practical and emotional support and advice, and helping them settle into their career.

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

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

We were delighted when this team won the Preceptorship of the Year award at The Nursing Times Workforce Awards in October. They were recognised for developing a successful mentorship and coaching programme for new nurses which has had a fantastic impact on improving our retention of new nurses and midwives, and at the time of writing, they had also been shortlisted for the RCNi Nurse Awards.

Academy of Surgery

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

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

Doctors on this scheme benefit from vital support, helping them to achieve their career goals, and we're also offering a sponsored MSc in a subject of their choice, while we benefit from their expertise, and are less reliant of agency or locum doctors.

We welcomed over 20 doctors to join our first 'class' in the Academy of Surgery - from countries including Egypt, Iraq, Pakistan, Sri Lanka and Greece.

They have been really positive about the scheme, about the support they are afforded, through

clinical and educational supervision, and the unique way our programme allows them to work extensively in different specialities to get a real feel for the work. We've been delighted with the results.

It meant that for the first time in years, in early 2019, we were able to report that all our surgical registrars were permanent staff, with no temporary staff. We intend to roll out similar schemes in other divisions.

Volunteers

This year has been another great year for volunteering at our Trust. We have seen a steady increase in people wishing to volunteer and are seeing more and more of our community apply to volunteer in our hospitals, in particular, younger people.

Currently we have an army of 538 volunteers who are ready to serve our patients, staff and our services. For example if you have ever visited one of our hospitals and you were a little lost, there is a good chance one of our wayfinder volunteers helped you find exactly where you needed to be. In 2018-19, our information desk and wayfinder volunteers assisted a whopping 101,656 people find their location.

We focussed heavily on fundraising for our volunteers' charity in a range of innovative and in some cases, quite extreme endeavours. Volunteer Champion and Patient Partnership Council member Charlie Richardson (aged 70) jumped out of a plane raising a staggering £2,000. Our volunteers' charity funds an annual thank you parties for our volunteers throughout the year.

We continue to work closely with the schools and colleges locally, in our Students in Volunteering Programme and plan to develop the programme further in the oncoming year. Havering College visited us for three days, with four of their photography students taking pictures of our volunteers in action.

Our volunteers donate thousands of hours annually, in 2018-19 they gave over 26,000 hours and for that are very grateful. Our volunteers are a massive support to our hospital's and patients and we want to thank everyone.

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 health care assistants; who have completed a care certificate; and registered nurses.

We have one of the largest cohorts of Nursing Associates in the country and we are really proud of them. We see this as a great potential alternative route for people to enter nursing.

We were delighted that our first cohort graduated this year, having spent two years in an apprentice-style working and learning environment, with one day a week spent at London South Bank University (our local education partner).

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

Support groups

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

We are pleased that these are active groups, but we can always get better engagement, as a

means of sharing ideas, experiences and feedback, so hopefully that will continue to be seen in the year ahead.

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

Our Ethnic Minority Network meets regularly and was a particular area of focus in the latter months of the financial year as we deal with the issues we know exist around BME representation and opportunity within our Trust.

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

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

Celebrating our teams

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

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

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

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

Team of the Week continues to be a popular way that staff can be publicly recognised for their efforts, via FFT results and also nominations.

As the financial year drew to a close, we were preparing to relaunch our primary staff award scheme under a new banner – the You Made a Difference Awards.

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

WORKING IN PARTNERSHIP

- **Work with our local partners to integrate our clinical pathways and maximise our use of resources**
- **Embed strong engagement and involve our patients and the public in our work**

Towards an Integrated Care System

This year has seen an acceleration of effort as we work collaboratively towards establishing an Integrated Care System in Barking, Havering and Redbridge.

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

We are not doing this alone. After a number of years of sometimes difficult relationships, we are now working far more closely with our commissioners, NELFT and other members of the wider Barking and Dagenham, Havering and Redbridge health economy – including those who work in health and social care in the three local authorities we serve.

Nowhere is this better illustrated than by the fact that we were able to agree a shared financial recovery plan for the whole BHR health economy – a major step forward.

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

We are also active in the context of a 'provider alliance' which includes us, our community and mental health partners: North East London Health Foundation Trust, Barking and Dagenham, Havering and Redbridge GP Federation Chairs and HealthWatch representatives from each of the boroughs and the local authorities.

We are all in agreement that we need to focus on pathways in order to improve patient care and to drive efficiencies.

Clinical Strategy

As the year ended, we were about to commission a major body of work into the delivery of our new Clinical Strategy, which will likely take up most of the next financial year.

This will require significant engagement and consultation with partners and the public as we work towards delivering a joined-up and effective health and social care system which meets the needs of our community.

This will be an interesting period as we work together internally and externally to design what our hospitals will look like in the years to come, so we can continue to provide high quality care for the people we serve.

Of course there are many questions still to answer, for example: what sort of maternity and young people's services will we need for our growing population? How should we develop specialist services, such as cancer and neuroscience, with other partners? What will the two emergency departments at our hospitals look like?

Our strategy will have to align with the ambitious and challenging plan we have developed with our partners in Barking and Dagenham, Havering and

Redbridge (BHR) to move out of our financial deficit.

Engaging Patients

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

The PPC brings our patient partners and our staff together to help 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/vice chair); clinical staff (including doctors, nurses and a Deputy Chief Nurse); and non-clinical staff. The council's work touches on all aspects of the care we provide, services and pathways.

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 hospital, at every level. Patient partners are a key part of everything we do and we have recruited many this year to support us in improving our services.

Stakeholder engagement

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

Our Local Representatives' Panel, which has continued to meet, giving the opportunity for dialogue and engagement with members including Healthwatch and local councillors, and critically try and bring our hospitals and work to life for them, but we hope to re-energise this channel and ensure It continues to be adding value.

We have continued to 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 council scrutiny sessions, Oversight Groups, 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.

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.

The celebrations of NHS@70 last year were a particular success – we welcomed several of our key MPs to a celebratory breakfast at Queen's Hospital. Separatelywe've also welcomed Mike Gapes, Wes Streeting, Julia Lopez and Margaret Hodge on separate occasions.

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

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

We have continued to aim to provide a fast and effective press office, responding to queries and questions promptly. The year has had its share of both positive and negative coverage – mainly due

to the circumstances in the Trust which are described elsewhere, but the reporting has been mainly balanced, accurate and fair, and where less so, we have challenged as we should.

Working with GPs

The year has seen good progress in engagement with our local community of GPs.

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

By the year end, we were pleased to have completed the transition of our system of management of GP Alerts away from a locally held spreadsheet run by the GP Liaison Manager, and onto the central trust system Safeguard.

This was a very positive step to providing appropriate clinical escalation and better oversight, improving the robustness of our process, and so improving quality and safety, with better visibility at key clinical oversight meetings, and offering a better framework for reporting, investigating, monitoring and evaluating emerging themes, as well as managing the specific issues reported.

The support of the Quality and Safety team will assist greatly in pursuing these issues to a successful resolution.

The additional time released will enable our GP Liaison Manager to spend more time on strategic issues and relationship development, working with GPs to improve our relationships and working practices.

We have routinely attended all Local Medical Councils, which is a good opportunity to engage.

We continue to circulate the dedicated GP e-newsletter – GP Connect (launched last year) to compile and summarise key information – which is well-regarded and read.

Over the year we also saw the implementation of the 'paper switch off' with movement away from paper-based referrals and the taking up of the e-referral service (e-RS), which went generally smoothly.

Our role in delivering the East London Health & Care Partnership (ELHCP) Plan

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

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

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

MANAGING OUR FINANCES

- **Deliver our ambitious Quality and Cost Improvement Plan**
- **Embed clear processes, roles and responsibilities to ensure strong financial governance and budgetary control**

2018/19 has been an important year in stabilising the Trust's financial position and establishing relationships with commissioners and regulators, to enable the laying of foundations for a brighter future.

Although we remain in Financial Special Measures and reported a deficit of £60.3m, we have made important progress.

We entered the financial year with an income and expenditure plan set to deliver a £34.8m deficit against a deficit control total of £9.3m before Provider Sustainability Funds. Being unable to accept this control total meant we were not eligible to earn Provider Sustainability Funding of £26.2m.

Delivery of the plan required £39m of savings (7.1%) and an assumed level of locally commissioned clinical income which was not underpinned by a signed contract with our main commissioner, Barking, Havering and Redbridge Clinical Commissioning Groups (CCG).

The Trust and CCG were going through an expert determination of the 2017/18 contract which did not conclude until 22 June 2018. This prevented both parties from being able to reach agreement on a contract for 2018/19 in advance of the plan being finalised.

The eventual outcome of the determination had a negative impact on the Trust's income plan of nearly £13m. In addition, the savings ambition reduced by £11m to £28m (c5%). Consequently we went through a process with NHS Improvement to formally re-forecast a deficit of £60.4m at month 6.

On average in months 1 to 6 we reported an average monthly deficit of £6m. In line with the forecast, we delivered an improvement in run-rate in the second half of the year, reducing the average monthly deficit to £5m per month. It is important to recognise that although our reported position is £60.3m, we start 2019/20 with an underlying deficit of £65m, with the difference being non-recurrent CCG support.

The Trust is required to deploy cash available for capital investment initially to repayment of PFI principal and repayment of other capital loans and finance leases. This left the Trust with £5.9m to finance a capital programme.

In addition the Trust received £1.4m of central programme funding from the Department of Health and Social Care (DHSC) in the form of Public Dividend Capital (PDC). With these combined funds we delivered the following investment in our infrastructure:

Capital investment	Cost
Medical Equipment	£1.6m
CT Scanner – KGH	£1.3m
RAFTing Area at Queen's	£1.2m
Backlog Maintenance	£1.0m
ED Primary Care Streaming	£1.0m
Other	£1.2m
Total	£7.3m

Being in financial deficit and financing our PFI makes the level of Trust generated cash for investment in capital very limited for a provider of our size. An application for emergency capital

loan support of £4.3m was made to DHSC but approval was not granted.

Cash loans of £65.6m were drawn down to support our revenue position. We have managed our working capital to ensure sustained significant improvement in payment to suppliers, such that the Trust has sustained average performance above 90% against the Better Payment Practice Code and in a number of months we have exceeded 95%.

We have continued to deliver against the recommendations of the Grant Thornton and Deloitte financial governance reports and the focus going forward is to ensure these are embedded in how we run our organisation on a day to day basis.

Developing a Financial Recovery Plan

During quarter 3, the Trust developed a Financial Recovery Plan (FRP) to answer "what would need to be achieved to breakeven by March 2021?". We undertook an evidence based diagnosis which has shown there are no material structural drivers of our deficit. There are however significant strategic and operational opportunities which will require ambition to cure.

Our internal aim needs to target upper quartile Model Hospital cost performance. However, this alone will not be enough. Demand on the Trust's services are unaffordable to the local health economy and to resolve this will require a level of system working aligned to the national plan for Integrated Care System (ICS) but not apparent in our local health economy over recent years. We have made very positive progress in this area and a commitment to work as an ICS for the benefit of the population has been put in place. Working with our system partners we need to redesign pathways for the benefit of our patients and be one of the first ICS's to deliver financial value. Work focussed on Outpatients, Older Peoples Services and patients with Long Term Conditions are already underway.

We and the CCG are serious about working together and have established an agreement to stop "intercompany squabbling" and pursue real savings which will be shared equally.

The FRP was formally accepted by our Regulators in November 2018 and a copy is available at https://www.bhrhospitals.nhs.uk/system -financial -recovery-plan-

Financial Outlook

The Trust has submitted a financial plan to NHS Improvement in line with the deficit control total of £23.1m for 2019/20. The underlying deficit will be £51m with the gap being Provider Sustainability Funds and Financial Recovery Funds of £28m. This is consistent with the ambition set out in our FRP.

Once again we will have a constrained capital programme, with internal funds available after PFI capital repayment, other leases and loan repayments of just £3.8m. We will be seeking emergency capital loan support of £11m whilst in addition looking to access available programme capital held by STPs or nationally for investment in IT where available.

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

Our Performance Report

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

Overview

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

This year has been a difficult year in terms of delivery against the emergency access target. We have not achieved the standard despite the hard work and commitment of staff.

We worked closely across the winter with a range of partners to try to find ways to improve performance, and have reintroduced Red2Green as a means of reducing patient stays and improving flow with some very positive results - we now need to successfully embed this practice across the organisation. We also opened a new RAFTing area at Queen's at the very end of the financial year, which we hope will improve ambulance transfers for patients and staff alike.

The major challenge for the year was bringing our finances back under control, so it is pleasing that we have achieved our agreed control total for the year.

However, this is really only the first step in a longer journey. There will be many challenges ahead as we continue to tackle our deficit and move towards a breakeven operating position.

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

It is very pleasing to be in a position today where this hard work has shown clear positive impact for our patients – an entire year of achieving the 62-day target.

Our recovery performance for those people waiting for elective treatment (RTT) has been a mixed picture this year.

We did not hit the target of 92% of patients being treated within 18 weeks. Our original plan for the year was to work towards maintaining the delivery of this standard, but capacity challenges have made this difficult. Good progress has been made in a number of areas, but over the next year, as part of our joint system recovery plan, we will be completely transforming how outpatients works in our health economy, aiming to dramatically reduce numbers.

We did not hit the target for diagnostic performance of ensuring 99% of patients receive their diagnostic test within six weeks, by some distance. This was due to significant issues around our endoscopy capacity – the fire in our Endoscopy Unit at Queen's Hospital that affected the endoscope decontamination facilities, requiring a mobile unit and outsourcing. As the year ended, we were pleased to reopen the decontamination unit with new kit installed which should have a positive impact.

Secondly, for MRI we experienced mechanical failures and subsequent capacity issues which also required outsourcing, but towards the end of the financial year we brought in a mobile unit.

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

Fundamentally, we will all have to think differently in the future about how we provide services and how we deliver the NHS Long Term Plan. We have made good progress this year

towards becoming an Integrated Care System, and I expect that momentum to increase in coming months.

Our maternity care is a continued point of pride, with fantastic feedback from women using the service, and we are continuing 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.

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

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

We achieved our targets for staffing fill rates through successful recruitment of nursing staff, supported by our in-house temporary staffing supplier. A highly effective preceptorship programme, which achieved a Nursing Times award in 2018, 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 and apprenticeship programmes.

Finally, we identified here last year that we wanted to reduce the number of healthcare acquired infections we recorded. I am pleased to report that we showed improvements in numbers of both MRSA and Clostridium difficile (C.diff) which was pleasing although we still registered cases in both so there is more room for improvement.

Chris Bown, Interim Chief Executive

Performance Analysis

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

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

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

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

We have the following assurance measures for our performance reports:

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

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

Performance	The standard	Our results
Emergency access	95% of all patients attending our Emergency Departments to be treated, admitted or discharged within a maximum of four hours	Not achieved: 80.68%
Referral To Treatment	92% of our patients to be seen within 18 weeks of referral from their GP for elective care	Not achieved: 84.01%
Cancer: urgent referrals	93% of our patients to be seen in two weeks following an urgent referral from their GP	Achieved: 93.87%
Cancer: 31 days	96% of our patients to have a diagnosis and first definitive treatment within 31 days of the decision to treat	Achieved: 98.32%

Performance	The standard	Our results
Cancer: 62 days	Target of 85% of patients receiving first treatment from the date of GP referral	Achieved: 86.67%
Infection control: C diff	No more than 30 cases	Achieved: 9
Infection control: MRSA	Zero cases of MRSA bacteraemia	Not achieved: 5

Performance Trends

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

Standard to achieve		2018/19 Target	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 position	2018/19 Total	2017/18	2016/17	2015/16	2014/15	2013/14
Infection Control	Number of Clostridium difficile cases	<29	1	3	2	3	9	15	29	36	33	N/A
	Number of MRSA blood stream infection cases	0	1	1	0	3	5	6	7	5	6	N/A
Access to Cancer services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96.00%	99.05%	98.40%	98.45%	97.39%	98.32%	98.52%	98.67%	96.10%	98.00%	96.10%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.80%	99.70%	99.60%	100.00%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94.00%	98.18%	98.36%	100.00%	98.44%	98.73%	99.56%	99.15%	96.10%	98.30%	87.80%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	94.00%	100.00%	98.99%	100.00%	99.60%	99.66%	99.89%	99.47%	98.70%	98.70%	95.30%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment *	85.00%	87.93%	85.77%	87.21%	86.20%	86.92%	86.21%	74.22%	74.00%	81.20%	84.20%
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	90.00%	93.70%	93.00%	94.12%	93.88%	93.68%	96.78%	95.16%	93.70%	94.00%	96.20%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	95.82%	94.30%	93.14%	91.75%	93.87%	96.79%	95.20%	94.50%	91.30%	90.50%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93.00%	96.77%	99.41%	98.66%	96.36%	97.79%	97.89%	93.47%	93.20%	80.10%	80.40%
Access to treatment	18 weeks referral to treatment - total incomplete	92.00%	86.50%	84.46%	83.09%	82.08%	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%	82.26%	83.23%	80.62%	76.95%	80.68%	81.84%	85.65%	87.90%	85.30%	88.60%
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	297	168	298	372	1135	651	974	524	494	378
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	72	22	39	72	205	77	42	38	39	14

Risks

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

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

There is a risk that financial pressures will impact on performance. As we have not achieved a break even position, our auditors have raised a Section 30 referral with the Secretary of State. We have received assurance from NHS Improvement that it expects us to continue as a going concern and that it will make sufficient financing available to the organisation in line with our operational plans.

While we have seen some 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.

Interserve

Following a competitive open tendering process, we appointed Interserve to run the TFM contract at King George Hospital, commencing in October 2018.

Subsequent to that, Interserve underwent a period of difficult trading and performance which resulted in it entering administration at the very end of March 2019. There have been no concerns from the trust's perspective about the performance of Interserve since starting the contract.

For some time we worked with Interserve and on our own contingency plans, so this was not a surprise and we were prepared, with the necessary assurances and protections in place.

We will work closely with the administrators in the year ahead to ensure the contract is delivered, and to ensure the impacts on the 220 staff at King George are managed appropriately.

Brexit

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

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

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

Sustainability

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

Demonstrating that we consider the social and

environmental impacts 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 at least 80% by 2050, and 26% by 2020.

This ambition is supported by the Department of Health and Social Care and in response the NHS Sustainable Development Unit (SDU) published a revised NHS Carbon Reduction Strategy 2020. This strategy establishes that the NHS organisations should have a plan to meet the carbon reduction target.

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 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supersede this target by reducing our carbon emissions 28% by 2019/20. To date, our performance is 24.5%.

Sustainable Development Assessment Tool

The SDAT assesses 10 modules across multi-disciplines. The overall score for our latest assessment was 72%, well-above the average for similar acute trusts – this is reinforced by benchmarking against the Model Hospital.

This result indicates that we are already contributing to some United Nations sustainable development goals and making progress in most of them.

Key performance highlights

We have now delivered a 6% increase in recycling based on the 2012/13 baseline, with zero domestic waste going to landfill.

This year we made significant progress with reducing our plastic waste (20%) by introducing reusable sharps waste containers through SharpSmart. This service is both cheaper and more environmentally sustainable – a win-win.

We have made continued good progress in our energy usage and efficiency – 99% of our electricity is renewable. 23% of our electricity at Queen's Hospital is generated onsite through a Combined Heat and Power (CHP) plant. Our total energy consumption has done down by 18% in comparison with the 2012/13 baseline.

On the travel front, we now have around 5% of staff cycling to work (against a target of 3%) and we have increased cycle parking. We are also pleased with the results of our first year of using FAXI – a car-sharing scheme. We have 500 staff engaged as passengers or drivers – one of the largest car share communities in the country, which is saving around 47,000 miles a year, as well as reducing demand for much needed car parking spaces!

We were delighted to win three awards this year in recognition of our performance – 2018 Sustainable Excellence – Corporate Approach; the Carbon Reduction award at the Sustainable Health and Care Awards; and the Environmental Award at the Essex Business Awards.

SECTION 2 – OUR ACCOUNTABILITY REPORT

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

Directors' Report

Our Trust

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

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

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

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

Leadership

The Chairman is responsible for the leadership of our 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 role of the Trust Board

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

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

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

The Chief Executive is responsible for executing the strategy agreed by the Board and developing the Trust's objectives through leadership of the

executive team. He recommends to the Board any investment or new business opportunities which meet this strategy. He also ensures that the Trust's risks are adequately addressed and appropriate internal controls are in place.

Appointments

It is the role of NHSI to appoint or re-appoint the Chairman and Non-Executive Directors (NEDs). An interim Chief Executive, Mr Chris Bown, was appointed in August 2018. The previous Chief Executive, Mr Matthew Hopkins, left the Trust in August 2018.

Two Non-Executive Directors departed the Trust in-year. Mr Eric Sorensen completed his term on 31 December 2018, and Mr Mark Lam resigned as a Non-Executive Director, in order to focus on his appointment as chairman of a mental health trust, on 31 March 2019. Both vacancies were being recruited to at the time of this report.

At the end of the year, three non-executive directors were considered independent in character and judgement using the criteria for independence listed within the UK Corporate Governance Code. There were two NED vacancies at year-end, which were being recruited to.

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

There were two fixed term executive director appointments during 2018/19: Mr Nick Swift as Director of Finance and Investment from September 2018, replacing Mr Ian O'Connor who left the Trust in September 2018 and Dr Magda Smith as Chief Medical Officer from January 2019, having acted up from August 2018 when Dr Nadeem Moghal left the Trust.

The Trust appointed Mr David Amos as interim Director of People and Organisational Development in January 2019, after Ms Deborah Tarrant departed the Trust in December.

As with all staff, new directors receive an induction on joining the Board. The Board ensures that directors, especially non-executive directors, have access to funded, independent professional advice. This is facilitated through the Trust Secretary. The availability of independent external sources of advice is made clear at the time of appointment.

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

Ms Sandra Malone – People and Culture Committee (until 1 January 2019);

Mr Jonathan Steinert – Quality Assurance Committee (resigned as a NEDA in October 2018);

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

Mr George Wood is the Chair of the Charitable Funds Committee (appointed to Finance and Investment Committee 20 February 2019);

Ms Sue Levy – Finance and Investment Committee (from 4 July 2019);

Ms Caroline Roberts was not a member of any Board Committees in 2018/19;

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 2018/19 to improve its corporate governance framework through:

- continuing to drive improvement actions following the strategic governance review in 2015 supported by the Good Governance Institute
- re-phasing of the VMI inspired PRIDE Way programme at the Trust
- embedding of an improved Board Assurance Framework (BAF) to manage risks and deliver objectives in conjunction with ongoing board development
- establishment of a Board level task and finish group, the continued implementation of recommendations from a number of external reviews
- establishment of a board development programme, including scoping, and scheduling board, executive team and non-executive team away days
- recruitment of new non-executive directors, and interim and fixed-term Board level positions
- moved to monthly Board meetings and refreshed the Board committees to provide focus on key areas and challenges

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 2018/19, the Trust further embedded its new management structure and refined its committee structure.

How we conduct Trust Board meetings

The Trust has maintained its support of the Principles of Public Life and makes the majority of its decisions at Board meetings held in public. During the year, the Trust held 11 Board meetings in public.

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

Attendance

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

Table: Directors' attendance at meetings: 2018/19

	Trust Board	Audit	Finance and Investment (FIC)	Remuneration	Quality Assurance (QAC)	People and Culture (PCC)
Non-Executive Directors						
Joe Fielder	11/11		6/7	6/6		
Tom Phillips	10/11	5/6	6/8	4/6		
Jackie Westaway	8/11	4/5	2/2	5/6	8/8	
Mark Lam	7/11	3/6	4/10	3/6		3/3
Joan Saddler	4/11			4/6	4/8	3/3
Eric Sorensen	8/8	4/4	8/8	5/5		

	Trust Board	Audit	Finance and Investment (FIC)	Remuneration	Quality Assurance (QAC)	People and Culture (PCC)
Prof Anthony Warrens	8/11			1/6	1/8	
Executive Directors						
Matthew Hopkins	4/4		3/4		2/4	1/1
Chris Bown	7/7		4/6		1/1	2/2
Kathryn Halford	10/11		6/7		6/8	3/3
Dr Nadeem Moghal	3/4		4/4		4/4	0/1
Dr Magda Smith	6/7		0/3		3/4	2/2
Ian O'Connor	5/5		5/5		0/4	0/1
Nick Swift	3/6		3/5		0/1	0/2
Deborah Tarrant	4/6		3/7		0/6	1/2
David Amos	2/2		2/2		1/2	1/1
Shelagh Smith	10/11		10/10		8/8	2/3
Jason Seez	9/9		9/9			
Peter Hunt	9/11					

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

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

Audit Committee

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

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

Key activities for 2018/19 included:

- Review and approval of the internal audit plan, and more detailed programme of work, ensuring that this was consistent with the audit needs of the Trust
- Consideration of the major findings of internal audit work, the appropriateness of management responses, and the timeliness of completion of agreed actions
- Review of all external audit reports and the annual audit letter
- Review of the Trust's Annual Report and Financial Statements including the Annual

Governance Statement and changes in, and compliance with, accounting policies and practices

- Review of the Trust's Quality Account
- Review of all work related to security, fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect
- Review the structure and process of the Board Assurance Framework
- Review divisional and corporate risk registers.

The Audit Committee also received regular or specific reports on:

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

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

Members of the Audit Committee in 2018/19 were Mr Tom Phillips (Chair), Mr Eric Sorensen (until 31 December 2018), Mr Mark Lam, and Ms Jackie Westaway.

Mr Joe Fielder

Chairman

Member: FIC (until 7 November 2018), Remuneration Committee

Joe is chairman-in-common, being also the chairman of the North East London Foundation Trust since April 2016.

Prior to his NHS roles, Joe gained a number of years' experience at Board level within BT, having served on both south west and south east regional boards. He was previously Sales & Marketing Director of BT Fleet Ltd, a wholly owned subsidiary of BT Plc.

Joe has a track record in delivering transformational change programmes for cost improvement and in driving business growth in a variety of senior sales, marketing and operational roles. Joe was reappointed chairman by NHSI until 30 October 2021.

Eric Sorensen

Independent Non-Executive Director, Vice Chairman / Senior Independent Director, Chair Finance and Investment Committee

Member: Audit Committee, Remuneration Committee

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

Eric is an experienced NHS non-executive director having held posts at Homerton Hospital and at South East London Healthcare Trust. Eric completed his term and ceased to be a Non-Executive Director on 31 December 2018.

Mark Lam

Independent Non-Executive Director, Chair, People and Culture Committee

Member: Audit Committee, Finance and Investment Committee, Remuneration Committee

Mark Lam was appointed in September 2014. A senior corporate executive, Mark has extensive global experience in telecommunications and information technology. He is an executive and Chief Information Officer at Openreach, a BT Group business, and has previously held

management positions at Siemens and The Carphone Warehouse. His experience of global business spans Europe, the USA and Asia, where he has led major contracts and operations. Mark ceased to be a Non-Executive Director on 31 March 2019.

Joan Saddler OBE

Independent Non-Executive Director

Member: Quality Assurance Committee, People and Culture Committee, Remuneration Committee

Joan Saddler OBE was appointed in September 2014 for a four year term of office. Joan spent five years as the National Director of Patient and Public Affairs at the Department of Health and is now responsible for national policy and practice in public and patient engagement at the NHS Confederation. She previously served as the Chair of Waltham Forest Primary Care Trust. Joan was reappointed for a one-year term on 30 September 2019.

Professor Anthony Warrens

Non-Executive Director

Member: Quality Assurance Committee, Remuneration Committee

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

He is a former President of the British Transplantation Society.

Since 2010 he has been Dean for Education at Barts and The London School of Medicine and Dentistry, where he has re-organised educational structures within the School and improved basic science teaching. Anthony was reappointed for another for six months until 31 December 2018 and then reappointed again for one-year term to expire on 31 December 2019.

Tom Phillips

Independent Non-Executive Director, Senior Independent Director (from January 2019), Chair, Audit Committee

Member: Remuneration Committee and Finance and Investment Committee

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

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

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

Jackie Westaway

Independent Non-Executive Director, Vice Chairman, Chair, Quality Assurance Committee

Member: Finance and Investment Committee (until 31 May 2018), Remuneration Committee

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

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

director of HealthWatch Bucks and a Trustee of an Academy.

Chris Bown

Interim Chief Executive

Member: Finance and Investment Committee, Quality Assurance Committee (until 3 October 2018), People and Culture Committee

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

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

Dr Magda Smith

Chief Medical Officer

Member: Finance and Investment Committee (until 7 November 2018), Quality Assurance Committee, 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.

Kathryn Halford

Chief Nurse

Member: Finance and Investment Committee (until 7 November 2018), Quality Assurance Committee, People and Culture Committee.

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

Nick Swift

Director of Finance and Investment

Member: Finance and Investment Committee, People and Culture Committee, Quality Assurance Committee (until 3 October 2018).

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

Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

David Amos 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.

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

Shelagh Smith

Chief Operating Officer

Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee

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

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

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

Peter Hunt

Director of Communications and Engagement

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

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 to be published in 2019.

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 2019 were KPMG LLP. KPMG LLP has not carried out any non-audit work for the Trust during the year.

Cost allocation and charges for information

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

Better Payment for Suppliers

The Trust supported The Better Payment Practice Code that was established in 1998 by business and government together, to help improve the payment culture amongst organisations trading in the UK. The Code is supported by public as well as private sector organisations. Collectively they

represent about 20% of the UK's gross domestic product.

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

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

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

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

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

Modern Slavery Act 2015

Barking, Havering and Redbridge University Hospitals NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015 and we expect our staff and suppliers to comply with the legislation.

We have updated a number of relevant policies and ensured that training about slavery and human trafficking is available to staff through the safeguarding team. Future actions include scoping our procurement flows and developing a clear action plan to ensure Modern Slavery is not taking place in any part of business or any of our supply chains.

Political and charitable donations

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

Exit packages and severance payments

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

Off payroll engagements

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

Information Governance

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

- A solicitor obtained an address for the Trust via Bing.com (which was incorrect) and sent patient details (personal, confidential and sensitive information) to a resident address in Upminster via the post, believing that was the Trust's address;
- A number of clinical letters had not been sent to patients because staff had not been trained to navigate the system. 25000 letters were awaiting to be sent to GPs and patients;
- The Trusts Radiology department MRI2 scanner stopped sending images to PACS. A third party organisation Siemens who supports the hardware attempted to resolve the issue but in the process sent personal information to Germany for fault analysis without the Trust's express permission;
- A handover sheet containing details of 43 patients was found at a bus stop on Old Church Road;
- Patient appointment reminder letters had to been sent to the wrong address for just under 2500 patients. This was because the database configured to automatically send letters to updated addresses had been set up incorrectly;

- Anaesthetists in the Trust had been recorded Dural Tap information via a Red Book. The book contained information for patients who had this carried out during pregnancy. The book was reported lost.

Directors' statement to the auditor

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

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses 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.

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 access the NHS trust's performance, business model and strategy.

By order of the Board

Chief Executive.....

Date24/05/19.

Finance Director.....

Date 24/05/19

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 Development Authority, has designated that the chief executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officer's Memorandum.

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, recognised gains and losses and cash flows for the year

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

Chris Bown, Interim Chief Executive:

Date: 24/05/19

Annual Governance Statement 2018/19

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Barking, Havering and Redbridge University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them effectively, efficiently, and economically. The system of internal control has been in place in Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risks

The Trust faced risk management challenges throughout the year 2017/18, as well as uncovering some weaknesses in its controls, and during the course of the year 2018/19 it worked to improve its related processes. The Trust has ensured that its risk management system received the appropriate leadership and management. We have a Risk Management Strategy, which applies to all our staff, and this was refreshed and approved by the Board of Directors at its January 2019 meeting. At the strategic level, our board assurance framework (BAF) enables us to assess and evaluate the principal risks to achieving our strategic objectives. In 2017/18 it received only 'partial assurance' from an internal audit review, however in 2018/19 this had improved to 'reasonable assurance'. A review of risk management by internal audit also moved from partial assurance to reasonable assurance in the last year, however we acknowledge that there is still more work to do, which the Audit Committee will oversee.

During the year, the BAF was regularly updated and reviewed by the Board, as well as periodically being presented to the Audit Committee. It provides a current view around the risks to our meeting the strategic objectives, and the appropriate controls, assurances, gaps in controls and planned actions. Risks are assigned to executive directors. Risk appetite is determined by the Board in accordance with the Trust Risk Management Strategy.

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

Assurance around operational risks is provided to our Board through both the management route, and from additional scrutiny from the committee structure. The Risk and Compliance Group reviews the Trust risk register monthly. The Audit Committee invites divisional directors and corporate directors to attend meetings to present their risk registers, the Trust Executive Committee reviews the Trust corporate risk register.

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

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

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

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

The Audit Committee, on behalf of the Trust Board, gains assurance that risk management is properly implemented and controlled within the Trust. In 2018/19, the committee met six times, and retains the capacity to meet more often, if necessary, and oversees the integrity of the Trust's risk management processes and the board assurance framework (BAF). The Quality Assurance Committee meets bi-monthly as the high-level committee which scrutinises quality assurance and quality risks on behalf of the board. The Finance and Investment Committee meets monthly to scrutinise, and assure the Board of, matters related to finance, and the People and Culture Committee meets quarterly to oversee, for Board assurance, all workforce and culture related issues in the Trust. The Trust also has a Trust Executive Committee (TEC), chaired by the Chief Executive, which provides a forum and mechanism for executive decisions and management. During 2018/19 the TEC changed its meeting schedule from monthly to weekly.

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

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

- Executives directors and managers within the organisation who have responsibility for the

development and maintenance of the system of risk management and internal control

- Performance against national and local standards

- The work of Internal Audit (RSM) through the year

- The results of External Audit's (KPMG) work on our annual accounts

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

Throughout the financial year, the Trust continued its work to embed risk management in the organisation in the following ways:

- corporate and divisional objectives are risk assessed as part of the annual business planning and performance management process;

- structured processes are used for the completion of local risk assessments to populate the Trust's risk register;

- the Risk and Compliance Group monitors risk registers;

- there are structured processes in place for incident reporting, the investigation of Serious Incidents (SIs), complaints and litigation cases;

- the Audit Committee reviews divisional and corporate risk register at its meetings, and the Trust Executive Committee reviews the corporate risk register;

- all executive directors regularly review the BAF to ensure that appropriate action is being taken against key risks to the Trust strategic objectives and the Board formally reviews the BAF at its meetings in public.

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

The major risks to the Trust over the last year and into the current year include:

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

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

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

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

- inability to sustainably deliver income and expenditure financial recovery.

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

The PRIDE Way is a fundamental change in the way we work. It's about our staff having the power to make continuous improvements to the care we give to our patients and influence change in our Trust. The Trust's progress of its PRIDE Way programme had diminished, and during 2018/19 we made a conscious effort to inject new momentum into this work. Since then it achieved a significant increase in senior managers commencing PRIDE Way for leaders training.

There were 128 SIs reported during the year and three never events. These and other year-end key performance indicators are referenced in the performance report section of the annual report and within the quality account. The Trust achieved the targets for safe staffing in all four quarters, and the Trust achieved the national benchmark for harm free care in all four quarters.

The Trust has received multiple quality based visits and inspections to its Emergency Departments, all of which provided assurance that quality and safety were at a high level.

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

The Trust had an initial financial plan of a £35m deficit agreed with NHS Improvement at the start of the year, which included recognised risks and which was adjusted to a forecast outturn of £60.4m deficit. The formal forecast was only changed with NHSI once and that was at month 9 to £60.4m. Since then, the financial performance of the Trust has steadily approaching a stabilised position. At year-end the Trust reported a full year deficit of £60m which included a number of one-off benefits totalling £5m. Excluding these non-recurring items, the underlying deficit was £65m, in line with forecast.

In 2017/18, in response to unexpected cash flow issues, the Trust commissioned Grant Thornton to conduct a financial analysis and financial governance review. Later in the year, there was also a review conducted by Deloitte. Both reports had a number of recommendations, which the Trust continued to complete in 2018/19, overseen by the Financial and Performance Governance Steering Group, reporting to Audit Committee and Board. The Trust was placed in special measures for finances by NHSI in February 2018, and during the year the Board agreed a series of undertakings from NHSI, which it was reporting progress against to the Board. By year-end the Trust was paying 96.1% of its non-NHS creditors within 30 days, a significant improvement from less than 20% during the 2017/18 year.

With reference to the requirements of our Standing Orders and SFIs, the Director of Finance and Investment assessed the arrangements for the discharge of statutory functions. No irregularities or gaps in legal compliance have been identified other than those identified within this statement. The Trust, after review, made some changes to the Standing Orders and SFIs to provide clarity on authority to commit Trust funds and make the business activities more efficient, which were ratified at the April 2019 Board meeting.

The Board reviews and monitors monthly performance reports to meet the requirements of NHS Improvement's (NHSI) Accountability Framework building those requirements into its annual operational plan, and ensuring that they

are addressed as part of our integrated planning process.

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

The Care Quality Commission (CQC) inspected Barking, Havering and Redbridge Trust between 23 January 2018 until the 15th March 2018, with the final report published on 22nd June 2018.

Four core services were reviewed, which were: Urgent and Emergency Care, Medical Care (including older peoples care), Surgery and Maternity Services, under the five domains of safe, effective, caring, responsive and well led. Overall the Trust was rated as "Requires Improvement". "Four "Must Do" actions were identified and 55 "should dos" recommended, to avoid breaching any legal requirement in the future, and to improve the quality of the care and services. Actions have been taken to address these.

This was the first time that the Use of Resources element was assessed. This assessment is undertaken by NHS Improvement and was completed on the 5th April 2018. It was published by CQC. The Trust was rated as inadequate for the Use of Resources, and has now completed eight of the eleven recommendations, with the remaining to be completed by end of quarter 1.

There is an overarching action plan to improve the Trust's performance for use of resources. The CQC has not taken any enforcement action against the Trust during 2018/19.

We have complied with the relevant guidance on Corporate Governance. The Trust implemented a new Board development programme throughout the year. The Trust moved from bimonthly meetings in public with development seminars in the intervening months, to holding monthly meetings – with the exception of August and, in future years December – to setting away days for the Board as well as separately for non-executive directors and the executive director team. This has provided opportunities for the Board to reflect on priorities, behaviours and working assumptions around key strategic issues, as well as complete necessary training. During the year, it focused on the development of equality and diversity issues, IT security, mandatory fire training, discussed strategic topics such the development of an ACS, and financial issues and the Trust FRP, as well as general board development.

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

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

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

Timely and accurate data input is one of the key factors in ensuring that the Trust is able to accurately monitor RTT performance. To facilitate this, the Trust has appropriate guidance and training for staff to ensure data quality, and the required validation and monitoring processes in

place to ensure that common data quality issues are identified and rectified. In order to provide assurance that the Trust has robust underlying data, an RTT Data Quality Assurance Audit report is completed by the Trust Data Quality Assurance Manager on an annual basis and reviewed by the Operational Management Group with recommendations for improvements being agreed and acted upon. The preparation of the returns is undertaken by experienced and appropriately qualified staff and is reviewed by Senior Managers before submission. We use performance data that is uploaded by us and partners e.g LAS and agreed with CCG and NHSI – 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 ongoing basis.

Based on our three objectives setting out how we will become an Employer of Choice, which are: becoming a good place to work; demonstrating we are a more inclusive organisation; as well as reducing our vacancy rates, the Trust has developed a Recruitment and Retention strategy and OD Strategy. Both set out how improvements will be made and also support the delivery of the Financial Recovery Plan. These have been agreed and will be monitored by the People and Culture Committee, which is a committee of the Trust Board.

The Trust has actively participated in events related to the publication of 'developing workforce safeguards (October 2018)' and is delivering on the requirements. Using published self-assessment standards demonstrating 'levels of attainment' the organisation shows a mature advanced delivery of e-rostering across medical (all grades), nursing (ward and specialist) and AHP's. Building on the existing workforce safeguard processes the organisation has strengthened its daily operational and strategic review process to fully encompass clinical outcomes and evidence based tools. Innovative recruitment and retention actions have been highly effective are addressing the number of vacancies across the Trust and show reversal of a former trend.

During 2018/19 bi-annual nurse staffing reviews were completed and presented to the Trust Board. The reviews included acuity and dependency assessment and benchmarks to calculate and assess establishments. In addition to this work a detailed review of Ward and Emergency Department nurse staffing was completed by NHSI; this concluded appropriate establishments and safeguards were in place.

Pensions

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

Carbon reduction

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

Equality, diversity, and human rights

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has an established process to ensure that equality and diversity and human rights is embedded in its policy development process. All new, and reviewed,

policies have an equality impact assessment completed, which is considered by the approving group and the Trust's Policy Ratification Group. Board papers require an assessment of equality and diversity issues.

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

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

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit which replaced the Information Governance Toolkit in May 2018. 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 Hospital 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. The Trust published a compliant assessment having met all the assertions.

Throughout the year the Trust has been reviewing policies and procedures to ensure compliance and meet the standards introduced by the Data Protection Act 2018. Following these changes the Trust has put in place processes to ensure incidents are reported to the ICO (where necessary) and recorded as part of the Network Information System Regulation 2018. We are developing information risk assessments and management procedures and a program will be established to fully embed an information risk culture throughout the organisation against our identified risks contained within our risk register for information governance.

Between April 2018 and March 2019 there were six 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 protect and manages data appropriately.

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

Annual Quality Account

Our Quality Account is the annual report to the public from providers of NHS healthcare about the quality of services delivered. The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Our 2018/19 Quality Account will:

· aim to improve organisational accountability to the public and engage our board in the quality improvement agenda for the organisation

· enable us to review our services, decide and show where we are doing well, but also where improvement is required

· enable us to demonstrate what improvements we have made against our 2018/19 priorities

· provide information on the quality of our services to patients and the public

· demonstrate how we involve and respond to feedback from patients and the public, as well as other stakeholders.

We will also include a review of mortality, as we are expected by NHS England to report our progress in using learning from deaths to inform our quality improvement plans for the 2018/19 Quality Account. This will build on the work of the Royal College of Physicians in developing a methodology to support our process.

The Trust continued to strengthen its mortality review process during the year as well as developing a strong Mortality Faculty, and establishing a mortality assurance group. Using its Learning from Deaths policy, the Trust reviewed all deaths as per national guidance and escalated any, where there were concerns, to a Structured Judgement Review using the Royal College of Physicians approved methodology. The Trust's measures of mortality (HSMR and SHMI) reduced over the year, and continued to be within 'expected limits'. Performance around this is regularly scrutinised by the Quality Assurance Committee and presented to the Board. Risks in relation to data security are placed on the risk register.

We will include progress in implementing the priority clinical standards for seven day hospital services, as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement.

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, we will provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure will explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

As part of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Trust is committed to the management of rota gaps. We will provide progress on this and our plans for improvement to reduce these gaps.

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that has responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining

assurance and on the controls reviewed as part of the work that Internal Audit has undertaken. Internal Audit has issued the following opinion: the organisation has an adequate and effective framework for risk management, governance and internal control. However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

All internal audit reports are presented to Audit Committee and the Trust implements management actions to address weaknesses, which is overseen by Audit Committee. The Trust has made reasonable progress during the year at implementing agreed actions. Over the year, the following finalised audits returned partial assurance:

- Procurement
- Recruitment and retention
- Management of Agency Cap
- Data Quality RTT
- Conflict of Interest (draft)

Conclusion

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

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

Date: 24/05/19

Chris Bown

Interim Chief Executive and Accountable Officer

Barking, Havering and Redbridge University Hospitals NHS Trust

Remuneration and staff report

Remuneration Report

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

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

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

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

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

Table 1: Salary and Pensions entitlements of Senior Managers

Name and Title (all figures in £'000)	Period (See Note 1) From	To	2018-19 Salary (bands of £5,000)	Taxable expenses payments to nearest £100	Performance pay & bonuses (bands of £5,000)	Long term performance pay (bands of £5,000)	All Pension-related benefits (bands of £2,500)	Total (bands of £5,000)	2017-18 Total (bands of £5,000)
Joe Fielder - Chair			35-40	0	0	0	0	35-40	15-20
Matthew Hopkins - Chief Executive	01/04/2018	31/07/2018	60-65	0	0	0	0	30-35	240 - 245
Chris Bown - Chief Executive	01/08/2018	31/03/2019	140-145	0	0	0	0.0 - 2.5	140-145	70-75
Shelagh Smith - Chief Operating Officer			150-155	0	0	0	320 - 322.5	470-475	(67.5 - 70.0)
Dr Nadeem Moghal - Medical Director	01/04/2018	31/08/2018	75-80	0	0	0	62.5 - 65.0	135-140	265 - 270
Dr Magda Smith - Medical Director	01/08/2018	31/03/2019	110-115	0	0	0	25.0 - 27.5	140-145	110 - 115
Ian O'Connor - Acting Director of Finance & Investment	01/04/2018	30/09/2018	75-80	0	0	0	0.0 - 2.5	75-80	35 - 40
Nick Swift - Acting Director of Finance & Investment	01/09/2018	31/03/2019	105-110	0	0	0	0.0 - 2.5	105-110	0
Jason Seez - Director of Planning & Governance	01/04/2018	10/02/2019	125-130	0	0	0	0	125-130	170 - 175
Deborah Tarrant -Director of People & Organisational Development	01/04/2018	31/01/2019	145-150	0	0	0	55.0 - 57.5	200-205	110 - 115
Kathryn Halford - Chief Nurse			155-160	0	0	0	145.0 - 147.5	300-305	175 - 180
Peter Hunt - Director of Communications and Engagement			110-115	0	0	0	42.5 - 45.0	155-160	55 - 60
David Amos - Director of People & Organisational Development	01/01/2019	31/03/2019	30-35	0	0	0	0.0 - 2.5	30-35	0
Eric Sorensen - Non-executive Director			5-10	0	0	0	0	5-10	5-10
Prof. Anthony Warrens - Non-executive Director			5-10	0	0	0	0	5-10	0-5
Mark Lam- Non-executive Director			5-10	0	0	0	0	5-10	5-10
Jackie Westway - Non-executive Director			5-10	0	0	0	0	5-10	0-5
Joan Saddler - Non-executive Director			5-10	0	0	0	0	5-10	5-10
Tom Philips - Non-executive Director			5-10	0	0	0	0	5-10	5-10
Median remuneration of all staff in the Trust (£)			34,488						33,058
Highest paid director of the Trust (£5k band)			205-210						200-205
Ratio of the above two figures			6.0						6.1

Notes

1) Unless the period is stated the Directors were here throughout the full financial year (ie 1st April 2018 - 31st March 2019)

Signature .....

Chris Bown, Chief Executive

Table 2:

Name and title (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 2019 (bands of £5000) £000	Total related lump sum at age 60 at 31 March 2019 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Real Increase in Cash Equivalent Transfer £000	Employers Contribution to Stakeholder Pension To nearest £100
Matthew Hopkins - Chief Executive	0	0	85.0 - 90.0	255.0 - 260.0	1,574	1,783	162	0
Chris Bown - Chief Executive	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Shelagh Smith - (Chief Operating Officer)	15.0 -17.5	17.5 - 20.0	55.0 - 60.0	85.0 - 90.0	767	1,148	358	0
Dr Nadeem Moghal - Medical Director	2.5 - 5.0	7.5- 10.0	70.0 - 75.0	210.0 - 215.0	1,385	1,632	206	0
Dr Magda Smith - Medical Director	0.0 - 2.5	0.0 - 2.5	60.0 - 65.0	180.0 - 185.0	1,184	1,368	149	0
Ian O'Connor - Acting Director of Finance & Investment	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Nick Swift - Acting Director of Finance & Investment	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0
Jason Seez - Director of Planning & Governance	0.0 - 2.5	0	45.0 - 50.0	105.0 - 110.0	689	800	90	0
Deborah Tarrant -Director of People & Organisational Development	2.5 - 5.0	0	45.0 - 50.0	115.0 - 120.0	825	981	131	0
Kathryn Halford - Chief Nurse	5.0 - 7.5	17.5 - 20.0	65.0 - 70.0	195.0 - 200.0	1,150	1,448	264	0
Peter Hunt (Director of Communications and Engagement)	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	9	41	32	0
David Amos - Director of People & Organisational Development	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	0	0	0	0

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

Cash Equivalent Transfer Values

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

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

are calculated in accordance with the Occupational Pension Schemes (Transfer Values) regulations 2008.

Real Increase in CETV

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

Signature 

Chris Bown, Chief Executive

Compensation for loss of office

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

Fair pay (ratios) disclosure

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

	2018-19	2017-18
Band of the highest paid director's total remuneration (£000)	205-210	200-205
Median pay remuneration (£)	34,488	33,058
Median pay multiple	6.0	6.1
Range of staff remuneration	20,079-207,468	19,224-204,500

The highest paid director salary was £207,468 (2017/18, £204,500) in the current year against a median salary of £34,488 (2017/18, £33,058), resulting in a minor change to the median pay multiple.

The banded remuneration of the highest-paid director in the Trust in the financial year 2018/19 was in the band £205k-£210k (2017/18, £200k-£205k). This was 6.0 times (2017/18, 5.8) the median remuneration of the workforce, which was £34,488 (2017/18, £33,058). Total remuneration includes salary and nonconsolidated performance-related payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

During the year the Trust reached an agreement of a payment in lieu of notice of £102,000 for Matthew Hopkins (Chief Executive Officer). This is referenced in Note 55 of the accounts under Payments in Lieu of Notice. The total salary banding for Matthew Hopkins includes a negative pension contribution in year, whilst we disclose this as nil in table 1, the impact of this is that the total banding is reduced to the figure shown.

During the year the Trust reached an agreement of a payment in lieu of notice of £75,000 for Deborah Tarrant (Director of People & Organisational Development). This is referenced in Note 55 of the accounts under Payments in Lieu of Notice.

The Trust reached an agreement with the Royal College of Pathologists and The Nuffield Trust, for Nadeem Moghul (Medical Director) to be on secondment after the 31st August 2018.

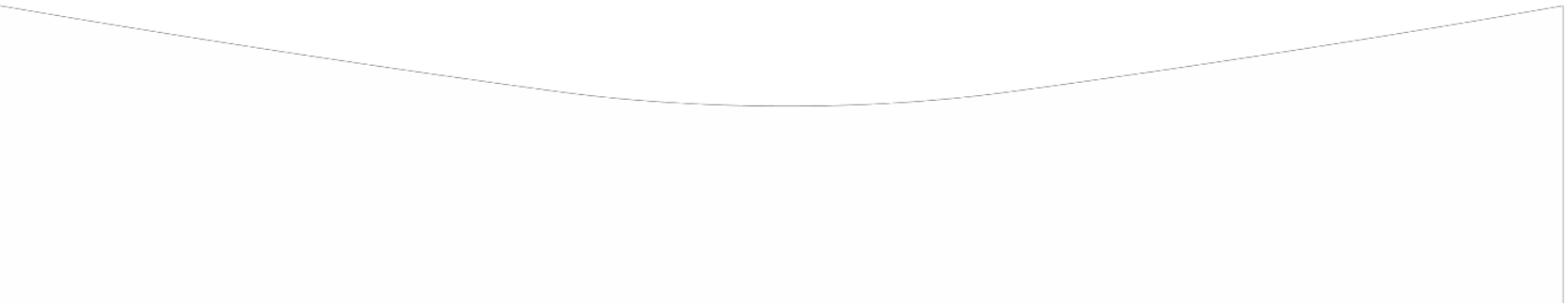
Staff costs have been outlined in detail in note 9 of the accounts. In 2018/19, the Trust spent a total of £613m of which staff costs accounted for £381m (62%).

Expenditure on consultancy

In 2018/19 the Trust spent £4,405k on consultancy services

Exit packages

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



Staff Report

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

Ethnicity	Headcount
White:British	2710
White:Irish	137
White but not British or Irish	522
Black or Black British:African	762
Black or Black British:Caribbean	194
Black or Black British but not Caribbean or African	240
Asian or Asian British:Bangladeshi	107
Asian or Asian British:Indian	523
Asian or Asian British:Pakistani	186
Asian or Asian British but Unlisted	407
Chinese	50

Ethnicity	Headcount
Filipino	333
Mixed:Other Mixed Background	67
Mixed:White & Asian	28
Mixed:White & Black African	28
Mixed:White & Black Caribbean	38
An unlisted ethnic group	146
Not stated or unavailable	127
Grand Total	**6605**

The table below gives the gender breakdown within the Trust (as at 31 March 2019).

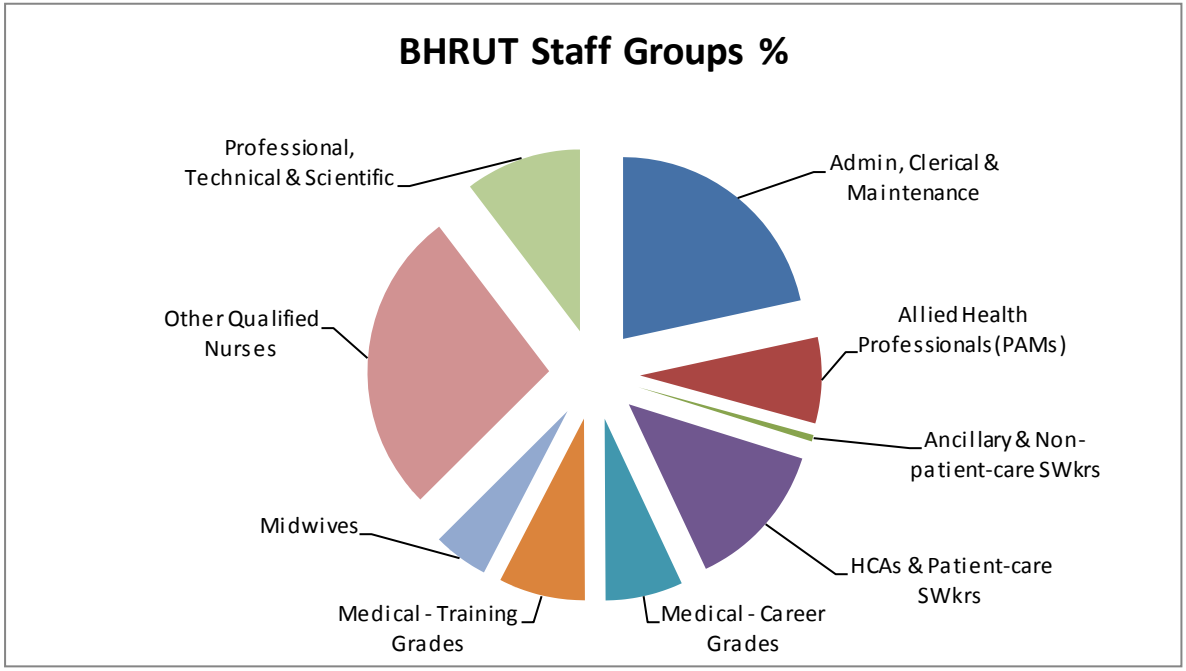
	Female	Male
Board Level Director	2	5
Non Exec / Chair	2	5
Senior Manager	295	153
All Other Employees	4790	1353

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).

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

Staff Group	Headcount	%
Admin, Clerical & Maintenance	1426	21.6%
Allied Health Professionals (PAMs)	506	7.7%
Ancillary & Non-patient-care SWkrs	38	0.6%
HCAs & Patient-care SWkrs	872	13.2%
Medical - Career Grades	455	6.9%
Medical - Training Grades	508	7.7%
Midwives	325	4.9%
Other Qualified Nurses	1791	27.1%
Professional, Technical & Scientific	684	10.4%



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

Staff Policies applied during the year

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

Off-Payroll Engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New Off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and March 2019, form more than £245 per day and that last for longer than six months

Table 2: New Off-payroll engagements	
	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	
Of which...	
No. assessed as caught by IR35	**4**
No. assessed as not caught by IR35	**0**
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	**4**
No. of engagements reassessed for consistency / assurance purposes during the year.	**0**
No. of engagements that saw a change to IR35 status following the consistency review	**0**

Table 3: Off-payroll board member/senior official engagements	**0**
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2019.	

Table 3: Off-payroll board member/senior official engagements	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.(2)	12

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Barking Havering and Redbridge University Hospitals NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note one.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

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

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of exiting the European Union, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

We draw attention to note 1.2 in the financial statements which indicates that there are material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least 12 months from the date of approval of the financial statements. These are that there may be significant changes in planned and contracted levels of patient activity; not delivering the cost improvements of £28m described in our Financial Recovery Plan; not receiving working capital loans of £30m to support the level of deficit; not delivering the control total and therefore not receiving Provider Sustainability Fund (PSF) of £12.87m, and Financial Recovery Fund (FRF) of £14.81m; changes to the receipt of £16.0m PFI support from NHS England.

In past years, the Trust has secured funding from the Department of Health and Social Care during the year when required, and the Directors expect that this support will continue to be granted.

These events and conditions, along with the other matters explained in note 1.2, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover

the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

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

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 51, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 51 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Barking Havering and Redbridge University Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for adverse conclusion

In considering the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources we identified two significant use of resources risks upon completion of value for money risk assessment against the criteria identified within the Code of Audit Practice.

The first was the financial sustainability of the Trust; the financial priority of the Trust continues to be the sustainable reduction of the deficit, to meet its control total and to exit financial special measures, which NHS Improvement placed the Trust into on 12 February 2018. The Trust also received two related independent reviews; a review of financial governance published on 29 March 2018 and a review of Board Governance published on 2 August 2018.

The second was organisational governance arrangements; as the Trust has seen significant turnover in the Board and senior management during the year ended 31 March 2019 and received a related independent review of allegations made in relation to bullying and engagement of medical staff, which identified issues around the Trust's clinical governance arrangements and management.

The Trust has developed a financial recovery plan which sets out the financial recovery actions to bring the Trust to a breakeven financial position by 31 March 2021. This was reported to the public Trust Board meeting on 30 January and reports the need to identify and make savings of £100 million. The plan is effective from 1 April 2019 with a large proportion of the savings, £60 million, being realised through working with the Trust's lead Commissioner: Barking and Dagenham; Havering; and Redbridge Clinical Commissioning Groups.

On the 22 June 2018 the CQC published a report on its inspection of the Trust with an overall combined rating of Requires Improvement. The report raised, amongst others, issues relating to the governance of the Trust aligned to the concerns raised by the independent Financial Governance and Board Governance reviews.

As at 31 March 2019 these various improvement plans have been fully enacted but their actions are yet to complete and the Trust remains in financial special measures and subject to undertakings to NHS Improvement. This, combined with the prospective nature of the Trust's financial recovery plans means we do not have sufficient assurance of the sustainable deployment of resources or informed decision making. It is as a result of this that we have issued a qualified audit opinion.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 51, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

Statutory reporting matters

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

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

On 9 January 2019 we wrote to the Secretary of State in accordance with Section 30(b) of the Local Audit and Accountability Act 2014 in respect of the Trust's plan to, taking into account the Department of Health's Guidance on Breakeven Duty and Provisions, be in breach of its 'breakeven duty' as set out in paragraph 2(1) of Schedule 5 of the National Health Service Act 2006. The Trust's budgeted financial position was a deficit of £52.5 million. As at the date of our referral the reported financial position as at 7 November 2018 was a forecast year end deficit of £52.5 million, which would create a cumulative deficit of £604.8 million.

We have no other matters to report in these respects

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

Neil Thomas
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
London

28 May 2019

SECTION 3 – FINANCIAL STATEMENTS AND NOTES

Barking, Havering and Redbridge University Hospitals NHS Trust

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	505,223	515,754
Other operating income	4	44,854	53,853
Operating expenses	7, 9	(579,437)	(576,380)
Operating surplus/(deficit) from continuing operations		**(29,360)**	**(6,773)**
Finance income	12	150	287
Finance expenses	13	(33,234)	(28,539)
Net finance costs		**(33,084)**	**(28,252)**
Other gains / (losses)	14	(65)	(10)
Surplus / (deficit) for the year from continuing operations		**(62,509)**	**(35,035)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15		**752**
Surplus / (deficit) for the year		**(62,509)**	**(34,283)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(106)	(641)
Total comprehensive income / (expense) for the period		**(62,615)**	**(34,924)**

Footnote to SOCI - recorded financial performance against the control total:		
Surplus / (deficit) for the period	(62,509)	(34,283)
Remove net impairments not scoring to the Departmental expenditure limit	(9,741)	(14,751)
Remove I&E impact of capital grants and donations	31	57
Remove impact of 2017/18 expert determination	11,885	-
Adjusted financial performance surplus / (deficit)	**(60,334)**	**(48,977)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	5,552	6,436
Property, plant and equipment	17	328,486	316,706
Receivables	25	5,140	4,499
Total non-current assets		**339,178**	**327,641**
Current assets			
Inventories	24	15,680	16,895
Receivables	25	30,890	52,780
Non-current assets held for sale / assets in disposal groups	27	-	24
Cash and cash equivalents	28	12,060	3,249
Total current assets		**58,630**	**72,948**
Current liabilities			
Trade and other payables	29	(54,034)	(60,028)
Borrowings	32	(76,725)	(36,942)
Provisions	34	(535)	(309)
Other liabilities	31	(5,190)	(5,251)
Total current liabilities		**(136,484)**	**(102,530)**
Total assets less current liabilities		**261,323**	**298,059**
Non-current liabilities			
Borrowings	32	(353,172)	(327,709)
Provisions	34	(5,683)	(6,682)
Other liabilities	31	(3,638)	(3,638)
Total non-current liabilities		**(362,493)**	**(338,029)**
Total assets employed		**(101,169)**	**(39,970)**
Financed by			
Public dividend capital		482,450	481,033
Revaluation reserve		1,196	1,302
Income and expenditure reserve		(584,814)	(522,305)
Total taxpayers' equity		**(101,169)**	**(39,970)**

The notes on pages 7 to 62 form part of these accounts.

Name Chris Bown
Position Chief Executive
Date **24 May 2019**

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

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**481,033**	**1,302**	**-**	**-**	**-**	**(522,305)**	**(39,970)**
Surplus/(deficit) for the year	-	-	-	-	-	(62,509)	**(62,509)**
Impairments	-	(106)	-	-	-	-	**(106)**
Public dividend capital received	1,417	-	-	-	-	-	**1,417**
Taxpayers' equity at 31 March 2019	**482,450**	**1,196**	**-**	**-**	**-**	**(584,814)**	**(101,169)**

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

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**477,076**	**1,943**	**-**	**-**	**-**	**(488,022)**	**(9,003)**
Prior period adjustment	-	-	-	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**477,076**	**1,943**	**-**	**-**	**-**	**(488,022)**	**(9,003)**
Surplus/(deficit) for the year	-	-	-	-	-	(34,283)	**(34,283)**
Impairments	-	(641)	-	-	-	-	**(641)**
Public dividend capital received	3,957	-	-	-	-	-	**3,957**
Taxpayers' equity at 31 March 2018	**481,033**	**1,302**	**-**	**-**	**-**	**(522,305)**	**(39,970)**

Information on reserves

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

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

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

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

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(29,360)	(6,021)
Non-cash income and expense:			
Depreciation and amortisation	7.1	15,380	14,051
Net impairments	8	(9,741)	(14,751)
Income recognised in respect of capital donations	4	(80)	(59)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		21,077	(5,846)
(Increase) / decrease in inventories		1,215	1,174
Increase / (decrease) in payables and other liabilities		(6,860)	7,014
Increase / (decrease) in provisions		(792)	3,513
Net cash generated from / (used in) operating activities		**(9,161)**	**(925)**
Cash flows from investing activities			
Interest received		150	287
Purchase of intangible assets		(1,719)	-
Purchase of property, plant, equipment and investment property		(5,856)	(11,374)
Sales of property, plant, equipment and investment property		87	65
Receipt of cash donations to purchase capital assets		-	59
Net cash generated from / (used in) investing activities		**(7,338)**	**(10,963)**
Cash flows from financing activities			
Public dividend capital received		1,417	3,957
Movement on loans from the Department of Health and Social Care		64,624	45,210
Capital element of PFI, LIFT and other service concession payments		(9,013)	(8,373)
Interest on loans		(3,396)	(974)
Other interest		(6)	-
Interest paid on PFI, LIFT and other service concession obligations		(28,315)	(26,506)
PDC dividend (paid) / refunded		-	276
Net cash generated from / (used in) financing activities		**25,311**	**13,589**
Increase / (decrease) in cash and cash equivalents		**8,812**	**1,701**
Cash and cash equivalents at 1 April - brought forward		**3,249**	**1,548**
Cash and cash equivalents at 1 April - restated		**3,249**	**1,548**
Cash and cash equivalents at 31 March	28.1	**12,060**	**3,249**

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 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

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

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

There are currently no plans to transfer services currently provided by the Trust outside of the NHS.
The Trust has submitted a 2019/20 plan to NHS Improvement for an in-year deficit of £23.1m. The Trust's financial priority is to introduce and seek to embed the Financial Recovery Plan (FRP) as part of its longer term financial strategy.
In 2019/20 the Trust will implement its strategy to include
- working with stakeholders, including consultancy support, in delivering the first year of the FRP;
- requesting a total working capital loans of £23.1m to fund the operating deficit;
- ensuring aged creditors are kept to the minimum and maintain the sustained improvements in the better payment practice code (BPPC);
- continuing to deliver and embed the actions of the Financial Governance Review;
- delivering the annual income and expenditure targets using Service Line Management (SLM); and information technology to manage the run rates of expenditure to ensure delivery of savings.

2019/20 healthcare contracts with Clinical Commissioning Groups (CCGs) in North East London, NHS England and Essex have been agreed and signed off.
The 2019/20 cash flow forecast is based on delivery of the 2019/20 operating plan. 13 week forecasts are reported to NHS Improvement (NHSI) to support access to working capital loans. Internally, 12 month rolling cash flow forecasts are updated daily and reviewed.

Key risks of material uncertainties that could impact the Trusts cash position are:

a) Significant changes in planned and contracted levels of patient activity;
b) Not delivering the cost improvements of £28m described in our Financial Recovery Plan.
c) Not receiving working capital loans of £30m to support the level of deficit;
d) Not delivering the control total and therefore not receiving Provider Sustainability Fund (PSF) of £12.87m, and Financial Recovery Fund (FRF) of £14.81m; and
e) Changes to the receipt of £16.0m PFI support from NHS England.

The QCIP and service improvement plans (which total savings of £28m) include key work stream targets to improve productivity in theatres, outpatients, and diagnostics as well improving efficiency in resourcing and medicines management.
The Trust is working with other health economy partners as part of the development of the Sustainability and Transformation Program (STP) to identify service improvements and deliver long term financial sustainability.

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

Note 1.3 Interests in other entities

The charity is registered with the Charity Commission for England and Wales (number 10259455) as "Barking, Havering and Redbridge University Hospitals NHS Charity Fund". The Trust is the corporate trustee (a sole trustee). The working name of the charity used for fundraising purposes is "King George and Queen's Hospital Charity".
At the end of the financial year the charity held capital and reserves of £2.13m, an increase in year of £0.1m.

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies can be consolidated within the entity's financial statements. Such a consolidation has not been done in these accounts as the 2018-19 income and total funds are viewed below materiality.
The Trust determined this by comparing the total charities turnover to the Trust's and concluded that as it was less than 5% and therefore deemed immaterial, and consolidation was therefore not necessary.
The Charity continues to publish a separate set of accounts for 2018/19 in accordance with the Statement of Recommended Accounting Practice "Accounting and Reporting by Charities"; FRS 102.

Note 1.4.1 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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

Revenue from NHS contracts

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

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

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

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

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

Revenue from research contracts

At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract

NHS injury cost recovery scheme

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

Note 1.4.2 Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits Short-

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

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

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

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

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

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a 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.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

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

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive [income / net expenditure] in the [Statement of Comprehensive Income / Net Expenditure].

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

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

Note 1.7.3 De-recognition

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

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

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

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

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

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.

Note 1.7.6 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
Land	-	-
Buildings, excluding dwellings	15	70
Dwellings	15	50
Plant & machinery	7	15
Transport equipment	7	15
Information technology	4	10
Furniture & fittings	7	15

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

Note 1.8 Intangible

assets Note 1.8.1

Recognition

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

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

Expenditure on research is not capitalised.

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

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

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.

Note 1.8.2 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 under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.8.3 Useful economic life 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

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

Note 1.9 Inventories

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

Note 1.10 Investment properties
The Trust does not have any investment properties

Note 1.11 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.12 Carbon Reduction Commitment scheme (CRC)

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 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.

Note 1.13.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

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

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

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

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

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

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

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

The Trust has no assets which are measured at fair value through income and expenditure

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.

Note 1.13.3 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 1.14 Leases

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

Note 1.14.1 The trust as lessee

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

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

The annual rental 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. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

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

Leases of land and buildings

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

Note 1.14.2 The trust as lessor

Finance leases

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

Operating leases

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

Note 1.15 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

•A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 34.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability. Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Note 1.17 Public dividend capital

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

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

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

The average net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health 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. T he dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

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

Note1.20 Foreign exchange

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

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

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

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

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 28.2 to the accounts.

Note 1.22 Losses and special payments

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

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

Note 1.23 Gifts

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

Note 1.24 Transfers of functions [to / from] [other NHS bodies / local government bodies]

There was no transfer of functions between the Trust and other organisations in 2018-19.

Note 1.2 Critical judgements in applying accounting policies

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

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

Note 1.2.1 Sources of estimation uncertainty

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

Our material estimates and judgements are:
-revaluation of Land & Buildings
-provision for impairment of receivables
In addition to these there are other matters which we wish to disclose (not because they are material) but because management have been required to estimate or take a judgement about how they have been treated.

As part of the NHS contracting process the Trust makes judgements on the resource base required to support such services, and the income expectations for services delivered at the agreed activity levels.

The NHS Pensions Scheme provides cover for past and present employees, and is subject to a full actuarial valuation every five years (see note 9). The Trust carries provisions in certain instances relating to early retirement, based on latest actuarial information provided by the NHS Pensions Agency. This is therefore subject to change which is recognised in the period to which it arises.

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

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

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

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

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

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

- Pension provision is calculated based on individuals total estimated pension payments with reference to actuarial life expectancy tables and discounted cash flows.

- Legal claim provision values are provided by our service providers based on outstanding cases.
- Redundancy provision is calculated based on payroll information in respect of the commitment agreed as at 31 March 2019.
- The Carbon Reduction Commitment (CRC) scheme provision is calculated based on utility usage during the previous financial year.
- Accruals are based on the value of invoices relating to the 2018-19 financial year received after 31 March 2019; orders receipted; previous invoice values when relating to an ongoing supplier of products or services; and costs directly advised by the supplier.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	63,412	64,492
Non elective income	190,281	181,396
First outpatient income	37,475	39,362
Follow up outpatient income	36,837	34,302
A & E income	35,301	37,026
High cost drugs income from commissioners (excluding pass-through costs)	36,337	36,357
Other NHS clinical income	94,985	118,998
Community services		
Income from other sources (e.g. local authorities)	3,840	-
All services		
Private patient income	264	2,646
Agenda for Change pay award central funding	4,827	-
Other clinical income	1,664	1,176
Total income from activities	**505,223**	**515,754**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	89,977	89,712
Clinical commissioning groups	400,147	415,693
Department of Health and Social Care	4,850	20
Other NHS providers	783	436
NHS other	36	70
Local authorities	3,840	4,260
Non-NHS: private patients	264	182
Non-NHS: overseas patients (chargeable to patient)	2,276	2,463
Injury cost recovery scheme	2,830	2,777
Non NHS: other	220	141
Total income from activities	**505,223**	**515,754**
Of which:		
Related to continuing operations	505,223	515,754

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

	2018/19 £000	2017/18 £000
Income recognised this year	2,276	2,463
Cash payments received in-year	611	419
Amounts added to provision for impairment of receivables	830	4,624
Amounts written off in-year	4,701	-

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	1,329	1,879
Education and training (excluding notional apprenticeship levy income)	16,491	15,758 Non-
patient care services to other bodies	-	43
/ STF)	-	6,109
Income in respect of employee benefits accounted on a gross basis	1,707	1,679
Other contract income	20,888	27,088
Other non-contract operating income		
Receipt of capital grants and donations	80	59
Charitable and other contributions to expenditure	289	715
Rental revenue from operating leases	4,070	2,690
Total other operating income	**44,854**	**56,020**
Of which:		
Related to continuing operations	44,854	53,853
Related to discontinued operations	-	2,167

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	3,802

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2019
	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
Total revenue allocated to remaining performance obligations	-

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

Note 6 Fees and charges

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.

	2018/19	2017/18
	£000	£000
Income	3,327	3,366
Full cost	(2,495)	(2,525)
Surplus / (deficit)	832	842

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,603	3,122
Purchase of healthcare from non-NHS and non-DHSC bodies	3,600	4,859
Staff and executive directors costs	380,662	369,739
Remuneration of non-executive directors	109	77
Supplies and services - clinical (excluding drugs costs)	38,249	38,961
Supplies and services - general	11,425	11,430
drugs)	46,533	48,484
Consultancy costs	4,363	4,700
Establishment	5,159	4,785
Premises	20,885	17,676
Transport (including patient travel)	4,272	4,377
Depreciation on property, plant and equipment	12,777	11,948
Amortisation on intangible assets	2,603	2,103
Net impairments	(9,741)	(14,751)
Movement in credit loss allowance: contract receivables / contract assets	1,201	
Movement in credit loss allowance: all other receivables and investments	-	8,508
Increase/(decrease) in other provisions	97	4,653
Change in provisions discount rate(s)	(155)	-
Audit fees payable to the external auditor		
audit services- statutory audit	90	71
other auditor remuneration (external auditor only)	13	11
Internal audit costs	118	135
Clinical negligence	26,088	30,705
Legal fees	1,762	1,415
Insurance	345	17
Education and training	491	238
Rentals under operating leases	196	195
LIFT)	22,661	22,750
Hospitality	52	71
Other	1,979	1,516
Total	**579,437**	**577,795**
Of which:		
Related to continuing operations	579,437	576,380
Related to discontinued operations	-	1,415

During 2018/19 the Trust agreed additional fees for the statutory audit of the 2017/18 financial statements of £12,090 in addition to the prior year fee of £59,012 (excl. VAT). In respect of the statutory audit of the financial statements for the year ended 31 March 2019, the Trust's auditor KPMG have been paid £63,012 (excl. VAT)

Note 7.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	13	11
Total	**13**	**11**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 8 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	(652)	681
Changes in market price	(9,089)	(15,432)
Total net impairments charged to operating surplus / deficit	**(9,741)**	**(14,751)**
Impairments charged to the revaluation reserve	106	641
Total net impairments	**(9,635)**	**(14,110)**

Impairments reversals due to the changes in the Trust's Land and Building valuation as performed by an independent valuer.

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	289,331	275,776
Social security costs	29,980	28,521
Apprenticeship levy	1,425	1,342
Employer's contributions to NHS pensions	31,016	30,248
Pension cost - other	44	22
Termination benefits	-	21
Temporary staff (including agency)	28,946	34,323
Total gross staff costs	**380,742**	**370,253**
Total staff costs	**380,742**	**370,253**
Of which		
Costs capitalised as part of assets	80	514

Note 9.1 Retirements due to ill-health

During 2018/19 there was 1 early retirement from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is ££101k (£755k in 2017/18).

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

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

In addition to the NHS Pension Scheme the trust offers the National Employment Savings Scheme (NEST), an additional defined contribution workplace pension scheme.

Note 11 Operating leases

Trust as a lessor

This note discloses income generated in operating lease agreements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessor.

1) A 60 year land lease at King George Hospital, Redbridge, granted in 2006 to operate an Independent Sector Treatment Centre.

2) The Trust leases ward space at King George Hospital to an NHS Foundation Trust.

3) The Trust leases space at both hospitals to Barts Health NHS Trust for renal services.

4) The Trust leases space at King George Hospital for GP services.

5) The Trust leases two staff accommodation blocks at King George Hospital to a Housing Association which manages tenancy occupation to NHS employees, keyworkers or other public sector workers.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	4,070	2,571
Contingent rent	-	119
Total	**4,070**	**2,690**

	31 March 2019 £000	31 March 2018 £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.	1,823	1,86
Total	**2,040**	**2,083**

Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Barking, Havering and Redbridge University Hospitals NHS T rust is the lessee.

The Trust acts as an operating lessee for a number of leases under five years, which include laundry, linen and sterile services, and accommodation in Romford and Dagenham

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	196	195
Total	**196**	**195**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	658	476
- later than one year and not later than five years;	1,933	1,142
Total	**2,591**	**1,618**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	150	28
Other finance income	-	259
Total finance income	**150**	**287**

Note 13.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	4,690	1,490
Interest on late payment of commercial debt	6	123
Main finance costs on PFI and LIFT schemes obligations	19,392	18,981
Contingent finance costs on PFI and LIFT scheme obligations	9,127	7,913
Total interest expense	**33,215**	**28,507**
Unwinding of discount on provisions	19	32
Total finance costs	**33,234**	**28,539**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	6	-
legislation	6	123

Note 14 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(65)	(10)
Total gains / (losses) on disposal of assets	**(65)**	**(10)**
Total other gains / (losses)	**(65)**	**(10)**

Note 15 Discontinued operations

	2018/19	2017/18
	£000	£000
Operating income of discontinued operations	-	2,167
Operating expenses of discontinued operations	-	(1,415)
Total	**-**	**752**

Note 16.1 Intangible assets - 2018/19

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**-**	**263**	**-**	**14,466**	**979**	**-**	**-**	**-**	**-**	**15,708**
Additions	-	-	-	1,719	-	-	-	-	-	**1,719**
Valuation / gross cost at 31 March 2019	**-**	**263**	**-**	**16,185**	**979**	**-**	**-**	**-**	**-**	**17,427**
Amortisation at 1 April 2018 - brought forward	**-**	**263**	**-**	**8,726**	**283**	**-**	**-**	**-**	**-**	**9,272**
Provided during the year	-	-	-	2,603	-	-	-	-	-	**2,603**
Amortisation at 31 March 2019	**-**	**263**	**-**	**11,329**	**283**	**-**	**-**	**-**	**-**	**11,875**
Net book value at 31 March 2019	**-**	**-**	**-**	**4,856**	**696**	**-**	**-**	**-**	**-**	**5,552**
Net book value at 1 April 2018	**-**	**-**	**-**	**5,740**	**696**	**-**	**-**	**-**	**-**	**6,436**

Note 16.2 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Goodwill	Websites	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**-**	**263**	**-**	**11,470**	**979**	**-**	**-**	**-**	**-**	**12,712**
Valuation / gross cost at 1 April 2017 - restated	**-**	**263**	**-**	**11,470**	**979**	**-**	**-**	**-**	**-**	**12,712**
Reclassifications	-	-	-	2,996	-	-	-	-	-	**2,996**
Valuation / gross cost at 31 March 2018	**-**	**263**	**-**	**14,466**	**979**	**-**	**-**	**-**	**-**	**15,708**
Amortisation at 1 April 2017 - as previously stated	**-**	**263**	**-**	**6,623**	**283**	**-**	**-**	**-**	**-**	**7,169**
Amortisation at 1 April 2017 - restated	**-**	**263**	**-**	**6,623**	**283**	**-**	**-**	**-**	**-**	**7,169**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	-	-	2,103	-	-	-	-	-	**2,103**
Amortisation at 31 March 2018	**-**	**263**	**-**	**8,726**	**283**	**-**	**-**	**-**	**-**	**9,272**
Net book value at 31 March 2018	**-**	**-**	**-**	**5,740**	**696**	**-**	**-**	**-**	**-**	**6,436**
Net book value at 1 April 2017	**-**	**-**	**-**	**4,847**	**696**	**-**	**-**	**-**	**-**	**5,543**

Note 17.1 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dw ellings £000	Dw ellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**32,320**	**233,439**	**9,782**	**6,434**	**89,470**	**-**	**24,019**	**6,443**	**401,907**
Additions	-	1,588	-	5,675	7,786	-	-	-	**15,049**
Impairments	-	(202)	-	-	(34)	-	-	-	**(236)**
Reversals of impairments	-	1,373	-	-	702	-	-	-	**2,075**
Reclassifications	-	6,988	-	(10,344)	2,792	-	424	140	**(0)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	(3,175)	-	-	-	**(3,175)**
Valuation/gross cost at 31 March 2019	**32,320**	**243,186**	**9,782**	**1,765**	**97,541**	**-**	**24,442**	**6,583**	**415,620**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**5,376**	**9,772**	**-**	**53,084**	**-**	**14,514**	**2,455**	**85,201**
Provided during the year	-	3,709	-	-	6,390	-	2,190	488	**12,777**
Impairments	-	(0)	-	-	-	-	-	-	**(0)**
Reversals of impairments	-	(7,811)	-	-	-	-	-	-	**(7,811)**
Disposals / de-recognition	-	-	-	-	(3,033)	-	-	-	**(3,033)**
Accumulated depreciation at 31 March 201	**-**	**1,274**	**9,772**	**-**	**56,441**	**-**	**16,704**	**2,943**	**87,134**
Net book value at 31 March 2019	**32,320**	**241,912**	**10**	**1,765**	**41,100**	**-**	**7,738**	**3,640**	**328,486**
Net book value at 1 April 2018	**32,320**	**228,063**	**10**	**6,434**	**36,386**	**-**	**9,505**	**3,988**	**316,706**

Note 17.2 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**31,470**	**213,916**	**9,782**	**10,129**	**77,668**	**-**	**22,447**	**4,293**	**369,705**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**31,470**	**213,916**	**9,782**	**10,129**	**77,668**	**-**	**22,447**	**4,293**	**369,705**
Additions	-	1,638	-	9,437	10,318	-	-	21	**21,414**
Impairments	-	76	-	-	(717)	-	-	-	**(641)**
Reversals of impairments	850	14,582	-	-	-	-	-	-	**15,432**
Reclassifications	-	3,227	-	(13,132)	3,208	-	1,572	2,129	**(2,996)**
Disposals / de-recognition	-	-	-	-	(1,007)	-	-	-	**(1,007)**
Valuation/gross cost at 31 March 2018	**32,320**	**233,439**	**9,782**	**6,434**	**89,470**	**-**	**24,019**	**6,443**	**401,907**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**3,320**	**9,772**	**-**	**45,894**	**-**	**12,274**	**2,274**	**73,534**
Accumulated depreciation at 1 April 2017 - restated	**-**	**3,320**	**9,772**	**-**	**45,894**	**-**	**12,274**	**2,274**	**73,534**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,532	-	-	5,995	-	2,240	181	**11,948**
Impairments	-	(1,476)	-	-	2,157	-	-	-	**681**
Disposals / de-recognition	-	-	-	-	(962)	-	-	-	**(962)**
Accumulated depreciation at 31 March 201	**-**	**5,376**	**9,772**	**-**	**53,084**	**-**	**14,514**	**2,455**	**85,201**
Net book value at 31 March 2018	**32,320**	**228,063**	**10**	**6,434**	**36,386**	**-**	**9,505**	**3,988**	**316,706**
Net book value at 1 April 2017	**31,470**	**210,596**	**10**	**10,129**	**31,774**	**-**	**10,173**	**2,019**	**296,171**

Note 17.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	32,320	61,955	10	1,765	15,231	-	7,738	3,640	**122,660**
On-SoFP PFI contracts and other service concession arrangements	-	179,820	-	-	24,872	-	-	-	**204,692**
Owned - donated	-	137	-	-	997	-	-	-	**1,134**
NBV total at 31 March 2019	**32,320**	**241,912**	**10**	**1,765**	**41,100**	**-**	**7,738**	**3,640**	**328,486**

Note 17.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	32,320	52,481	10	6,434	15,324	-	9,505	3,988	**120,062**
On-SoFP PFI contracts and other service concession arrangements	-	175,443	-	-	20,098	-	-	-	**195,541**
Owned - donated	-	139	-	-	964	-	-	-	**1,103**
NBV total at 31 March 2018	**32,320**	**228,063**	**10**	**6,434**	**36,386**	**-**	**9,505**	**3,988**	**316,706**

Note 18 Donations of property, plant and equipment	£000s
Bakey Plasama Thawar and Blood Scanner Prime	25
Hand held vein viewing system and Life card holter recorder	12
RITA 22" Touchscreen PC FOC and Ultralite ABP Monitor	43

Note 19 Revaluations of property, plant and equipment

Professional revaluations of Land and Buildings are normally undertaken at least once in every five year period (last undertaken in 2017) and are normally revalued annually, by professional valuers, using indices.

In view of property price changes in the London region Land and Buildings were revalued as at 31st March 2019 by Cushman & Wakefield (professional valuers and RICS accredited).

The valuations were carried out in accordance with the Roy al Institute of Chartered Surveyors (RICS) Appraisal & Valuation

Manual in so f ar 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 f air 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 f or existing use; and

· specialised buildings – depreciated replacement cost (DRC).

The property valuations are carried out primarily on the basis of (DRC) f or specialised operational property (e.g. NHS patient treatment facilities) and Existing Use Value (EUV) f or non-specialised operational property . The value of land f or existing use purposes is assessed at EVU. For non-operational land including surplus land, the valuations are carried out at Market Value.

The Department of Health has adopted the Modern Equivalent Asset (MEA) approach f or its DRC valuations rather than the previous identical replacement method. The MEA approach used to value the property will normally be based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence.

Non Property based assets including Equipment and Fixtures, are held at depreciated historic cost as this is not considered to be materially different from fair value.

Gains arising from indexation and revaluation are taken to the revaluation reserve, except when it reverses an impairment f or 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 impairment s and are charged to the charged to the current y ear'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 pay able arising in any reduction in the asset value.

In 2018-19, 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 Roy al Institute of Chartered Surveyors (RICS) guidance, and does not represent a change in accounting policy.

Note 20.1 Investment Property	**2018/19 £000**	**2017/18 £000**
Carrying value at 1 April - brought forward		
Carrying value at 1 April - restated	**-**	**-**
Carrying value at 31 March		**-**

Note 20.2 Investment property income and expenses	**2018/19 £000**	**2017/18 £000**
Total investment property expenses		**-**
Investment property income	-	-

Note 21 Investments in associates and joint ventures

	2018/19	2017/18
	£000	£000
Carrying value at 1 April - brought forward	-	-
Carrying value at 1 April - restated	-	-
Carrying value at 31 March	-	-

Note 22 Other investments / financial assets (non-current)

	2018/19	2017/18
	£000	£000
Carrying value at 1 April - brought forward	-	-
Carrying value at 1 April - restated	-	-
Carrying value at 31 March	-	-

Note 22.1 Other investments / financial assets (current)

	31 March 2019	31 March 2018
	£000	£000
Total current investments / financial assets	-	-

Note 23 Disclosure of interests in other entities

The Trust operates a Charity whose details are below

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

Note 24 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	2,996	3,192
Consumables	12,556	13,588
Energy	128	115
Total inventories	**15,680**	**16,895**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £73,346k (2017/18: £76,328k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 25.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	25,606	
Trade receivables*		52,168
Allowance for impaired contract receivables / assets*	(5,305)	
Allowance for other impaired receivables	-	(10,405)
Prepayments (non-PFI)	8,458	6,974
PFI lifecycle prepayments	900	868
VAT receivable	1,153	1,189
Other receivables	78	1,986
Total current trade and other receivables	**30,890**	**52,780**
Non-current		
Contract receivables*	4,071	
Prepayments (non-PFI)	1,069	16
PFI lifecycle prepayments	-	684
Other receivables	-	3,799
Total non-current trade and other receivables	**5,140**	**4,499**
Of which receivables from NHS and DHSC group bodies:		
Current	16,614	39,858
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 25.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		**10,405**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	10,405	(10,405)
New allowances arising	1,201	-
Utilisation of allowances (write offs)	(6,301)	
Allowances as at 31 Mar 2019	**5,305**	

Note 25.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**3,223**
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	**3,223**
Transfers by absorption	
Increase in provision	8,508
Amounts utilised	(1,326)
Allowances as at 31 Mar 2018	**10,405**

Note 25.4 Exposure to credit risk

There is very little exposure to credit risk as the bulk of Trust funds are provided by the Central Government

Adequate provisions are made for invoices and income raised to overseas patients in line with IFRS 9

Note 26 Other assets

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Total other current assets	**-**	**-**
Non-current		
Total other non-current assets	**-**	**-**

Note 27 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**24**	**54**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**24**	**54**
Assets sold in year	(9)	(30)
Impairment of assets held for sale	(15)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**24**

Note 27.1 Liabilities in disposal groups

	31 March 2019 £000	31 March 2018 £000
Categorised as:		
Total	**-**	**-**

Note 28.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19 £000	2017/18 £000
At 1 April	**3,249**	**1,548**
At 1 April (restated)	**3,249**	**1,548**
Net change in year	8,811	1,701
At 31 March	**12,060**	**3,249**
Broken down into:		
Cash at commercial banks and in hand	3	-
Cash with the Government Banking Service	12,057	3,249
Total cash and cash equivalents as in SoFP	**12,060**	**3,249**
Total cash and cash equivalents as in SoCF	**12,060**	**3,249**

Note 28.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019 £000	31 March 2018 £000
Monies on deposit	2	6
Total third party assets	**2**	**6**

Note 29.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	20,859	36,963
Capital payables	4,530	3,091
Accruals	14,347	7,303
Social security costs	4,553	4,006
Other taxes payable	4,516	3,694
Accrued interest on loans*		634
Other payables (relates to deferred income)	5,229	4,337
Total current trade and other payables	**54,034**	**60,028**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	5,883	10,982

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 29.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

31 March 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number

Note 30 Other financial liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Total	**-**	**-**
Non-current		
Total	**-**	**-**

Note 31 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	4,947	5,251
Other deferred income	243	
Total other current liabilities	**5,190**	**5,251**
Non-current		
Deferred income: contract liabilities	3,638	3,638
Total other non-current liabilities	**3,638**	**3,638**

Note 32 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	66,951	29,072
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	9,774	7,870
Total current borrowings	**76,725**	**36,942**
Non-current		
Loans from the Department of Health and Social Care	117,036	88,363
Obligations under PFI, LIFT or other service concession contracts	236,136	239,346
Total non-current borrowings	**353,172**	**327,709**

Note 32.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**117,435**	**-**	**-**	**247,216**	**364,651**
Cash movements:					
Financing cash flows - payments and receipts of principal	64,624	-	-	(9,013)	**55,611**
Financing cash flows - payments of interest	(3,396)	-	-	(19,391)	**(22,787)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	634	-	-	-	**634**
Additions	-	-	-	7,706	**7,706**
Application of effective interest rate	4,690	-	-	19,392	**24,082**
Carrying value at 31 March 2019	**183,987**	**-**	**-**	**245,910**	**429,897**

Note 33 Finance leases

Trust as a lessor

Future lease receipts due under finance lease agreements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessor:

	31 March 2019 £000	31 March 2018 £000
Gross lease receivables	-	-
of which those receivable:		
Net lease receivables	-	-

Trust as a lessee

Obligations under finance leases where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	-	-
Net lease liabilities	-	-

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	**5,549**	**1,330**	**28**	**-**	**-**	**84**	**-**	**6,991**
Change in the discount rate	(155)	-	-	-	-	-	-	**(155)**
Arising during the year	-	-	97	-	-	-	-	**97**
Utilised during the year	(398)	(89)	(24)	-	-	(22)	-	**(533)**
Reversed unused	-	(212)	11	-	-	-	-	**(201)**
Unwinding of discount	16	3	-	-	-	-	-	**19**
At 31 March 2019	**5,012**	**1,032**	**112**	**-**	**-**	**62**	**-**	**6,218**
Expected timing of cash flows:								
- not later than one year;	393	96	24	-	-	22	-	**535**
- later than one year and not later than five years;	1,572	385	88	-	-	40	-	**2,085**
- later than five years.	3,047	551	0	-	-	-	-	**3,598**
Total	**5,012**	**1,032**	**112**	**-**	**-**	**62**	**-**	**6,218**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £515,359k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barking, Havering and Redbridge University Hospitals NHS Trust (31 March 2018: £438,925k).

Note 35 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	**-**	**-**

Note 36 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	3,320	3,906
Intangible assets	680	297
Total	**4,000**	**4,203**

Note 37 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2019 £000	31 March 2018 £000
Total	**-**	**-**

Note 38 Defined benefit pension schemes

Not applicable

Note 38.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2018/19	2017/18
	£000	£000
Present value of the defined benefit obligation at 1 April	-	-
Present value of the defined benefit obligation at 1 April - restated	-	-
Present value of the defined benefit obligation at 31 March	-	-
Plan assets at fair value at 1 April	-	-
Plan assets at fair value at 1 April -restated	-	-
Plan assets at fair value at 31 March	-	-
Plan surplus/(deficit) at 31 March	-	-

Note 38.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2019	31 March 2018
	£000	£000
Net defined benefit (obligation) / asset recognised in the SoFP	-	-
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	-	-

Note 38.3 Amounts recognised in the SoCI

	2018/19	2017/18
	£000	£000
Total net (charge) / gain recognised in SOCI	-	-

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

Note 39.1 Imputed finance lease obligations

Barking, Havering and Redbridge University Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**464,212**	**482,304**
Of which liabilities are due		
- not later than one year;	27,679	25,944
- later than one year and not later than five years;	104,305	97,467
- later than five years.	332,228	358,893
Finance charges allocated to future periods	(218,302)	(235,088)
Net PFI, LIFT or other service concession arrangement obligation	**245,910**	**247,216**
- not later than one year;	9,774	7,870
- later than one year and not later than five years;	40,634	35,652
- later than five years.	195,502	203,694

Note 39.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,286,192**	**1,325,706**
Of which liabilities are due:		
- not later than one year;	61,985	60,952
- later than one year and not later than five years;	247,940	243,808
- later than five years.	976,267	1,020,946

Note 39.3 Analysis of amounts payable to service concession operator

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

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**61,764**	**60,952**
Consisting of:		
- Interest charge	19,392	18,981
- Repayment of finance lease liability	9,013	8,373
- Service element and other charges to operating expenditure	22,613	22,628
- Capital lifecycle maintenance	1,588	1,638
- Contingent rent	9,127	7,913
- Addition to lifecycle prepayment	31	1,419
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	48	122
Total amount paid to service concession operator	**61,812**	**61,074**

Note 40 Off-SoFP PFI, LIFT and other service concession arrangements

Barking, Havering and Redbridge University Hospitals NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2019 £000	31 March 2018 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	**-**	**-**
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
Total	**-**	**-**

Note 41 Financial instruments

Note 41.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with CCGs/NHS England (Commissioners of healthcare) and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations, although it should be noted that some equipment and consumables are sourced from overseas and may be subject to price changes fluctuations given market volatility seen the UK's decision to leave the European Union.

Interest rate risk

The Trust borrows from government for revenue financing and capital expenditure, subject to approval by NHS Improvement and Department of Health. The borrowings are for 1 – 25 years and interest rates are confirmed by the Department of Health. These are fixed for the life of the loan and range between 1.5% and 6.0%. The Trust therefore has low exposure to future interest rate fluctuations.

Credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies, so the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with commissioners of healthcare (CCGs/NHS England), which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 41.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	To tal book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	24,450	-	-	**24,450**
hand	12,060	-	-	**12,060**
Total at 31 March 2019	**36,510**	**-**	**-**	**36,510**

	Loans and receivable s	Assets at fair value through the I&E	Held to maturity	Available-for-sale	To tal book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	41,725	-	-	-	**41,725**
hand	3,249	-	-	-	**3,249**
Total at 31 March 2018	**44,974**	**-**	**-**	**-**	**44,974**

Note 41.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	To tal book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IFR			
Loans from the Department of Health and Social Care	183,987	-	**183,987**
Obligations under PFI, LIFT and other service concession contracts	245,910	-	**245,910**
Trade and other payables excluding non financial liabilities	44,965	-	**44,965**
Total at 31 March 2019	**474,862**	**-**	**474,862**

	Other financial liabilities	Held at fair value through the I&E	To tal book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2018 under IAS			
Loans from the Department of Health and Social Care	117,435	-	**117,435**
Obligations under PFI, LIFT and other service concession contracts	247,216	-	**247,216**
Trade and other payables excluding non financial liabilities	59,549	-	**59,549**
Total at 31 March 2018	**424,200**	**-**	**424,200**

Note 41.4 Fair values of financial assets and liabilities

Not applicable

Note 41.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	**£000**
In one year or less	118,362	101,643
In more than one year but not more than two years	123,512	86,968
In more than two years but not more than five year	33,787	30,629
In more than five years	199,201	204,960
Total	**474,862**	**424,200**

Note 42 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	57	8	67	10
Bad debts and claims abandoned	1,185	4,701	-	-
Total losses	**1,242**	**4,709**	**67**	**10**
Special payments				
Compensation under court order or legally binding arbitration award	3	4	9	17
Extra-contractual payments	20	10	-	-
Ex-gratia payments	6	-	16	6
Total special payments	**29**	**14**	**25**	**23**
Total losses and special payments	**1,271**	**4,723**	**92**	**33**
Compensation payments received		-		-

Note 43 Gifts

The value of any gifts received did not exceed £300,00 0

	2018/19		2017/18	
	Total number of cases Number	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Gifts made	-	-	4	1

Note 44.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £634k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £4,781k.

Note 44.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 45 Related parties

During the year none of the Department of Health Ministers have undertaken any transactions with the Trust. Similarly, no Trust Board members undertook transactions with the Trust via their limited liability companies.

The Trust also recorded the following transactions with organisations that some members of the board were associated with

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000s	£'000s	£'000s	£'000s
Capsticks Solicitors LLP	148		32	-
NHS Confederation	7		-	
Queen Mary University of London		25		3

The Department of Health is regarded as a related party.During the year Barking, Havering & Redbridge University Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are :

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000s	£'000s	£'000s	£'000s
Barking and Dagenham CCG, Havering CCG and Redbridge CCG*	32	343,375	4,750	6,593
Basildon and Brentwood CCG	-	22,816	24	1,358
Barts Health NHS Trust	1,578	2,956	359	1,615
Health Education England	-	16,341	221	-
Homerton University Hospital NHS Foundation Trust	93	144	143	144
Imperial College Healthcare NHS Trust	42	6	25	30
NHS Blood and Transplant (NHSBT)	13	36	142	-
NHS Business Services Authority (NHSBSA)	352	-	-	-
NHS England	4	107,610	167	2,450
NHS Improvement	-	187	21	79
NHS Litigation Authority (NHSLA)	26,088	-	9	-
NHS Property Services Limited	2,049	-	2,577	-
North East London NHS Foundation Trust	656	1,756	288	363
North Middlesex University Hospitals NHS Trust	2	52	22	13
St George's University Hospitals NHS Foundation Trust	26	132	25	135
University College London NHS Foundation Trust (UCL)	406	318	969	156
NHS Newham CCG	-	4,658	-	400
NHS Thurrock CCG	-	4,593	-	406
NHS Waltham Forest CCG	-	2,250	-	21
NHS West Essex CCG	-	7,714	-	-
London Regional Office	-	5,012	-	425
London Specialised Commissioning Hub	-	86,191	-	1,899

*Barking and Dagenham CCG, Havering CCG and Redbridge CCG commission services jointly for the Trust. Therefore we have disclosed the aggregate position of our transactions with the three CCGs.

The Trust has one related party which is non-NHS or governmental departmental. It is the Barking Havering University Hospitals NHS Charity which recorded an income of £823k, expenditure of £717k, year end receivables of £23k, and payables of £182k.

Note 46 Transfers by absorption
There has been no transfers by absorption in the year where the trust has been either the receiving or divesting party.

Note 47 Prior period adjustments
There has been no prior period adjustments in the current year

Note 48 Events after the reporting date
There are no reportable events after the end of the reporting period, up to date of submitting these accounts

Note 49 Final period of operation as a trust providing NHS healthcare
Not applicable

Note 50 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	58,822	255,300	80,645	254,207
Total non-NHS trade invoices paid within target	51,757	233,084	12,611	139,991
Percentage of non-NHS trade invoices paid within target	88.0%	91.3%	15.6%	55.1%
NHS Payables				
Total NHS trade invoices paid in the year	4,276	16,806	3,637	11,232
Total NHS trade invoices paid within target	2,658	9,786	339	1,480
Percentage of NHS trade invoices paid within target	62.2%	58.2%	9.3%	13.2%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 51 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	**48,216**	**39,093**
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**48,216**	**39,093**
External financing limit (EFL)	60,899	39,646
Under / (over) spend against EFL	**12,683**	**553**

Note 52 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	16,768	21,414
Less: Disposals	(151)	(75)
Less: Donated and granted capital additions	(80)	(59)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**16,537**	**21,280**
Capital Resource Limit	16,694	22,119
Under / (over) spend against CRL	**157**	**839**

Note 53 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(60,334)
Impact of 2017/18 expert determination	(11,885)
Breakeven duty financial performance surplus / (deficit)	**(72,219)**

Note 54 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£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)	(33,719)	(10,874)	(48,977)	(72,219)
Breakeven duty cumulative position	(94,668)	(116,949)	(149,935)	(199,848)	(239,340)	(277,094)	(315,044)	(348,763)	(359,637)	(408,614)	(480,833)
Operating income		397,456	407,107	419,121	438,354	457,495	477,993	505,239	557,966	571,774	550,077
Cumulative breakeven position as a percentage of operating income		(29.4%)	(36.8%)	(47.7%)	(54.6%)	(60.6%)	(65.9%)	(69.0%)	(64.5%)	(71.5%)	(87.4%)

Note 55 Staff costs

	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	256,425	32,906	**289,331**	275,776
Social security costs	27,209	2,771	**29,980**	28,521
Apprenticeship levy	1,416	8	**1,425**	1,342
Employer's contributions to NHS pensions	29,755	1,261	**31,016**	30,248
Pension cost - other	41	3	**44**	22
Termination benefits	-	-		21
Temporary staff	-	28,946	**28,946**	34,323
Total gross staff costs	**314,847**	**65,895**	**380,742**	**370,253**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**314,847**	**65,895**	**380,742**	**370,253**
Of which				
Costs capitalised as part of assets	80	-	**80**	514

Average number of employees (WTE basis)

	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	895	196	**1,092**	1,069
Ambulance staff	3	-	**3**	3
Administration and estates	474	113	**587**	608
Healthcare assistants and other support staff	1,930	245	**2,175**	2,106
Nursing, midwifery and health visiting staff	1,969	358	**2,327**	2,305
Scientific, therapeutic and technical staff	530	40	**570**	580
Healthcare science staff	203	7	**210**	203
Other	14	-	**14**	14
Total average numbers	**6,018**	**960**	**6,979**	**6,889**
Of which:				
Number of employees (WTE) engaged on capital projects	1	-	**1**	9

Reporting of compensation schemes - exit packages 2018/19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	7	**7**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	1	**1**
£100,001 - £150,000	-	1	**1**
Total number of exit packages by type	**-**	**10**	**10**
Total cost (£)	£0	£245,000	**£245,000**

Reporting of compensation schemes - exit packages 2017/18

	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	4	**5**
£10,000 - £25,000	1	-	**1**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	2	**2**
Total number of exit packages by type	**2**	**7**	**9**
Total cost (£)	£20,000	£150,000	**£170,000**

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	10	245	4	15
Exit payments following Employment Tribunals or court orders			3	135
Total	**10**	**245**	**7**	**150**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-