ANNUAL REPORT AND ACCOUNTS 2016-17
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Welcome to our annual report for 2016/17: a year which will be memorable for everyone associated with our Trust as a big step on our journey, as we left special measures – the first Trust in London to do so.

Having been placed in special measures towards the end of 2013, it was extremely gratifying that all the efforts of our staff, patients, volunteers and partners to make significant and sustained improvements in our hospitals was recognised by the Care Quality Commission (CQC) in its focused inspection, and by NHS Improvement.

What impressed me most overall was the resolve and ambition showed by every member of staff I spoke with, that while this was a moment to stop, reflect and acknowledge the journey they’ve been on, they were absolutely committed to continuing towards achieving our vision of delivering outstanding care for our community. We all remain focused on this, and so the next challenge is to maintain our standards, and improve.

I think this year will prove to be one which put us in a place where we can start to think about framing our future. Two big pieces of work completed towards the end of the year – our Clinical Services Strategy and our two – year Operational Plan – will help us take us further along the road.

I was also very pleased with the findings of this year’s national NHS Staff Survey, which has shown further improvement, continuing the trend we have seen in recent years. This is testament to the hard work of staff, and demonstrates that listening to, and acting on feedback helps to continue to improve their working lives. With a much better response rate than in recent years, we also saw that 86% of staff felt satisfied with the quality of the care we’re able to provide to patients. That’s 30% more than in 2013.

As you will read in this report, one of the recurring themes is partnership. I believe this year has shown real progress in the way we have worked closely with partners – be it our Patient Partners – who have become an invaluable asset to our Trust, or our partners in the local and national health economy – the CCGs, GPs, NHS England and NHS Improvement to name a few, or internationally, the Virginia Mason Institute.

We have engaged fully with our local Sustainability and Transformation Plan (STP) for North East London, which will undoubtedly be a significant part of the big picture for the NHS across the country in coming years.

All of this has been occurring against a backdrop of continued financial challenge within the NHS – hitting our control total for the third year in a row was a real achievement – and the broader challenges of the NHS and increasing numbers of patients with complex needs.

As you will read in this report, the King George and Queen’s Hospitals Charity has funded many projects this year which will continue to make a real difference to our patients, visitors and staff. I’d like to thank everyone who supports our charity – your contribution is hugely appreciated.

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

After an eventful year, I would like to give my heartfelt thanks to every one of our staff, volunteers and partners for their huge support, dedication and hard work.

The icing on the cake was unquestionably the final confirmation, in March, following a CQC inspection in October, that after three years, our Trust would be leaving special measures. It has been evident to me since the day I joined that there was a team of people here with huge passion and commitment to our patients, but there were some areas we needed to transform in order to turn goodwill into good care.

While any inspection process can be a challenging affair, Matthew Hopkins said in his introduction to this report last year that we would look forward to welcoming the CQC. We had great confidence that the improvements we know our staff and patients notice every day would shine through, and they certainly did.

However we know this isn’t the end of our journey – it’s just the end of the beginning and it’s more important now than ever to sustain our confidence that the improvements we know our staff and patients notice every day would shine through, and they certainly did.

However we know this isn’t the end of our journey – it’s just the end of the beginning and it’s more important now than ever to sustain our focus on driving forward more improvements, through delivering our Clinical Services Strategy and Operational Plan, and through the PRIDE Way and our Improvement Portfolio.

Our performances against the constitutional standards – particularly in cancer, Referral To Treatment (RTT) and the Four Hour Emergency Access Target – tell a similar story.

We have performed well this year – our waiting lists for elective care have shrunk dramatically thanks to a huge collective effort across the local health community. We have hit most of our cancer targets this year, with the 62-day standard being achieved for the first time in March. In terms of emergency access, we were one of the best performing Trusts in London across a Winter of unparalleled demand.

But in each case, there is still more we can, and will, do to improve.

We now want to work towards achieving our vision of providing outstanding care to our community, delivered with PRIDE. This will make our hospitals amongst the best places for safe, high quality care, and amongst the best places to work, and the lifting of the ‘special measures’ label will help us to build more freedom to do just that.

For the third year we again met all our financial targets whilst continuing to invest in frontline services to improve patient care, and vital infrastructure like Trust-wide IT systems. While these improvements don’t always get much recognition, they are absolutely crucial to improving our efficiency and effectiveness.
The most significant development in our Trust in 2016/17 was the announcement at the beginning of March 2017, that after three years, we were leaving special measures.

The announcement from NHS Improvement followed the recommendation of the Care Quality Commission (CQC) on the back of a positive focused inspection at the back end of 2016.

It was a huge confidence boost to have the improvements we have made across our Trust recognised.

We were delighted to be able to acknowledge the massive contribution made by staff, volunteers, patients and partners and say thank you to them all. It also provided a welcome platform to reflect on our journey, and refocus our collective attention on the next challenges ahead, as we continue to improve every element of our work, and ultimately, our care for patients.

The inspection team found that every one of the four core services assessed as part of the ‘focused inspection’ had shown significant improvement across the five ‘domains’ measured by the CQC.

We were also pleased to see improvements acknowledged at both Queen’s Hospital and King George Hospital.

Two services: ‘children and young people’ and ‘outpatients and diagnostic imaging’ had made particularly transformational improvements, across both sites, and received special praise – both are now rated ‘Good’.

The inspection team highlighted a number of areas of ‘outstanding practice’, including the tailored care offered to patients with dementia, which has included specialist training for staff and implementing the ‘Butterfly Scheme’, as well as a range of practical day-to-day methods, described by CQC as ‘compassionate and thoughtful’.

While everyone involved with the Trust was rightly able to take the moment to celebrate, we continue to look at this as just a big step on the longer road, to continue our progress towards providing outstanding care to our community.

The CQC identified a number of ‘must do’ actions, including the improvement of training, and oversight of training, and further focus on sepsis and hand hygiene – all of which have already been put at the centre of our operational focus for next year.

The 2015 and 2016 CQC reports show a remarkable transformation. In total, 18 of the 40 areas inspected were given an improved rating.
HOW WE MARKED LEAVING SPECIAL MEASURES
We had our first feline visitor to Queen’s Hospital when staff on Mandarin A ward, and our palliative care team, arranged for beloved cat Patch to be brought in to say goodbye to his owner, Gladys Wray, 66, before she died of lung cancer.

Our caring staff granted the last wish of terminally ill patient Donald Naughton, 66, arranging for him to marry his partner of 20 years, Lucy Rayner, from his intensive care bed.

Tumelo Sibanda, 12, was the first in a series of young visitors to our pathology lab. The visits were an opportunity for the children, all with long-term conditions, to see what happened to their blood.

We launched our annual flu jab campaign to keep our patients, staff and visitors protected from the winter bug – this time with some Strictly glamour.

A family whose 15-year-old son was treated at our hospitals for acute lymphoblastic leukaemia as a toddler came back to donate an end of treatment bell to our children’s ward. It is for children to ring once they complete their treatment.

We marked the tenth anniversary since Queen’s Hospital opened to our patients, with a Queen’s Hospital shaped cake, balloons and a special performance by our choir.
SECTION ONE: PERFORMANCE REPORT

This section of the Annual Report details our operational performance over the 2016/17 financial year.

It is structured into five sections, which align with our five core Objectives, as set out in our Operational Plan for 2016/17.

These core Objectives, and those which sit beneath them, were led by our staff and volunteers, working in partnership with key local stakeholders and patient representatives.
OUR 2016-17

DELIVERING HIGH QUALITY CARE
• Embedding quality and safety systems
• Ensuring the highest standards of infection control
• Continuing development of a learning culture

RUNNING OUR HOSPITALS EFFICIENTLY
• Developing our operational leadership and management
• Improving delivery of constitutional standards
• Ensuring our buildings equipment and IT systems are fit for purpose and used effectively

OBJECTIVES

BECOMING AN EMPLOYER OF CHOICE
• Creating the right environment and improving people management to enable staff to achieve excellence
• Increasing the engagement of our people to drive improvement in quality, safety and patient experience
• Increasing and retaining our substantive workforce

WORKING IN PARTNERSHIP
• Updating our clinical services strategy
• Developing services in line with strategy
• Improving stakeholder engagement

MANAGING OUR FINANCES
• Developing robust budgetary management
• Making sure we get paid for all the work we do
• Implementing our Quality and Cost Improvement Programme
OUR HOSPITALS IN 2016/17:

- **Income of £558 Million**
- **40% Water Births in our Birth Centre**
- **98% Positive Recommendations**
- **8,058 Babies Delivered This Year**

MATERNITY

PAEDIATRICS

- **12,181 Paediatric Outpatients**
- **239,486 Attendances**
- **5,694 Paediatric Inpatients (Admissions)**
- **5,694 Paediatric Inpatients (Admissions)**

EMERGENCY

- **185 Ambulances a Day**
- **67,440 Ambulance Arrivals**
- **51,268 Emergency Admissions**

PLANNED CARE

- **48,000 Day Case Procedures**
- **28,000 Inpatient Operations**
- **737,000 Outpatient Appointments**

Barking, Havering and Redbridge University Hospitals NHS Trust
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 main priority.

This year, working with our partners, much of our focus has been on continuing to deliver our refreshed Improvement Plan: Delivering our potential, and ensuring we have the right processes in place to keep our patients safe. Our Improvement Portfolio Board continues to be one of the key channels through which we are able to make and sustain changes to improve our care.

When the Care Quality Commission published its report in March 2017, inspectors rated us ‘Good’ in the Safe domain in five out of six of the areas they reviewed. More detail on our performance this year is found in our Quality Account.

Improving safety

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

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

Having last year introduced a new expert quality and safety team to help our frontline staff to deliver high quality, safe care; this year has seen the embedding of key processes across the organisation.

There were four main objectives:

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

Incident Reporting

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

This is because often, any near misses which are spotted by staff first, before any patient is harmed, can result in pre-emptive action to mitigate the future risk.

We have not done well enough historically at reporting clinical incidents. Over the past year we have given a major push, featuring staff education activity and internal communications (such as Incident Reporting Awareness Week held in February) to reinforce its importance.

We are now reporting more incidents, improving our position to come more in line with other trusts. There has been a 23% increase in the number of incidents reported, with a similar number reported to the National Reporting and Learning System. Month on month, over 70% of our patient safety incident are no harm incidents.

When issues are reported, it is vital that we investigate quickly and then feed our findings back to staff so that we can learn and improve. We have also spent time improving and refining our investigative process, so that this happens as a matter of routine.

Delivering High Quality Care

- Embedding quality and safety systems
- Ensuring the highest standards of infection control
- Continuing development of a learning culture
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. Research we undertook last year showed that around a quarter of over 75s in our Emergency Departments had attended because they had had a fall.

This year we implemented a three-year Falls Strategy for 2016-19 with an annual action plan which was introduced across our hospitals. We have run a comprehensive training programme throughout the year, comprising sessions in our simulation suites and online, with supporting information made available for both staff and patients.

Our target for 2016/17 was to seek a 5% reduction in the number of falls overall per 1,000 bed days, and we were very pleased with achieving a 6% decrease. We had a further target to reduce falls with harm by 6%, and we were actually able to reduce these by 18%.

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 when pressure is applied to the same area of skin would result in a rise in hospital-acquired pressure damage.

We undertook a new awareness and training campaign to help reduce avoidable heel damage. ‘Take to the Heels’ has actively involved the wards and has been a very effective tool in helping staff to be vigilant and identify signs of redness early to ensure preventative measures were being effective.

We have increased pressure ulcer prevention and management training in the clinical areas, this is to allow staff to attend more easily.

We have seen a steady decline in patients with acquired pressure ulcers, returning an overall figure of 0.64% per 1,000 occupied bed days for the year.

In 2016/17, we have taken steps to investigate the care received by patients who develop grade 2, 3 or 4 pressure ulcers in our care and be open and honest about these wounds.

We discontinued the ‘72’ hour rule (pressure damage that occurred within 72 hours of admission having previously been said to be ‘community acquired’) to bring us in line with national reporting. Now if the wound is not identified at first assessment it is deemed hospital acquired.

We were aware that this increased responsibility would result in a rise in hospital-acquired pressure damage.

We were able to reduce pressure ulcers, and we were able to reduce these by 18%.

INFECTION PREVENTION AND CONTROL
This remains an area in which we need to improve our performance. We achieved the national stretch target for C. difficile infection (29 cases against a target of <30), but we missed our target for MRSA infections (7 cases against a target of 0).

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

We did not achieve the targets we set ourselves last year, and the CQC inspection highlighted this as an area to improve. There will be a specific focus on infection prevention and control this year, and an escalation so that disciplinary action will be taken against staff who do not comply with good practice.

END OF LIFE CARE
We continue to be proud of our commitment to providing good end of life care. Having been acknowledged as one of the best services in the country at last year’s national End of Life Care Review, we have built on this foundation to ensure that we provide the very best palliative care for patients.

As is featured later on in this report, in our section on The PRIDE Way, end of life care was one of the first areas we chose to focus on, so that we could find more ways to make further improvements.

As part of our commitment to helping bereaved families, we were pleased to open our new bereavement centre this year. The Daisy Centre has brought together chaplains, registrars and bereavement officers in a more welcoming and comfortable space, to help provide a more caring and compassionate service.

The PRIDE Way
As featured earlier in this report, the CQC rated this as ‘Good’ in its inspection. We believe that across our organisation, children and young people are better supported and cared for than they were a year ago.

This has required huge effort and improvements such as the dedicated paediatric recovery areas in our theatres, increasing the numbers of specially trained nurses in our Emergency Departments; and improving our ability to support children in the High Dependency Unit have all made a tangible difference.

CARING FOR WOMEN, CHILDREN AND YOUNG PEOPLE
This year has seen substantial improvements across our Trust in terms of the quality of care we are providing for children and young people.

As mentioned earlier in this report, the CQC rated this as ‘Good’ in its inspection. We believe that across our organisation, children and young people are better supported and cared for than they were a year ago.

This has required huge effort and improvements such as the dedicated paediatric recovery areas in our theatres; increasing the numbers of specially trained nurses in our Emergency Departments; and improving our ability to support children in the High Dependency Unit have all made a tangible difference.

WE BELIEVE THAT ACROSS OUR ORGANISATION, CHILDREN AND YOUNG PEOPLE ARE BETTER SUPPORTED AND CARED FOR THAN THEY WERE A YEAR AGO.

There has also been a concerted effort to improve the care for children with diabetes – investment in extra nurses, therapy sessions and consultants means we are now a model of good practice.

Introducing a one-step approach to dealing with potential endometrial cancer (cancer of the uterus) – a big step forward towards quicker diagnosis and improved outcomes for patients.

Our maternity team continues to deliver a busy and well-regarded service. Being named runner up in the RCM’s Annual Midwifery Awards for Service of the Year, was a notable achievement.

CLINICAL AUDITS
Clinical audit is a quality improvement process which involves reviewing the delivery of healthcare to ensure that best practice is being carried out.

It provides evidence of when standards are adhered to and can also highlight when a service is not meeting an agreed standard, providing a framework for suggesting improvements.

In 2016/17 we participated in around 350 local and national clinical audits. This participation helped us identify a range of actions to improve the quality of our healthcare (for detail, see our Quality Account).

RESEARCH & INNOVATION
We continue to do our best to encourage and promote research work in our Trust. We currently support nearly 300 research studies that have received a favourable opinion from the National Research Ethics Service (NRES).

Cancer research performance across the Trust has been excellent this year and this accounts for 51% of our CRN funding. 527 patients were recruited to cancer research studies. We have also been recognised for being the first active site within the UK for opening several commercial cancer studies and have over-recruited on predicted targets, which is a great achievement.

Patient participation in cancer research has increased enormously within the Trust over recent years. We are committed to providing patients with the opportunity to take part in high quality cancer research studies.
IMPROVING THE PATIENT EXPERIENCE

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

As across the NHS, we continue to utilise Patient-Led Assessments of the Care Environment (PLACE) inspections to drive action plans for the year ahead. We have a rolling programme of improvement works to keep our facilities as up-to-date and welcoming as possible.

At Queen’s Hospital, we saw the completion and installation of an outdoor gym, immediately outside the main entrance. We also opened our new food court, transforming the area, adding high street brands and healthier eating options for staff and patients.

We also made excellent progress on trialling new digital patient lockers and new wheelchairs – both of which will be progressed this coming year.

We installed 22 new points in our Hearing Loop at King George Hospital, to significantly increase the coverage and make life easier for our patients who use hearing aids.

We made major service relocations and improvements this year, with the move of our antenatal services at King George Hospital to new facilities on the 1st floor. The new area provides more room for future expansion, larger scanning rooms and a children’s play area.

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

KING GEORGE AND QUEEN’S HOSPITALS CHARITY
Our charity continues to provide invaluable support, raising funds so that we can make both of our hospitals even better for patients.

Over the course of the last year, the Charity has raised around £425,000, via a variety of means, including some very generous donations from individuals; through legacies and in memoriam donations, and from the traders selling goods in the hospitals. But, it remains the events such as the annual Christmas Ball which continue to be both popular and successful in terms of raising money.

All the money we receive is reinvested in our hospitals, via the Charitable Funds Committee, which meets to discuss applications.

CASE STUDY

SLEEPER CHAIRS
Having a child in hospital can be a real ordeal. It is made even worse if parents or carers are exhausted through a lack of sleep. To help, we invested in 30 specially-designed sleeper chairs at a cost of around £30,000.

Installed throughout the Tropical Lagoon, these chairs come in a variety of colours, and can be used in three different positions (upright, chaise longue and bed). The chairs are covered in anti-bacterial, fully washable vinyl and have a castor system for ease of moving.

Users have given us very positive feedback that they are very comfortable and much appreciated, giving tired parents and carers a chance to lie down.

CASE STUDY

MATERNITY TRAINING DEVICES
We invested just over £20,000 in four devices, purchased from Limbs & Things, a company that manufactures medical training products for healthcare professionals and students worldwide.

The simulators train maternity staff in various emergency situations which may occur during childbirth, in a clinical area. Trainers are able to transport the devices to different training rooms as each comes in its own carry bag.
PATIENT EXPERIENCE

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

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

This year we appointed external partner “I Want Great Care!” to help us gather and analyse data relating to our Friends and Family Test scores. We received just under 100,000 surveys this year – a significant evidence base from which we can further refine and improve in coming years.

We use these scores to identify and reward our Team of the Week, motivating our staff to continue encouraging patients to participate. Many of the comments and suggestions which we have received have already led to changes and improvements to our services. Some points to mention this year include:

• We have built on the successful introduction of the national #HelloMyNameIs campaign to further develop our own approach to greeting patients in our care. The essence of this initiative, started by terminal cancer sufferer Dr Kate Granger, is to ensure all patients get a more positive first impression when in hospitals. We now want to encourage our staff to create a great impression by smiling, introducing themselves, explaining their role and either offering to help, or explaining what they are here to do. It’s really simple, but it has a big impact.

• To help ensure we are providing the very best information ready to patients, we launched a new Patient Information Library on our website, which contains a huge array of supporting information.

• We have continued to progress our efforts to become the first NHS Trust to achieve the Deaf Aware Quality Mark from the Royal Association for Deaf People. At the time of writing, we had just been awarded this for Queen’s Hospital – making us the first in the country. We were pleased that our work to improve communication with deaf and hard of hearing patients was acknowledged at the Patient Experience Network National Awards.

• Our relaunched children’s menu has proven to be a hit, as have our two local therapy dogs (Mercedes and Bentley) who continue to visit our Trust.

LEARNING FROM PATIENT FEEDBACK

Despite our best intentions, we don’t always get things right. We have taken steps this year to improve our complaints processes to make them more responsive.

We introduced a new grading system for complaints in November, to ensure that complaints are given the right amount of time to sufficiently investigate to greater depth. These can then be escalated depending on the risk grading.

We received 754 complaints (an improvement on the 843 received in 2015/16) and against our target of 100% of complaints being acknowledged within three working days, we achieved this on 753 occasions.

Overall however, we failed to meet our internal target of 85% of responses to complaints within the required (and appropriate) timescales, which are decided individually on a case-by-case basis.

This annual performance figure was mainly due to issues in Quarter 1. We met the target for the final three quarters of the year, so we will be aiming to build on this performance level in the coming year.

A PATIENT’S STORY – KATE BAKER

I come to be a patient at Queen’s in December after a turbulent five weeks of continual migraines, vomiting and a dubious looking CAT scan (which we now know was a benign brain tumour) at Goldsmith A&E that was sent to the Neurology Team for a second opinion.

I was blue lighted down the A12 on a Monday morning, in the peak of rush hour, unconscious, with the surgical team ready and waiting. Just a few hours later, I was recovering well from my External Ventricular Drain (EVD) operation. My first, genuine, heartfelt thank you is to the kind person who cut and shaved my hair to enable the drain to be inserted into my head. I’m very proud of my hair. So, when I eventually suffered in Sahara B ward to find that a big strip of my hair had gone, I was a smidge freaked.

That was until I ascertained that my lifesaving undercut had been blended so well with the parting of my hair that you can’t even tell I have hair missing. In the words of my hairdresser: “That is a very impressive job, they’ve really gone above and beyond to factor it in with the rest of your hair.” And that’s the point; they did take the time to think about it and they didn’t have to.

They could have taken all my hair off or just shaved it in a non-flattering way because if the priority is to remove fluid that is essentially boiling my brain, discussing hair dos’ is probably just wasting precious time. But somebody stopped, thought about the emotional impact on me and demonstrated a level of empathy that is really hard to come by these days.

And then there’s Sahara B ward. I can hand-on-heart say that the six days I spent on Sahara B were some of the most positive and pleasurable I have had. I remember one nurse called Maria (who I was keen had been stretched up with an extra-long shift) who never dropped her smile once and remained polite and extremely professional throughout.

There is one nurse who I have to extend a personal thank you to – Louise who was working a nightshift one night when I was having what can only be described as a ‘ridiculous meltdown’. Louise was extremely kind and patient with me – she even went to the effort of making me a hot chocolate to help me sleep.

And last, but by no means least I have to say a huge, massive, profound thank you to the utterly gorgeous and very talented Mr Vindlicherous. This guy is without doubt not only the hero of the whole situation, but my very own hero who categorically saved my life. I hope that you are genuinely proud of all your colleagues because they are truly remarkable and they represent everything that is fantastic about the NHS. Their hard work, commitment and compassion means so much to me, that I will always think the world of every single one of them.
Case Study
Identification of end-of-life patients
We undertook this work so that we could better identify and focus on this vulnerable cohort of patients, and ensure that we were providing the very best, most appropriate care to suit their needs.

As a result, we have improved our Board Rounds, to include representatives from Palliative Care; and developed our Frail and Older Persons Advice and Liaison (FOPAL) assessment to introduce it earlier.

Patients who are identified as end-of-life using the Gold Standards Framework will have appropriate care plans put in place meaning that they will receive the most appropriate care in their preferred care setting. We reduced the proportion of patients who are not discussed for their end-of-life needs from 97% to 0% and reduced the number of patients waiting to be identified/assessed for end-of-life needs from 30 to five.

Case Study
Biopsy booking and sample preparation
Two separate topics were tackled to improve our processes around the booking and preparation of biopsies and samples.

We implemented a daily radiologist huddle to review and approve all biopsy requests; used visual control in the administration area to improve awareness of requests; and developed an escalation process for outstanding requests; as well as moving staff and redistributing work.

As a result, we were able to significantly reduce the times taken to vet and book appointments (from 142 hours to 22 hours); and preparing and process samples (from 21 hours to 5.5 hours).

The changes allow us to vet each request, make sure the most appropriate test is booked, improving the likelihood of a better result, and quicker diagnosis, so patients can get results far more quickly.
I came back to our Trust in July last year after a five-year break, and I’m so glad that I’m back with my NHS family. After I qualified in 2008, I worked in the Emergency Department for a couple of years before I went travelling in 2011. It wasn’t the best place to work when I left, so when I came back I didn’t return to the NHS. I worked as a forensic nurse and then as part of a medical unit on a construction site. It was my matron, Sandra Mahoney, who encouraged me to come back to work with her on Amber A ward. I started in July and became the ward manager in September. I’m really glad I came back as I prefer the NHS because you feel like you’re making a difference. I like that it’s a bigger team and there are lots of different specialties and support from your colleagues. I love being a part of it.

I’ve noticed a lot of improvements at our Trust too. There’s more senior presence, we have weekly meetings with the Chief Nurse and she’s really approachable so we feel comfortable taking any problems to the top. The Chief Executive comes onto the ward too and the morale is much better, you can see that everyone is happier.

Since coming back, I’ve looked at where I can make improvements on my own ward. I wanted to add more details to our handover sheets to make it easier when we take over from the night staff, and we also introduced afternoon ward rounds with doctors. These help us plan discharges, so our patients can go home as soon as they are well and has seen patient flow on the ward improve. As we deal with broken bones, I like to see my patients to theatre and then on through their recovery. It’s been nice to come back to Amber A too as I worked on the ward during my training. Many of my colleagues also remember my mum, Theresa Bell, who was ward manager for orthopaedics at Oldchurch Hospital. It was coming to the hospital after school to wait for my mum that inspired me to become a nurse. I enjoy working with my colleagues at our Trust and helping our patients.
Over the last year, our teams have worked hard to improve our services against national and locally-agreed quality and performance measures. You can find out more detail about the quality of our services and the care we provided in our Quality Account, available on our website.

**EXTERNAL ASSESSMENT – CQC**

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

When the CQC visits, it asks five key questions:

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

**RUNNING OUR HOSPITALS EFFICIENTLY**

- Developing our operational leadership and management
- Improving delivery of constitutional standards
- Ensuring our buildings, equipment and IT systems are fit for purpose and used effectively

**THE CQC INSPECTION IN NUMBERS**

**Targeted Inspections**
- five (two planned, three unannounced)
- Acute and specialist medical in patient wards
- Emergency departments
- Paediatric services
- Outpatients and diagnostics

**Requested by the CQC**
- 18 focus groups: 530 staff including patient partners, doctors, nurses, AHPs and support staff
- 34 interviews
- 210 requests for evidence, 628 documents submitted

**Draft report received January 2017**
- Trust challenged 52 points
- 93% successful

**Final report received March 2017**
- eight ‘must do’ actions
- 35 ‘should do’ actions
As shown earlier in this report, October’s visit from the CQC was a targeted inspection, focused on four areas:

- Urgent and emergency services
- Medical care
- Services for children and young people
- Outpatients and diagnostic imaging

The CQC report confirmed that improvements had been made and highlighted some areas of "outstanding practice". These included:

- The tailoring of care we provide to patients with dementia, which was described as "well considered". The report adds: "the staff were trained to deliver compassionate and thoughtful care...measures have been implemented to make their stay in hospital easier and reduce any emotional distress."
- The work of our neonatal and community teams in providing babies with oxygen home therapy which "significantly improved the quality of life for families."
- The introduction of support resources for children with learning difficulties via our dedicated paediatric learning disability nurse, who had helped staff to build better relationships with young patients and their families.
- Our child to adult transition services, which were highlighted for their involvement of the patient and parents; the individualised staging of empowerment, and the way we support patients going through this transition.

**MUST DO ACTIONS**

The CQC also identified a series of Must Do actions. These were:

- Ensure all patients attending the ED are seen by a clinician in a timely manner.
- Take action to improve levels of resuscitation training.
- Ensure there is oversight of all training done by locums, particularly around advanced life support training.
- Take action to improve the response to patients with suspected sepsis.
- Take action to address the poor levels of hand hygiene compliance.
- Ensure fire safety is maintained by ensuring fire doors are not forced to remain open.
- Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment.
- Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.

In most instances, the priority areas identified by the CQC were consistent with our own assessments, with action plans and mitigating measures already in place. These will continue to be areas of high priority over the coming year.

**LEADERSHIP DEVELOPMENT — LEADERS’ AGREEMENT**

At the centre of the change in culture required to deliver continuous improvement in our organisation is the development of a Leaders’ Agreement. The Leaders’ Agreement sets out a series of expected behaviours of staff in leadership roles as well as articulating what the organisation will do to support leaders to create this new, dynamic change culture.

We have worked to engage over 1,000 staff, patients and visitors to develop the content of our agreement. This will be rolled out across our organisation through a series of workshops and interactive sessions throughout summer 2017.

**EMERGENCY SERVICES REDIRECTION**

In July we introduced a new trial – the Emergency Department Redirection at Queen’s Hospital. Its purpose was to try and change the way people access emergency care so the hospital’s ED team can focus on those patients with life threatening illnesses or injuries who really need their help and expertise – which is what the ED is really for.

We ensured that all patients arriving at the ED were seen by a doctor (either a GP or consultant), to assess their condition and give advice about where to go to get the appropriate care they need – such as self-care from a local pharmacy, to their GP, or to be seen within our urgent care centres.

After a successful trial period, this has become our standard operating practice at Queen’s Hospital. We are currently redirecting between 60 and 90 patients a day – that’s over 20,000 a year.

We facilitated many visits throughout the year from colleagues at NHS England, NHS Improvement, from other trusts and the Department of Health to explore our experiences and share our learning.

**OUTPATIENTS**

Around 14,000 people visit our outpatient departments every week – more than 70,000 a year. We also handle around 6,000 telephone calls to our appointments centre each week. We know that waiting for an appointment can be frustrating, so we have continued to improve our outpatient areas. We have introduced a dedicated children’s waiting area in Queen’s, to provide a better environment for children, and a dedicated waiting area for ophthalmology, to provide better seating.

We undertake regular walkabouts, led by the Matron and Patient Experience team, to take feedback from patients. We have also taken a more proactive approach to communicating the impact and costs of patients not attending appointments, to try and limit the numbers of “did not attend”.

We have updated most of our leaflets and supporting literature to make it clearer and easier to understand, and have developed our service to better cater for those patients with learning disabilities, to make their visits less anxious occasions.

**CAPITAL INVESTMENT**

As a result of our (and other trusts’) success with similar approaches, the Department of Health invited applications from trusts to bid for capital funding to invest in key changes to facilitate this new way of working.

We prepared a bid which set out the key changes we would seek to make to the layout and configuration of the ED at Queen’s. While the bid had not been announced as of the year end, we are confident that we will be able to secure funds to make significant changes and improve the service we provide to patients.

**ED STAFFING**

Over the course of the year we have introduced autonomous clinical practitioners to support our medical staff; increased the number of doctors and nurses in the ED by 25 posts and increased our consultant cover in the ED to 24 hours a day, seven days a week.

Overall, despite the increased numbers of people presenting, the number of people who were admitted to a hospital bed has decreased, as we (and partners in the local health economy) are able to treat more people in their own homes. Our focus on ambulatory care has been particularly successful in this way.

We continue to work with our primary care colleagues to encourage people to use services more appropriately – utilising pharmacists, GPs and urgent care centres to get the right care in the right place.

**CONSTITUTIONAL STANDARDS**

**FOUR HOUR TARGET AND ED PERFORMANCE**

There has been a continued focus on improving the experience for patients in our Emergency Departments (EDs) this year, despite the ongoing challenge across the NHS of ever-increasing pressure on emergency services.

As was seen across the country, attendances at our EDs have significantly risen in recent months, and that has had a huge impact on our performance.

In the last quarter of the year we saw attendances up 20% on 2015/16 - that’s 4,000 extra people a month coming through the doors of our EDs.

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

Although we are disappointed at this outcome, we know that much of the hard work this year in our emergency departments was innovative, creative, and most importantly, effective, in terms of providing the right care for patients, while easing the pressure on our services.

One particular approach to handling patients self-presenting in our ED’s has now been adopted nation wide as good practice.

**THE CQC CITED OUR NEONATAL AND COMMUNITY TEAMS IN PROVIDING BABIES WITH OXYGEN HOME THERAPY WHICH “SIGNIFICANTLY IMPROVED THE QUALITY OF LIFE FOR FAMILIES”**
Referral to Treatment (RTT)
We announced in 2014 that we had identified several issues with our Referral to Treatment reporting, dating back several years. RTT is national guidance which states that patients should receive hospital treatment within 18 weeks of having been referred by their GP.

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

This year has seen us, working hard with our system-wide partners, including our Clinical Commissioning Groups and GPs; make major inroads with the backlog, delivering a large number of additional operations (c.5,000) and outpatient appointments (c.95,000).

At the time of publication, we are around 7% ahead of our recovery trajectory, and we are confident that we will deliver the RTT national standard by the end of September 2017.

Despite the pressure on our EDs, we did not cancel any elective appointments over the winter – we felt it was important to continue to deliver the recovery plan as a top priority.

The comprehensive and robust recovery plan we have implemented has included a number of key workstreams, including:
- Validation of waiting list data
- Outsourcing of patients to independent providers
- Improving our theatre productivity
- Enhancing our resources to treat patients
- Carrying out detailed demand and capacity work
- Implementing processes to manage the demand from GP referrals.

One of the key elements of the recovery programme has been the clinical harm review of patients who have waited more than a year for their treatment.

The experience and expertise we have gained within the organisation and across our local health economy gave us a strong platform from which to host a national conference “And Your Time Starts...Now” in March, where we welcomed more than 70 colleagues from across the NHS to learn from our journey, discuss their own experience and share best practice.

Despite the pressure on our EDs, we did not cancel any elective appointments over the winter – we felt it was important to continue to deliver the recovery plan as a top priority.

Cancer Services
For 2016/17, 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 during 2016-17 with the exception of the 62 day target. Through 2016/17 we have been working to deliver a comprehensive and robust recovery trajectory and cancer action plan, developed with support from the CCGs and NHS Improvement (Intensive Support Team).

The encouraging result of this concerted activity was that for the month of March 2017, we achieved the 62 day target. We will now be working through the next year to maintain this performance for our patients.
BECOMING AN EMPLOYER OF CHOICE

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

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

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

At the end of March our vacancy rate stood at 12.3%. This is still higher than we would like, however we have increased the number of staff we employ.

Our management of recruitment has greatly improved and our ‘time to hire’ staff remains among the best in the country.

These achievements, along with a focus on using internal temporary staffing from our Trust Temps department, means we are less reliant on agency staffing. We know that using our own staff offers better consistency of care and better value for money than using expensive agency staff. During the year our spend on agency staff was 8% of our entire pay bill.

Attendance at work has improved through better support and management of sickness absence. We set a challenging target for sickness absence in April 2016 of 3.2%, and we achieved that figure at the end of year. This is partly due to a range of health and wellbeing initiatives to promote the importance of a healthy workplace and enable staff to keep fit and well for themselves and our patients.

Schemes include rapid access for staff to a physiotherapy service as well as access to mental health support when necessary.

We have also introduced schemes including; cycle to work healthy eating, walk to work week, teaming up with a personal trainer and introducing a Healthy Hike. One significant scheme introduced was our financial wellbeing support. Coupled with offering a range of employee benefits, these have supported our efforts to engage and retain staff.
CULTURE
Our Organisational Development (OD) strategy was approved by the Board in 2016, setting out our four strategic priorities: Culture, Leadership, People and Organisational Design.

Underpinning these priorities are our PRIDE values and commitment to equality, diversity and inclusion.

Key deliverables from this programme of work were:

- Launch and delivery of Leadership The PRIDE Way, a four-tiered leadership and management programme
- Launch of an Inclusion Steering Group and Ethnic Minorities Network to champion diversity and inclusion
- Coaching and mentoring training to establish networks of practice
- With our people, development of a Leaders’ Agreement, a behavioural framework born out of our partnership with VMI and building on our PRIDE values.

We will continue to focus on and prioritise developing leadership and management capability and improving our people’s experience at work with the aim of improving retention in the organisation. While we have had success in recruiting both to clinical and non-clinical roles, this has been negated by retention challenges once we hire staff.

STAFF SURVEY
More than 2,500 staff returned a completed questionnaire, giving an improved response rate of 43%. This makes us comparable with the average for all acute trusts in 2016, a great improvement after being below average in 2015 and in the lowest 20% in 2014, 2013 and 2012.

Our overall engagement score improved and is now in line with the national average – this is an indicator of staff motivation, advocacy and involvement in the organisation. We found 86% of staff felt satisfied with the quality of the care we’re able to provide to patients. That’s 30% more than in 2013.

95% of staff confirmed they know how to report unsafe clinical practice, up from 83% in 2013; and 92% were aware of our PRIDE behaviours, with 86% stating they were able to demonstrate these in their work day-to-day.

Our clinicians said that training and development has helped them to stay up to date with professional requirements, helping to provide better patient care and experience. Overall, staff are more confident, able to raise concerns and there are improvements in the communication and feedback from senior managers.

This year’s survey has illustrated a continuing issue which we are determined to tackle. Staff are continuing to experience harassment, bullying, abuse or discrimination. While this is most frequently from patients, relatives or the public, it is also a concern that some staff have reported these behaviours from each other.

While the picture has improved since last year, we remain below the acute trust average, so this is an area of concern to us.

We take a zero tolerance approach to this kind of behaviour, and we will be taking steps to support our staff as they continue to do their very best in demanding circumstances.

OUR VOLUNTEERS
We have taken some big steps forward this year. Thanks to efforts to promote volunteering both internally and externally, we now have over 300 volunteers involved with our Trust providing more than 23,000 hours of volunteering. We continue to receive lots of enquires about volunteering.

Some of our achievements this year include developing a new volunteers’ guide which gives a step by step guide to volunteering; relaunching the Mealtime Assistant role to support our elderly patients; opening a new information desk at King George Hospital; and boosting our numbers of staff volunteering too.

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

EDUCATION, TRAINING, LEARNING AND DEVELOPMENT
In 2016/17 we had three key priorities:

- Ensuring core skills compliance for the safe delivery of care
- Providing access to education through apprenticeships and job preparedness programmes, and;
- Improving the learning environments for trainees.

Improving our resuscitation training has been a key area for us this year. We identified a learning need in this area, so have doubled our training capacity in resuscitation. The successful accreditation of Queen’s as a resus training site also allowed us to deliver Advanced Life Support training in-house.

We have continued to develop online modules and e-learning through our BEST online system, which has helped us identify and address non-compliance.
This year we have done more to create conducive learning spaces by streamlining our teaching methods to increase the work based learning elements where staff learn close to the patients. We have concentrated on Doctors in Training and used National Training Survey results to target our improvements.

**ESSENTIAL SKILLS TRAINING (STATUTORY AND MANDATORY TRAINING)**

It is vital that staff are up to date with their Essential training so that we can be sure they provide the highest levels of care and safety for our patients.

We need to continue our focus on ensuring that all of our staff are fully compliant with their training. We now provide many e learning programmes making it far easier for people to complete their training via the BEST learning management system. This has also been of benefit to the compliance of Trust Temps (our in-house agency).

**APPRENTICESHIPS**

This year we have continued to encourage people to consider careers in the NHS. We have visited nine local schools promoting a wide range of careers in the NHS.

We have provided more than 225 work experience placements to local students, along with bringing 15 new apprentices into work, and supporting 40 substantive staff with further education qualifications.

We also hosted a two-week programme with the Prince’s Trust ‘Get into the NHS’ which saw us welcome 12 young adults to experience what it is like to work in the Health Service.

**NURSING ASSOCIATES PROGRAMME**

We are very proud of our progress in creating accessible career pathways into nursing, midwifery and other professions. Nowhere is this demonstrated more effectively than in our ground-breaking work with Nursing Associates.

We were delighted to host the Minister for Health, Philip Dunne in January to welcome the first cohort of BHRUT Trainee Nursing Associates take their first steps on a two-year journey to becoming the first generation of Nursing Associates.

The role is designed to bridge the gap between existing health care assistants; who have completed a care certificate, and registered nurses.

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

**CELEBRATING OUR PEOPLE**

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

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 find and celebrate the achievements of colleagues wherever we can, particularly via our internal communications channels – the intranet and The Link – and via social media.

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

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 – a total of 85 people this year.

**GUARDIAN SERVICE**

Our innovative Guardian Service, helping our staff to speak up about patient safety concerns, is now into its third year.

We were delighted to welcome Dr Henrietta Hughes, National Guardian, to our Trust earlier this year. Dr Hughes spoke to our staff and paid particular tribute to our written ‘speaking up’ policy, commending on how we help staff feel supported and confident in speaking up, and particularly that our Black and Minority Ethnic staff feel confident – something she asked us to elaborate on externally, so as to share learning and best practice.
Clinical Services Strategy
We were very pleased to be able to launch our refreshed Clinical Services Strategy this year. This has been led by our clinicians, with patient and partner input, to ensure that we can continue to provide the very best care (sustainably) to our patients, now and into the future.

Since our last strategy was published in 2013, we have faced growing demands on our healthcare system. Our doctors, nurses and frontline teams want to provide great care and whilst we (like every other NHS provider) face the challenge of growing communities with increasing healthcare needs, we see this strategy as a key way to meet these challenges, working collaboratively with our patients and partners.

The strategy aims to ensure that our facilities at King George Hospital and Queen’s Hospital are sustained to provide excellent care that will meet the needs of our communities for many years to come.

We remain committed to working with local authorities, patients and health partners to ensure that we support healthcare services across north east London, so that we make sure our patients are seen in the right place for their condition and treated at the right time.

The strategy sets out the key headlines and our ambitions across the full range of our core service areas: maternity, paediatrics, elective care, emergency care, specialist care, out of hospital care, clinical support services and training and research.

Engaging Patients
Launched this year, the Patient Partnership Council (PPC) and its members have become an increasingly vital part of our Trust’s operation. The PPC brings our patient partners and our staff together to help improve the quality and safety of the care we provide.

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

It comprises 10 lay members (including chair/vice chair); clinical staff (including doctors and 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, with a particular focus, each of which having a dedicated patient partner ‘lead’ on:

- emergency care
- inpatients and outpatients areas
- care of our vulnerable patients including elderly and those with learning disabilities
- children and young people
- care of long term conditions
- maternity care

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

Working in Partnership
- Updating our clinical services strategy
- Developing services in line with strategy
- Improving stakeholder engagement
We have made particular effort to engage with young people, and we partnered with both Havering VI Form College and Barking & Dagenham College to get feedback from hundreds of students, building on our first event with Redbridge Sixth Form College last year.

Their views on the care we provide help us to understand what is important to the younger generation and are invaluable as we design and improve services.

The sessions were also extremely valuable for giving us a platform to promote public health, introduce us to students as a prospective employer, as well as highlighting opportunities with apprenticeships.

**STAKEHOLDER ENGAGEMENT**

We have strengthened our relationships with partners and stakeholders this year. Our Local Representatives’ Panel continues to meet regularly, giving the opportunity for dialogue and engagement with members including Healthwatch and local councillors. We have continued to hold regular meetings with our MPs to keep them fully informed.

Our stakeholder e-newsletter was launched this year and is already a valuable channel of information.

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

We have routinely facilitated access to our hospitals via structured visits (average of more than two a month) so that local and national stakeholders, from both a health and policy perspective, can get a better idea of how we operate and the realities and challenges which face us.

Amongst others, we have welcomed: Jeremy Hunt, Secretary of State for Health; Philip Dunne, Minister of State for Health (twice); Ed Rose, Senior Adviser to the Chair, executive of NHS England; James Friend, Special Adviser to the Secretary of State; Dr Henrietta Hughes, National Guardian.

Our relationships with the media have improved, as we have concentrated on improving our responses to requests, with support from across the organisation. This has been shown by our improved percentages of favourable coverage, and the reduction in numbers of FOI requests from journalists, as we increasingly try to manage these through the media team, as we should.

**LISTENING EVENTS**

We have continued to build links with our local population with a series of listening events.

We have made public efforts to engage with young people, and we partnered with both Havering VI Form College and Barking & Dagenham College to get feedback from hundreds of students, building on our first event with Redbridge Sixth Form College last year.

Their views on the care we provide help us to understand what is important to the younger generation and are invaluable as we design and improve services.

The sessions were also extremely valuable for giving us a platform to promote public health, introduce us to students as a prospective employer, as well as highlighting opportunities with apprenticeships.

**WORKING WITH GENERAL PRACTITIONERS**

2016/17 has seen good progress in engagement with our local community of GPs. The GP Helpdesk operated by our GP Liaison team received nearly 400 calls of which 94% were resolved at the year end, and 75 patients had their cases escalated and dealt with more swiftly by the Trust as a result of this support.

Our staff now routinely attend all Local Medical Councils. Of the 137 GP practices across our patch, we have categorised 98 as ‘engaged’ – either through face-to-face meetings, or regular telephone/email contact. We have also introduced a dedicated GP e-newsletter – GP Connect – to compile and summarise key information – which is well-regarded. We have run a series of education events throughout the year on key topics for the local GP community, which have been extremely well supported.

GP Liaison helped drive through five of the six requirements for hospitals in the 2016/17 NHS Standard Contract, to play our part in alleviating the pressure where we can on GP colleagues.

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

Our Trust has been sending discharge summaries to all GP practices electronically via email since February 2016 and this January 2017 we commenced the electronic distribution of clinic letters, phasing out the use of fax.

We have also made significant steps to resolving some of the system-wide challenges around access to Cyberlab and other IT platforms which both the Trust and partners in Primary care must access. This continues to be an area of priority.

Our Trust has been sending discharge summaries to all GP practices electronically via email since February 2016 and this January 2017 we commenced the electronic distribution of clinic letters, phasing out the use of fax.

**ENGAGING WITH THE PUBLIC**

The launch of our new website at the beginning of the year was a major step forward in improving the accessibility of information for our patients and public.

Our website is a critical channel for people to find information about every aspect of our Trust, and the new design provides much easier navigation, saving everyone time and effort.

The new site offers improved two-way communications with patients, in a bright, colourful and friendly design based on our PRIDE communications with patients, in a bright, colourful and friendly design based on our PRIDE values and style. It is fully accessible in terms of design and it is “responsive”, so works on smartphones and tablets, detecting the size of the device and automatically resizing to fit the screen (which is important as mobile use has hugely increased). We have improved the navigation and search so visitors can find the information they need more quickly.

We have also included a number of new sections to provide openness about our performance, across the organisation.

We have seen an increase of 37% in our unique visitors – over 927,000 this year – and a total of nearly 4 million page views (an increase of 20% on the previous year).

**THE EAST LONDON HEALTH & CARE PARTNERSHIP (SUSTAINABILITY AND TRANSFORMATION PLAN)**

Our Trust is fully committed to continuing to work closely with partners across east London in the delivery of the Sustainability and Transformation Plan (STP) for our area.

Our population continues to grow rapidly, and there are undoubtedly pressures on all providers, including ourselves, as well as local GPs, mental health and community services, to continue to provide sustainable and high quality services into the future.

The plan which was drafted this year describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plug the shortfall in funding of services.

It proposes improvements across the whole of east London, such as the availability of specialist clinical treatments, how buildings and facilities could best be used, particularly those in need of renewal, and the introduction of digital technology to enhance services for local people.

The overall aim is to make local health and care services sustainable by 2021, but the Partnership is looking further ahead for longer-lasting solutions. The involvement of councils, for example, enables the vision for better health and care provision to be aligned with the development of housing, employment and education, all of which can have a big influence. Long term prevention of ill health is also key.
This year we continued to meet in-year financial targets despite increased financial pressure across the NHS.

For the third consecutive year, we hit our agreed control total, achieving a reported deficit of £10.9m, inclusive of all Sustainability and Transformation Funding (STF), against a plan of £11.9m. Our accumulated deficit now stands at £481m.

This included £21.0m received for STF, and savings of £20.7m from our Quality and Cost Improvement Programme (QCIP). Total income received grew to £558.0m, including £499.3m from direct patient care activities. Final full year positions were agreed with our primary commissioners.

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

For 2017/18 our agreed financial target will be to achieve a surplus of £1.3m. If we can deliver this, it would represent a significant step forwards, recognising our responsibility and duty to break even against an outlook of continued financial pressure in the local health economy.

As we worked to deliver our improvement plan, we made significant progress in improving financial control to support our aim to deliver great care to our patients.

As well as expanding our overall permanent workforce, we have improved our use of temporary staff by using our own temporary or part-time workers through Trust Temps, which we have promoted heavily this year. We also only use approved agencies to supply staff, working within the price limits set by the Department of Health for agency cover.

We have been part of the first cohort of trusts working together to deliver better value for money outlined by Lord Carter of Coles in areas including procurement, staffing, estates and medicines. This has helped to identify long term benefits and contribute to more than 30% of our QCIP savings.

The Quality and Cost Improvement Programme continues to provide a driving force towards the better use of our estates and facilities, better contracting for IT services, and more automation of our stock management and printing services.

**CAPITAL INVESTMENT**

This year, we invested more than £17m in capital items, focusing on delivering our improvement plans, our IT strategy, replacing and expanding our medical equipment and improving our estate and procurement. This included a major refresh of medical equipment as part of the Managed Equipment Service at Queen’s Hospital. This is where the money was spent:

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

**FINANCIAL OUTLOOK**

Our 2017-18 plan is to break even and achieve financial sustainability, and we will work towards that. This will be supported by work across the local health economy as part of the Sustainability and Transformation Plan, further implementation of Lord Carter’s proposals of the Model Hospital, our on-going commitment to service improvements and delivery of future Quality and Cost Improvement schemes.
PERFORMANCE ANALYSIS

OUR PERFORMANCE REPORT

The Care Quality Commission report has given a very helpful yardstick or benchmark against which we can continue to measure both our performance and our continued improvements.

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.

I am particularly pleased that we have managed to recruit more permanent staff, and that we have met our in-year financial targets for the third consecutive year. These are both very positive outcomes.

Cancer pathways remain a challenge that we are committed to tackling. Against a backdrop of ever-increasing numbers of GP referrals, we have worked with our primary care colleagues to look closely at all of our cancer pathways to see where they can be streamlined.

We are introducing one-stop clinics, so that patients can have their diagnostic tests before, or at the same time, as their first outpatient appointment to speed up the process.

A trajectory for improvement has been agreed with the Clinical Commissioning Groups and NHS Improvement, and we are meeting those revised targets. This resulted in good progress throughout the year, and hitting the 62 day target in March was a major achievement. The next objective will be for us to sustain this level as we move forward.

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

This year has been a difficult year in terms of delivery against the emergency access target, but this trend has been seen across the NHS.

We still have considerably more work to do with our partners to improve the situation so that patients are seen and treated as quickly as we would like.

We have seen an enormous rise in demand in our emergency departments, and will be looking at ways of encouraging people to access services more appropriately for their needs. Our redirection work (see elsewhere in this report) has played a key role, and we are committed to continuing this in the future.

Our recovery performance for those people waiting for elective treatment (RTT) has been one of the most positive stories of the year. The situation that we found ourselves in was not acceptable for our community, however, the last year has seen a transformation in the picture.

From over 1,000 people waiting for more than a year, we are now down to single figures. At the time of writing, we are at 87% and ahead of the agreed trajectory to return to the national standard of 92% of patients being seen within an 18-week timescale by the end of the summer.

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

Considerable work is also underway to reduce the number of healthcare – acquired infections we have recorded. Our performance worsened this year, and we are escalating actions to rectify that by re-training staff and raising awareness across the organisation to drive home the critical messages about reducing the risk of infection.

Jeff Buggle
Acting Chief Executive

OUR PERFORMANCE

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

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

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

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

We have the following assurance measures for our performance reports:

• We produce a series of monthly data quality reports against our performance data and test data completeness and timeliness.

We have developed a series of validation rules to test the validity of data that has been completed.

We have a data assurance team within data quality who undertake regular sampling of data to confirm its accuracy.

We have an annual risk assessment of data returns to identify what risks may exist against a new risk framework.

We ensure that all mandatory returns are produced from source data, by a trained professional from the information department.

We ensure that a set proportion of validations 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.

<table>
<thead>
<tr>
<th>PERFORMANCE</th>
<th>THE STANDARD</th>
<th>OUR RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency access</td>
<td>95% of all patients attending our Emergency Departments to be treated, admitted or discharged within a maximum of four hours</td>
<td>Not achieved: 85.7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>% of our mothers-to-be given one-to-one care in active labour</td>
<td>Achieved: 100%</td>
</tr>
<tr>
<td>Cancer: urgent referrals</td>
<td>93% of our patients to be seen in two weeks following an urgent referral from their GP</td>
<td>Achieved: 95.2%</td>
</tr>
<tr>
<td>Cancer: 31 days</td>
<td>96% of our patients to have a diagnosis and first treatment within 31 days of the decision to treat</td>
<td>Achieved: 98.7%</td>
</tr>
<tr>
<td>Cancer: 62 days</td>
<td>Target of 85% of patients receiving first treatment from the date of GP referral</td>
<td>Not achieved: 74%</td>
</tr>
<tr>
<td>Infection control: C. diff</td>
<td>No more than 30 cases</td>
<td>Achieved: 29</td>
</tr>
<tr>
<td>Infection control: MRSA</td>
<td>Zero cases of MRSA bacteraemia</td>
<td>Not achieved: 7</td>
</tr>
</tbody>
</table>
We have a series of action plans relating to carbon and energy savings, waste reduction and recycling water conservation, sustainable procurement, promoting green travel and behaviour and culture change.

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

Some key achievements/focal points over the past year include:

- We achieved 5% carbon savings (1,167 tonnes of carbon) against 2015/16, and again secured an exemption on UK CRC Tax (which equates to c.£250,000 saving annually)
- We now recycle over 51% of all our waste. Food waste recycling has increased by 7% more than in 2015/16 and 28% more than in 2014/15
- To encourage more people to cycle to our hospitals, we increased cycle parking capacity by 40% across the estates and installed free to use bike pumps for staff, visitors and public
- We successfully secured external funding from the London Borough of Havering and London Borough of Redbridge to implement and enhance Cycle to Work initiatives. Staff can now use a revised salary sacrifice scheme for Cycle to Work
- We now recycle over 51% of all our waste. Food waste recycling has increased by 7% more than in 2015/16 and 28% more than in 2014/15
- To encourage more people to cycle to our hospitals, we increased cycle parking capacity by 40% across the estates and installed free to use bike pumps for staff, visitors and public
- We successfully secured external funding from the London Borough of Havering and London Borough of Redbridge to implement and enhance Cycle to Work initiatives. Staff can now use a revised salary sacrifice scheme for Cycle to Work
- We provide live TfL bus information on display on dedicated large screens in the atria of both hospitals
- We have contributed to the TfL consultation to re-route Bus Route 5, to provide a further route into Queen’s Hospital. We are hopeful that TfL will bring this forward over the coming year.

SUSTAINABILITY
We take our commitment to sustainability seriously. This is driven in no small part by the UK Government’s target to cut carbon emissions by 80% by 2050, and the NHS Carbon Reduction Strategy 2020, which requires every NHS organisation to have a plan to work towards the reduction target.

We see clear connections between doing things more sustainably to save the environment or to save money, and also to educate and encourage our staff and patients to make sustainable choices – such as how they access our hospitals – so that there is a lower impact, as well as realising health and wellbeing benefits.

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

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

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

Financial pressures could also impact on performance, although we have Quality and Cost Improvement Programmes in place which are helping to mitigate that risk.

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

While we have seen real improvement in recruitment, we face on-going challenges in attracting and retaining permanent staff, which means that we are still using more bank and agency staff than we would like, which can impact performance. The launch of a significant nursing recruitment campaign toward the end of the year showed very positive initial results and we look forward to this bearing fruit this coming year.

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SECTION TWO: OUR ACCOUNTABILITY REPORT

This section of the Annual Report focuses on our governance, providing information about the legal status of our Trust and, the processes and structures by which we maintain our commitment to good governance.
Corporate Governance Report, 2016/17

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 2000/143). As an NHS Trust, it is governed by the NSH Act 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 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 leadership of our Board. She 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. She 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

One of the roles of NSH is to appoint or re-appoint the Chairman and Non-Executive Directors (NEDs). One new Independent NED, Mr Tom Phillips was selected during 2016/17 and took up post on 1 April 2017. He replaces Mr Rob Whiteley who resigned on 30 September 2016 to take up his appointment as Chair of the North East London Sustainability and Transformation Plan (STP). At the end of the year, four NEDs were considered independent in character and judgement using the criteria for independence listed within the UK Corporate Governance Code. The Chairman was considered to be independent on her appointment in February 2014.

There were no substantive executive directors appointed during 2016/17 but in order to maintain strong leadership during extended absences and provide support to the Board, the following appointments were made: Jeff Buggle as Acting Chief Executive on 14 March 2017, Steve Collins as Acting Director of Finance and Performance on 14 March 2017 and Anne Robson as Interim Director of People and Organisational Development on 1 February 2017. From 21 April 2017, Dr Magda Smith became Acting Medical Director.

As with all staff, new directors receive a full, formal and tailored induction on joining the Board. The Board ensures that directors, especially NEDs, have access to funded, independent professional advice. This is facilitated through the Trust Secretary. The availability of independent external sources of advice is made clear at the time of appointment. A full time Trust Secretary has been in place since June 2016.

In addition to the Board of Directors, the Board has appointed four NED Advisors who provide additional support and capacity to the Chair and Chief Executive by chairing Consultant Interview Panels, HR Hearings and Appeals. They are paid the same as the NEDs and during 2016/17 they have been invited to attend Trust Board meetings and Sub-Committee meetings as follows:

- Sandra Malone – People and Culture Committee
- Jonathan Steiner – Quality Assurance Committee, Audit Committee
- Mehboob Khan – Quality Assurance Committee, Audit Committee, People and Culture Committee
- George Wood – the Chair of the Charitable Funds 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

This will be even more important as we seek Special Measures and work collaboratively with local partners to support the ambitions of the East London Health and Care Partnership (which is the Sustainability and Transformation Plan that covers north east London). This plan describes how we will improve the way in which we deliver health and social care to patients across our communities. In doing so we will meet the demands of our growing population and ensure patients receive the very best care now and into the future.

The Trust has maintained its significant efforts during 2016/17 to improve its corporate governance framework through:

- Continuing to drive improvement actions following the strategic governance review in 2015 supported by the Good Governance Institute, embedding a system of governance and risk management meetings at both departmental and divisional levels across core services.
- Establishing the Improvement Portfolio in August 2016 to sustain the improvements already made, and to provide a framework for the way we monitor improvements, to ensure we keep a dedicated focus on quality of care
- Further improving engagement with external stakeholders (Local Authorities, CCGs, patients, Community Groups and staff)
- Implementing clearer leadership and investing resources into improving clinical governance structures and risk management which was commended by the Care Quality Commission
- Further development of the Board Assurance Framework (BAF) to manage risks and deliver objectives in conjunction with ongoing board development
- Development of the Trust’s Operating Plan for 2016/17 and 2017/18 with reference to priorities identified by NSH in the Shared planning guidance for NHS trusts.

During the year there has been a continued focus on stabilising the Trust and its performance delivery culminating in a positive CQC report and our exit from Special Measures. Looking forward to 2017/18, we will persist in our efforts to deliver and sustain the best quality of service to our patients which is our primary objective.

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 joint committee. During 2016/17 the Trust further embedded its new management structure and refined its committee structure. The Committees of the Board are described fully in the Governance Statement on page 68.

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 eleven monthly meetings in public. The Scheme of Reservation and Decision details what types of decisions are to be taken by the Board and which decisions are to be delegated to management and the Committees of the Board.
ATTENDANCE

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

*The Terms of Reference for the Quality Assurance Committee requires three Non-Executive Directors. The Trust Chairman is invited to attend any of the meetings.

The values shown are the number of attendances against the number of meetings held during the year that the director was eligible to attend. Where there is no entry, this means 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.

The Board has a well-established Audit Committee comprising independent NEDs. The Audit Committee supports the Board by critically reviewing governance 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 2016/17 included:

- Review of the Trust’s Quality Account before approval by the Trust Board
- 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
- 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 meets with auditors without officers present as part of established good practice.

Audit Committee members met as the Trust Auditor Panel in 2016 to recruit and select Trust External Auditors as of 1 April 2017. KPMG LLP was appointed in September 2016.

**TABLE 1**

Directors’ attendance at meetings: 2016/17

<table>
<thead>
<tr>
<th>Non-Executive Directors</th>
<th>Trust Board</th>
<th>Audit</th>
<th>Finance and Investment</th>
<th>Remuneration / Terms of service</th>
<th>Quality Assurance</th>
<th>People and Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Maureen Dalziel</td>
<td>11/11</td>
<td></td>
<td>9/11</td>
<td>3/3</td>
<td>4/11*</td>
<td></td>
</tr>
<tr>
<td>Dusty Amroliwala</td>
<td>9/11</td>
<td>1/1</td>
<td></td>
<td>2/3</td>
<td>9/9</td>
<td></td>
</tr>
<tr>
<td>Mark Lam</td>
<td>9/11</td>
<td>2/5</td>
<td>7/11</td>
<td>2/3</td>
<td>3/3</td>
<td></td>
</tr>
<tr>
<td>Joan Saddler</td>
<td>8/11</td>
<td></td>
<td></td>
<td>2/3</td>
<td>7/9</td>
<td>2/3</td>
</tr>
<tr>
<td>Eric Sorensen</td>
<td>11/11</td>
<td>5/5</td>
<td>11/11</td>
<td>3/3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prof Anthony Warrens</td>
<td>8/11</td>
<td></td>
<td></td>
<td>2/3</td>
<td>1/9</td>
<td></td>
</tr>
<tr>
<td>Rob Whitteman</td>
<td>3/4</td>
<td>3/3</td>
<td></td>
<td>0/0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Executive Directors</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Matthew Hopkins</td>
<td>10/11</td>
<td>9/10</td>
<td></td>
<td>7/9</td>
<td>2/2</td>
<td></td>
</tr>
<tr>
<td>Jeff Buggie</td>
<td>10/11</td>
<td>9/11</td>
<td></td>
<td>2/9</td>
<td>0/3</td>
<td></td>
</tr>
<tr>
<td>Kathryn Halford</td>
<td>10/11</td>
<td>5/11</td>
<td></td>
<td>9/9</td>
<td>3/3</td>
<td></td>
</tr>
<tr>
<td>Dr Nadeem Moghal</td>
<td>7/11</td>
<td>6/11</td>
<td></td>
<td>7/9</td>
<td>2/3</td>
<td></td>
</tr>
<tr>
<td>Steve Russell</td>
<td>6/6</td>
<td></td>
<td></td>
<td>4/4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jason Sez</td>
<td>10/11</td>
<td>9/11</td>
<td></td>
<td>9/9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deborah Tarrant</td>
<td>7/11</td>
<td>0/8</td>
<td></td>
<td>2/9</td>
<td>2/2</td>
<td></td>
</tr>
<tr>
<td>Sarah Tedford</td>
<td>11/11</td>
<td>9/11</td>
<td></td>
<td>4/9</td>
<td>2/3</td>
<td></td>
</tr>
<tr>
<td>Anne Robson</td>
<td>0/1</td>
<td>0/1</td>
<td></td>
<td>0/1</td>
<td>1/1</td>
<td></td>
</tr>
<tr>
<td>Steve Collins</td>
<td>1/1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The Terms of Reference for the Quality Assurance Committee requires three Non-Executive Directors. The Trust Chairman is invited to attend any of the meetings.*
Maureen Dalziel was appointed chair in February 2014. A qualified doctor and public health expert, Maureen has held a number of CEO and senior medical roles in regulatory, provider, research and commissioning organisations in the NHS.

Maureen is on the Board of Intensive Care National Audit and Research Centre - a charity which collects data and conducts health service research into critical care outcomes.

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, a grant-giving trust in Newham, and 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.

Air Commodore Dusty Amroliwala OBE MA MBA FCIPD Independent Non-Executive Director, Chair, Quality Assurance Committee and Remuneration Committee

Dusty Amroliwala joined the Trust in September 2014. His career has included many different sectors. He completed 27 years in the Royal Air Force, where he finished his career as the HMIC’s Director of Defence Diplomacy, moving to senior Director roles in the Home Office and Cabinet Office, then to Deputy Vice-Chancellor at the University of East London, where he was responsible for delivering the key services across this modern University with some 18,000 students (both in London and overseas).

At the end of 2016/17 he was appointed as Chair, North Middlesex University Hospitals NHS Trust.

Mark Lam was appointed in September 2014. A senior corporate executive, Mark has extensive global experience in telecommunications and information technology. He is an executive and chief information officer at Openreach, a BT Group business, and has previously held management positions at Siemens and The Carphone Warehouse.

His experience of global business spans Europe, the USA and Asia, where he has led major contracts and operations.

Joan Saddler OBE 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 PCT.

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 recently completed his term as 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.

Rob Whiteman joined the Trust in July 2014. Chief Executive of CIPFA he was Chair of the Audit Committee until he took up his appointment as independent Chair of the North East London Sustainability and Transformation Plan (STP) Board. An accountant by profession, he previously held chief executive positions at London Borough of Barking and Dagenham, the Improvement and Development Agency and the UK Border Agency, an organisation with 25,000 staff and a £1.8bn budget. He is a well-known commentator and writer on public service reform and modernisation across the public sector.

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

Steve Russell
Deputy Chief Executive, Senior Information Risk Owner (SIRO) to 31 July 2016

Steve Russell was appointed in June 2014 as Deputy Chief Executive and left the Trust on 31 July 2016 when he was appointed Executive Regional Managing Director (London). Steve was on the NHS Top Leaders Programme and has worked in a range of operational and strategic roles in NHS hospitals.

Between 2011 and 2013 he was Chief Operating Officer for South London Healthcare NHS Trust, having come from Northumbria Healthcare NHS Foundation Trust where he was Executive Director of Medicine and Emergency Care.

Dr Nadeem Moghal
Medical Director, Caldicott Guardian

Dr Nadeem Moghal joined us in January 2015. He is responsible for leading and directing our medical workforce, clinical standards, patient safety, and clinical governance.

Prior to joining our Trust, Nadeem was the Director of Strategy and Knowledge Management at George Eliot Hospital in North Warwickshire, where he led the implementation of a transformative and unique paediatric service model and worked with the senior leaders and teams to lead the organisation out of special measures.

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

Kathryn Halford
Chief Nurse

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.

Jason Seez
Director of Strategy and Planning

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

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

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

Deborah Tarrant
Director of People and Organisational Development

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

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

Deborah is President of the Healthcare People Management Association.

Sarah Tedford
Chief Operating Officer

Sarah Tedford joined us as Chief Operating Officer in November 2014 following three years as Deputy Chief Executive at Kingston Hospital NHS Foundation Trust. Sarah started as a nurse in the NHS in 1985 before moving into management and she has held a number of management and senior operational roles.

Prior to joining Kingston Hospital Sarah headed up the National NHS Intensive Support Team, designed to go into trusts that are struggling to achieve their performance targets and help them to understand and resolve their operational difficulties.

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

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

Deborah is President of the Healthcare People Management Association.
### DECLARATION OF INTERESTS

Our Standing Orders require all Board members to declare any outside interests which are relevant and material to their position. A register of all such declarations is maintained and updated on an on-going basis and confirmed at the end of each financial year by the Trust Secretary. The register below is correct as at 31 March 2017 and updates can be accessed from the Trust Secretary.

#### BOARD MEMBERS BETWEEN 1 APRIL 2016 AND 31 MARCH 2017

#### NON-EXECUTIVE DIRECTORS

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Interests</th>
</tr>
</thead>
</table>
| Dr Maureen Dalziel        | Chairman                   | Associate Zenon Consulting 1 Apr 2013 – Sept 2013  
Ian Dalziel Company Secretary, MD Health Consultancy Ltd (2004)  
Board Member, Intensive Care National Audit Research Centre (2004)  
Board member British Pregnancy Advisory Service (2007 – April 2013) |
| Dusty Amrolwalla          | Non-Executive Director     | MD of Synagoo Ltd  
Partner is CEO of the Parliamentary and Health Services Ombudsman  
Chair of Trustees, London Design and Engineering University Training College  
Law member of the Judicial Conduct and Investigations Office (Ministry of Justice)  
Chair of North Middlesex University Hospitals NHS Trust  
Strategic Advisor for VPS Global  
Trustee of Combat Stress (armed forces mental health charity) |
| Mark Lam                  | Non-Executive Director     | Chief Information Officer, Oopenreach, a BT Group business  
Company Director & Company Secretary, Insomnia Consulting Ltd |
| Joan Saddler              | Non-Executive Director     | Director DDC Ltd  
Trustee ADKA Charity  
Ambassador – Mary Seacole Statue Appeal  
Associate Director – NHS Confederation  
Co-Chair of the NHS Equality and Diversity Council  
Member of NHSI Strategic Advisory Group for Workforce  
Race Equality Standard |
| Prof Anthony Warrens      | Non-Executive Director     | Chair of Council London School of Jewish Studies  
Governor and Co-Chair Imperial College, Bury, Hants  
Member: Human Tissue Authority  
Consultant Private Practice at Wellington, BMI Hendon, London Bridge, Princess Grace and the Physician’s Clinic BMI London independent hospitals  
Private medico-legal Practice  
Professor and Dean for Education, Barts and London School of Medicine and Dentistry, Queen Mary, University of London  
Honorary Consultant and (paid) Clinical Director, Education Academy until April 2016 |
| Rob Whiteman              | Non-Executive Director     | Director, CIPFA Business Ltd  
Chair, Barking and Dagenham College |

#### EXECUTIVE DIRECTORS

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matthew Hopkins</td>
<td>Chief Executive</td>
<td>Spouse works for South East Commissioning Support Unit</td>
</tr>
</tbody>
</table>
| Jeff Buggle               | Director of Finance and Performance       | Acting Chief Executive from 14 March 2017  
Partner is a solicitor at the Department of Health advising the Secretary of State for Health (leading on primary care legislation)  
Sister in law is Deputy Chair of Havering Healthwatch |
| Nadeem Moghal             | Medical Director                          | Director at MMC Ltd  
Undertakes private medico and medico-legal work  
Spouse GP in Redbridge |
| Steve Russell             | Deputy Chief Executive until 31 July 2017 | Partner is Executive Director of Delivery and Improvement at St George’s NHS Trust  
Partner is Deputy Chief Executive of Southend University Hospitals NHS Trust |
| Jason Seez                | Director of Strategy and Planning         | Partner employed by NHS Improvement |
| Deborah Tarrant           | Director of People and Organisational Development | Partner is Executive Director of Delivery and Improvement at St George’s NHS Trust  
Partner is Deputy Chief Executive of Southend University Hospitals NHS Trust |
| Sarah Tedford             | Chief Operating Officer                   | No interests to declare                                                                        |
| Kathryn Halford           | Chief Nurse                               | No interests to declare                                                                        |
| Steve Collins             | Acting Director of Finance from 14 March 2017 | Director Flexit Ltd |
| Anne Robson               | Interim Director of People and Organisational Development from 1 February 2017 | No interests to declare                                                                        |
| Claire Pacey              | NHS Improvement Director                  | Husband works for SFR (Electronic Staff Record) (BMA)                                          |
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 2017 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. The Trust has 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 the Trust procurement flows and developing a clear action plan to ensure Modern Slavery is not taking place in any part of its own business or any of its 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.

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 the 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, 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 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 has 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.

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

By order of the Board

Jeff Buggle, Acting Chief Executive
Date: 24 May 2017

Steve Collins, Acting Director of Finance and Performance
Date: 24 May 2017

The Secretary of State for health has directed that the Chief Executive should be the accountable officer to the Trust. The relevant responsibilities of accountable officers are set out in the Accountable Officer’s Memorandum issued by the Department of Health. These include ensuring that:
• there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
• value for money is achieved from the resources available to the Trust
• the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
• effective and sound financial management systems are in place
• annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year
• under the National Health Service Act 2006 (as amended), the trust is required to prepare for each financial year financial statements in the form and on the basis set out in the accounts direction.

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. I confirm that, as far as I am aware, there is no relevant audit information of which the Trust’s auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust’s auditors are aware of that information. I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Jeff Buggle, Acting Chief Executive
Date: 24 May 2017
ANNUAL GOVERNANCE STATEMENT

1. SCOPE OF RESPONSIBILITY

Our Board is accountable for maintaining an effective system of internal control and putting in place arrangements for assuring our organisation’s effectiveness. As Accountable Officer, and Acting Chief Executive, I am responsible for ensuring compliance with our policies and for achieving our aims and objectives. I also have a responsibility to the taxpayers for safeguarding our assets and public funds. I am accountable to our Board and to Parliament (via the NHS Accounting Officer) for the stewardship of our resources.

I acknowledge my responsibilities as set out in the Accountable Officer Memorandum, including the production of statutory accounts, ensuring effective management systems, and regularity and propriety of expenditure.

2. OUR GOVERNANCE FRAMEWORK

Our governance framework and system of internal control helps us to manage risk to a reasonable level; it does not eliminate risk, and it therefore provides reasonable and not absolute assurance of effectiveness. The system of internal control was in place for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Our system of internal control aims to:
- identify and prioritise risks to compliance with policies, and the achievement of our aims and objectives;
- evaluate the impact and likelihood of risks being realised and to manage them efficiently, effectively and economically.

OUR BOARD AND COMMITTEE STRUCTURE

Our board is made up of the Chair and six other Non-Executive Directors (NEDs), the Chief Executive and four executive directors with voting rights, and three further executive directors without voting rights. It is the role of our board to effectively govern our hospitals, ensuring that we provide safe, high quality, patient-centred care within our resources and, in doing so, build public and stakeholder confidence in the services we provide.

During the year the key changes to the composition of the board were:
- Rob Whiteman Non-Executive Director left the board on 30 September 2016 to chair the North East London STP
- Steve Russell, Deputy Chief Executive left the board on 31 July 2016 to take up the role of Executive Regional Managing Director (London) with NHS Improvement.

We have also put in place cover arrangements in year for the posts of Chief Executive, Director of Finance, Medical Director and Director of People and Organisational Development.

Our Board, which met on 11 occasions in public during the year, regularly reviews performance against national standards and regulatory requirements. A summary of performance is included in our Annual Report. 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 challenges we face in meeting these standards and other statutory and regulatory requirements, together with issues identified in the Care Quality Commission (CQC) inspection report published in July 2015, resulted in our Trust remaining in Special Measures.

Significant and sustained actions have been taken to improve the Trust’s governance and the quality and safety of services provided through our Improvement Plan. Progress was closely monitored at our public board meetings. The CQC then reviewed progress in depth in autumn 2016 via a targeted inspection. I am delighted to report that this resulted in Special Measures being lifted in March 2017. The Improvement Plan has now been embedded and developed into a trust-owned Improvement Portfolio which has become part of our ‘business as usual’. This is being integrated into our quality improvement strategy flowing from our partnership with the Virginia Mason Institute.

During the year, the board conducted its annual review of the constitution and its risk appetite.

We have complied with the relevant guidance on Corporate Governance. Of particular note during the year, we have continued to move forward on an independent board and governance review (May 2015) via a focused programme of board development conducted by the Good Governance Institute (GGI). This has provided opportunities for the Board to reflect on priorities, behaviours and working assumptions around key strategic issues.

The board used part of its development programme to reflect on its performance and the need to develop a business cycle that includes sufficient headroom for strategic debate. Development work included a committee effectiveness review which will inform the next scheduled review of the Board Committee terms of reference in quarter 1 of 2017/18. Additionally the effectiveness work identified a need to improve the quality and focus of board papers with a workshop for authors being held in March 2017. The overarching development use programme has supported the board as the trust prepares to move from a focus on special measures to the context provided by the North East London STP. Board development will work in parallel with governance development and in particular will help to make the new cycle of board meetings (bi-monthly business meetings bi-monthly board seminars) work successfully.

The Audit Committee provides our board with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust’s activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. The committee monitors corporate governance such as compliance with standing financial instructions, and the maintenance of the register of interests. It oversees the work programmes for external and internal audit and receives assurance of its independence. The Committee’s terms of reference were subject to routine review in year.

The Remuneration and Terms of Service Committee determines our overall remuneration policy, sets the remuneration, allowances and other terms and conditions of office for executive directors and recommends and monitors the structure of remuneration for senior managers. The terms of reference for this Committee were subject to a planned significant review in 2016/17 in partnership with our legal advisers. I am assured that the new terms of reference are aligned with best practice and have strengthened our governance processes.

The Finance and Investment Committee scrutinises our annual operational and financial plan, long-term financial strategy and major investment decisions. The committee reviews monthly financial performance and identifies the key financial and investment issues and risks requiring escalation to the board. The Committee’s terms of reference were subject to routine review in year.

The People and Culture Committee oversees the development and delivery of our people development and organisational development strategy as well as monitoring progress against targets and objectives. The committee provides a formal reporting forum for workforce and education matters, including attendance at mandatory and statutory training, scrutiny of activity and expenditure (particularly related to temporary staffing), and evaluating progress on compliance with workforce equality and diversity requirements. The Committee’s terms of reference were subject to routine review in year.
The Charitable Funds Committee provides additional assurance to the board that our charitable activities are within the law and regulations set by the Charity Commission for England and Wales. It does not remove from the board the overall responsibility as corporate trustee; it provides a forum for more detailed consideration of charitable matters. The terms of reference for this Committee were subject to a planned significant review in 2016/17 in partnership with our legal advisers. I am assured that the new terms of reference are aligned with best practice and have strengthened our governance processes.

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 sub-committee agendas on escalation has helped ensure systematic consideration by all sub-committees about emerging key risks the board needs to consider.

### Risk Management and Assurance

We have a Risk Management Policy and Strategy which applies to all our staff. At the strategic level, our Board Assurance Framework (BAF) enables us to assess and evaluate the principal risks to achieving our strategic objectives. Acting on the recommendations of auditors, the BAF is a live document refined and updated to provide a current view around the risks to our meeting strategic objectives, and the appropriate controls, assurances, gaps in controls and assurances and planned actions. The board and the audit committee maintain close oversight and scrutiny of the BAF, with specific risks assigned to executive directors and assurances being monitored by the board and sub-committees. This process has been refined during the year with the support of our internal auditors (RSM) and external auditors (KPMG), including the development of crisper risk descriptions and a high level summary.

In terms of the management of operational risk, there is a robust risk management process that we are continually strengthening and refining. Whilst the management of risk is everyone’s responsibility, the Chief Executive and executive directors are accountable for managing risks within the scope of their management responsibilities as defined in the table below.

### TABLE 2

<table>
<thead>
<tr>
<th>ROLE</th>
<th>RISK RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Designated Accountable Officer and overall accountability for our risk management</td>
</tr>
<tr>
<td>Deputy Chief Executive</td>
<td>Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks to 23 July 2016, at which point responsibility transferred to the Director of Finance and Performance</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Caldicott Guardian and joint lead on the management of quality and patient safety</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>Joint lead on the management of quality and patient safety</td>
</tr>
<tr>
<td>Director of Finance and Investment</td>
<td>Financial control and investment risks. Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks from 01 August 2016</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Risk relating to the delivery of clinical services</td>
</tr>
<tr>
<td>Director of People and Organisational Development</td>
<td>Workforce and organisational development risks</td>
</tr>
<tr>
<td>Director of Planning and Governance</td>
<td>Risks relating to the development of strategy and planning</td>
</tr>
</tbody>
</table>

Assurance around operational risks is provided to our board through both the management route, direct reports to the board and from additional scrutiny from sub-committees.

Audit Committee advises the Trust board on risk management. The committee is constituted to meet five times a year, with additional meetings if felt necessary, and scrutinises the integrity of the Trust’s risk management processes and the Board Assurance Framework.

The Quality Assurance Committee meets monthly as the high level committee which scrutinises quality assurance and specific risks on behalf of the board.

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

A training and development programme is in place to enable staff at all levels to fulfill their responsibilities and work with those systems to minimise 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 PPI 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, Local Representatives’ Panel and the National Patient Survey Programme and the results of real time feedback on wards and departments, complaints, compliments and via social media.

Our Local Counter Fraud service ensures that the annual counter fraud plan work programme minimises the risk of fraud within our Trust and is fully compliant with NHS Protect Counter Fraud Standards for providers.

Preventative measures include reviewing our policies to ensure they are, as far as possible, fraud-proof, using intelligence, best practice and guidance from NHS Protect.

Detection exercises are undertaken where a known area is at high risk of fraud and the National Fraud Initiative (NFI) data-matching exercise is conducted biannually. 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.

### 4. NHS Pension Scheme

As Accountable Officer, I am responsible for reviewing the effectiveness of our system of internal control.
5. REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

As Accountable Officer, I am responsible for reviewing the effectiveness of our system of internal control.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance and on the controls reviewed as part of the work that Internal Audit has undertaken. The Head of Internal Audit Opinion concludes that 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 fit for purpose.

Our internal auditors, RSM, have completed a number of audits in the year and the Trust has achieved a 92% implementation rate for follow up actions identified from previously completed audits.

The outcome of the year’s internal audit programme is summarised below:

### ASSIGNMENT

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Opinion Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning from Patient Safety Indicators</td>
<td>Partial Assurance</td>
</tr>
<tr>
<td>Consultant Job Planning</td>
<td>Partial Assurance</td>
</tr>
<tr>
<td>Safeguarding – Referrals Process</td>
<td>Emergency Department – Partial Assurance</td>
</tr>
<tr>
<td></td>
<td>Paediatrics – Reasonable Assurance</td>
</tr>
<tr>
<td>Financial Planning and Reporting</td>
<td>Substantial Assurance</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Audit</td>
<td>No assurance</td>
</tr>
<tr>
<td>Clinical Audit Follow Up</td>
<td>Reasonable Progress</td>
</tr>
<tr>
<td>Service Line Reporting</td>
<td>Advisory</td>
</tr>
<tr>
<td>Research and Innovation Department</td>
<td>Advisory</td>
</tr>
<tr>
<td>Review</td>
<td></td>
</tr>
<tr>
<td>Cyber Security – top 20 controls</td>
<td>Reasonable Assurance</td>
</tr>
<tr>
<td>Key Financial Controls</td>
<td>Reasonable Assurance</td>
</tr>
<tr>
<td>Delivery of Safer Staffing Levels</td>
<td>Partial Assurance</td>
</tr>
</tbody>
</table>

Key findings of this programme are set out below.

I am pleased to report that at the November 2016 Audit Committee RSM presented their report on Financial Planning and Reporting (including QCPs) which RSM noted provided “substantial assurance for this area with no areas of weakness identified.” This represents a very positive outcome for the Trust… and… demonstrates a very positive journey with regards to improvements made with the Trust’s overall financial governance arrangements.

Three reports resulted in ‘partial assurance’ relating to: Learning from Patient Safety Indicators, Consultant Job Planning and Safeguarding Referral Process (EDI). Management actions are in place to reach a higher state of assurance.

One ‘no assurance’ report was issued to the Trust, relating to Clinical Audit with the audit “identifying that clinical audit is not embedded throughout the organisation and there is not an effective process in place to ensure that a robust and risk focused clinical audit plan is developed for the Trust”. We commissioned a further Internal Audit review from RSM to provide assurance that the areas of weakness identified as part of the original audit had been addressed. This audit was undertaken in March 2017 and demonstrated that reasonable progress had been made in addressing the areas of weakness identified in the original audit.

The Trust commissioned additional advisory reports from RSM including Service Line Reporting, and a Research and Innovation Department Review and a review on the extent to which SFIs / SOs are complied with. We will use the findings of these reports to enhance our governance systems and processes during 2017/18.

6. FREEDOM OF INFORMATION

We are aware of our responsibilities under the Freedom of Information Act 2000 (FOI). We have a statutory requirement to respond to all Freedom of Information requests within 20 working days. We received 738 cases in 2016/17, with a compliance of 70%. This is a significant increase in volume on 2015/16, which in turn saw many more requests than 2014/15.

Over the past year, FOI reporting and processes have been streamlined focusing on continuously improving our response rates. A weekly report is shared with the Executive Team highlighting cases that have already breached and those that are due for response in the coming week; the aim being to increase the proportion of requests responded to within the deadline.

To support the requirements of FOI and improve an understanding of our responsibilities, FOI training sessions have been co-ordinated with FOI leads from each division/department. In addition, we are working on expanding the data routinely available on our website as part of our publication scheme and our disclosure log.

7. FINANCIAL POSITION

The Trust had a deficit financial plan agreed with NHS Improvement and for the second year running, has achieved its financial target. These targets include; overall control total, External Financing Limit, Capital Resource Limit, and Quality and Cost Improvement Programme. In the year it has consistently delivered against in financial monthly financial requirements. Controls have been further strengthened for management of expenditure, along with improvements in forecasting.

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 Audits (KPMG) work on our annual accounts and local tailored performance management reviews
- Patient and staff surveys and feedback, NHS Litigation Authority and Care Quality Commission assessments, Ombudsman and other sources of external scrutiny and accreditation.

I have been advised on the implications of the result of my review into the effectiveness of the system of internal control by the various committees of the board and most of all by the Audit Committee.

8. QUALITY ACCOUNTS

Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of services delivered. All NHS healthcare providers are required to produce a Quality Account as set out in the Health Act 2009 and supporting regulations. Our 2016/17 Quality Account will:

- Demonstrate how we involve and respond to feedback from patients and the public
- Provide information on the quality of our services to patients and the public
- Demonstrate how we involve and respond to feedback from the public
- Enabling 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 2016/17 priorities
- Provide information on the quality of our services to patients and the public
- Enable us to improve organisational accountability to the public

As Accountable Officer, I am responsible for reporting to the board and external stakeholders over the quality and accuracy of our work. We will also include a review of mortality, as we are expected by NHS England to report our progress in using learning from deaths to inform our quality improvement plans for the 2017/18 Quality Account. This will build on the work of the Royal College of Physicians in developing a methodology to support our process.

The future themes for our 2017/18 Quality Account will extend from the 2016/17 priorities. We have noted the following additional suggested themes which will be further reviewed and tested:

- ‘Patient Experience – discharge’: make explicit reference to ensuring discharges across 7 days
- ‘Patient Experience – bereavement’: expand to cover all end of life care
- ‘Patient Experience’: include how we will work with patient partners
- Make reference to the mortality alerts where we are an outlier
- Include how we work with and support carers
- Include CQUIN delivery
- Include improving the use of clinical audit to improve care
- Include reference to being well-managed
- Make reference to embedding the PRIDE Way as our Trust approach to improvement.

An editorial group led by our Medical Director and Chief Nurse, has been established to, to review and to quality assure the account. The timeline for publication (June 2017) is on track including stakeholder meetings to obtain feedback on progress and planned objectives.

9. COMPLIANCE

Care Quality Commission (CQC)

As described above the Trust has made excellent progress in addressing the key CQC recommendations included within the July 2015 letter (and report) from Professor Sir Mike Richards, Chief Inspector of Hospitals. In autumn 2016 the CQC reviewed progress through a targeted inspection I am delighted that this resulted in Special Measures being lifted in March 2017. The Trust is compliant with CQC registration requirements.

National performance standards

The Trust’s operational performance has continued to improve, but performance was not fully achieved on the national four hour emergency access, the 18 week referral to treatment (RIT) or the 62 day cancer pathway standards. These areas have been vigorously addressed as part of the Trust’s improvement plan. In the run up to returning to report Referals to Treatment (RIT) performance and waiting time data last November 2016, we took a number of steps to reassure our board and external stakeholders over the quality and accuracy of our performance.
waiting time data. This was in line with good practice guidance from NHS England;
• A third party review of data quality
• There is assurance of the continued integrity of the Patient Tracking List (PTL) through training, a review of the access policy, an audit of the completion of outcome status, and a validation strategy and plan in place
• A robust and credible performance recovery trajectory – this included assurance on data quality of waiting lists and was eventually reviewed and agreed by NHS England on February 2017
• Reviews of the governance arrangements related to waiting time data and lists of patients
• Systems in place to ensure oversight of changes that would affect the PTL integrity
• A communications strategy to support the return to reporting as performance data is made public.

We continue to take a number of these steps on a regular basis to provide assurance on the quality of our waiting time data and its accuracy. Alongside these steps we developed a comprehensive validation and data quality strategy which has been overseen by our Chief Operating Officer (COO). We have recruited our own substantive validation team, provided training to our staff and we have worked with external teams to validate and review any data quality issues with our waiting time data.

A number of the key indicators for waiting times data are reviewed weekly through our system-wide RIT Performance Packs and Programme Board. All of our main internal meetings, in particular our board has received reports on the accuracy of our waiting times data and have been cited on the actions we have taken to improve this. We monitor on a weekly basis the validation of our waiting lists. Reports are presented at our weekly Access Board chaired by our Deputy Chief Operating Officer (DCOO) 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.

We provide an indicator to our Chief Operating Officer (COO) and board of the volume of data that has been validated prior to submitting our national returns. Our COO as the senior accountable officer for elective care signs off the monthly returns in line with good governance.

Our elective access policy has been reviewed by a third party – the Intensive Support Team from NHS Improvement.

Our Information and Management Team (I&MT) is also regularly audited by a third party.

We have worked hard to achieve a locally set target of 90% in all Essential Training topics and 95% in Information Governance. We are currently measured against an 85% target in all topics other than Information Governance where there is a national requirement of 95%. Essential Training has consistently been above 90% since August 2016, and for Information Governance the latest figure for staff compliant was 96.2%.

Looking ahead into 2017/18, a revised training needs analysis will be designed and implemented, this will focus on ensuring that all individuals receive an adequate set of essential training topics based on their role in the Trust.

Conclusion
The internal control issues that I have outlined in this statement confirm we have achieved improvements in our system of internal control to help assure compliance of our policies and to ensure we achieve our aims and objectives of providing great care to patients.

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 some weaknesses in the application of some internal controls. Management actions to address these weaknesses have been agreed with the Trust”. We have already implemented a number of these management actions and will continue to implement the remainder, and as the trust leaves Special Measures we will continue to make progress and improve our operation and management of controls.

Jeff Buggle
Acting Chief Executive and Accountable Officer
Barking, Havering and Redbridge University Hospitals NHS Trust

Never events

Three reportable never events occurred during 2016/17. Each incident occurred within the following categories:

Wrong route of administration: Oral morphine solution 0.5ml injected via an intravenous cannula in error. The patient came to no harm from the incident and immediate action of the clinician involved ensured prompt medical review, full compliance with the statutory duty of candour and ongoing monitoring.

The full serious incident investigation identified failure to use a dedicated oral syringe which does not allow connection to an intravenous cannula. Preventative action included a trust wide alert and prominent signage and availability of oral syringes in the vicinity of oral morphine solution. Assurance testing has been undertaken in respect of the embeddedness of actions.

Retained Foreign object: Dental drill fragment retained following oral surgery. Although the drill bit was included within counting and checking procedures a check of integrity was not undertaken. This led to a 2.5cm section being retained within the wound and surrounding metal framework. The retained drill section was not noted on post-operative x-ray and was discovered during planned surgery to remove the previously placed fixation (no additional surgery was undertaken). Full duty of candour was applied in this case and accepted by the patient. A trust wide alert was issued in respect to integrity checks during procedures and assurance testing in place.

Retained Foreign object: Two swabs were retained following abdominoplasty surgery. The patient was returned to theatre and wound was re-opened and the swabs removed. Actions include; unannounced assurance visits being conducted to Theatres to ensure swab counting and overall practice is being taken as per policy. A roundtable review of the incident occurred within 24hrs of occurrence. This gained important information as to events and initial cause. An alert to all staff has been issued as to identified risks and correct practice. A Serious Incident investigation has commenced. The duty of candour process has been undertaken and the patient is aware of the on-going investigation.

Regulation 28 reports - Coroner’s (Investigations) Regulations 2013

Prevention of Future Deaths

We received one Regulation 28 report from HM Coroner to prevent future deaths. Regular reports on inquests and Regulation 28 actions are now included within the incident and serious incident data reports which are received by the Trust Executive Committee, the Quality Governance Steering Group, and in summary to the Quality Assurance Committee. A robust process is in place for the management of inquests and follow-up of actions related to Regulation 28 reports. This process includes wide circulation, assurance testing and provision of detailed controls actions to HM Coroner to assure on preventative action.

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.

Information governance toolkit

Our Information Governance (IG) Assessment Report for the period 2015/16 was 71% and was rated as satisfactory. We have been able to meet the target that at least 95% of staff are up to date with their level 2 information governance training and we are seeking to complete the remainder. This target was achieved by 31 March 2017.

The information governance incidents scoring system relating to the identification of serious incidents changed on 1 June 2013 with new published guidance issued by the Health and Social Care Information Centre (HSCIC). Under the revised system, any Information Governance Serious Incident score at level two or above is reported on the Information Governance Toolkit Incident Reporting Tool, which is automatically escalated to the Department of Health, the Information Commissioner’s Office (ICO) and other relevant bodies.

I can confirm that there has been only one IG incident reported to the ICO during 2016/17, however, this incident relates to loss of staff (and not patient) data by a third party service provider. To date the ICO has taken no action.

Failure by an IT subcontractor resulted in the compromise of data relating to 674 individuals (past and present staff) held on behalf of the Trust for occupational health purposes. The Trust:
• Conducted an internal investigation
• Reported the incident to the ICO
• Contacted those concerned offering tailored support
• Updated the relevant ICT policies and procedures
• Took relevant follow up action with the contractor and the police.

Essential Training

The Trust launched a new Learning Management System (BEST) in the first quarter of 2016/17. All Essential Training and other learning subjects are now directly recorded in BEST. This allows all staff to complete e-learning packages where required and access classroom sessions to courses held locally within the Trust.

We have worked hard to achieve a locally set target of 90% in all Essential Training topics and 95% in Information Governance. We are currently measured against an 85% target in all topics other than Information Governance where there is a national requirement of 95%. Essential Training has consistently been above 90% since August 2016, and for Information Governance the latest figure for staff compliant was 96.2%.
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 the leadership qualities framework. 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 are no additional arrangements for early termination of contract.

The Trust is not liable for any compensation expenses for early termination of contract.

Notes
(1) Due to a planned period of absence Matthew Hopkins was not present to discharge his duties as Chief Executive from the 14th to the 31st of March 2017.
(2) Jeff Buggle was asked to act in the role of Chief Executive following Matthew Hopkins’ planned period of absence from the 14th of March to the 31st of March 2017.
(3) Steve Colline was asked to act into the role of Director of Finance and Performance from the 14th of March to the 31st of March 2017.
(4) Claire Pacey (NHSI Improvement Director) was appointed to cover the role of Director of People and Organisational Development following a period of absence for the role of Director of People and Organisational Development.
(5) Due to a planned period of absence Matthew Hopkins was not present to discharge his duties as Chief Executive from the 14th to the 31st of March 2017.
(6) Jeff Buggle was asked to act into the role of Chief Executive following Matthew Hopkins’ planned period of absence from the 14th of March to the 31st of March 2017.
(7) Steve Colline was asked to act into the role of Director of Finance and Performance from the 14th of March to the 31st of March 2017.
### TABLE 2

**Salary and Pension entitlements of senior managers (continued)**

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real</th>
<th>Pension Schemes (Transfer Values) regulations 2008.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rachel Royall - Director of Communications &amp; Marketing</td>
<td>£5,000</td>
<td></td>
</tr>
<tr>
<td>Kathryn Halford - Chief Nurse</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Dr Nadeem Moghal - Medical Director</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Sarah Tedford - Chief Operating Officer</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Deborah Tarrant - Director of People &amp; Organ. Development</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Jason Seez - Director of Strategy &amp; Planning</td>
<td>£000</td>
<td></td>
</tr>
</tbody>
</table>

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

**REAL INCREASE IN CETV**

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

**Compensation for Loss of Office**

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

- **Fair pay (ratios) disclosure**
  - Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation’s workforce.

<table>
<thead>
<tr>
<th>Band of the highest paid director’s total remuneration (£000)</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median pay remuneration (£)</td>
<td>33,205</td>
<td>32,407</td>
</tr>
<tr>
<td>Median pay multiple</td>
<td>6.1</td>
<td>5.8</td>
</tr>
</tbody>
</table>

The highest paid director salary was £204,500 (2015/16, £189,500) in the current year against a median salary of £33,205 (2015/16, £32,407), resulting in an insignificant change of 0.3 times of the median pay multiple.

The banded remuneration of the highest-paid director in the Trust in the financial year 2016/17 was in the band £200k-£205k (2015/16, £195k-£190k). This was 6.1 times the median remuneration of the workforce, which was £33,205 (2015/16, £32,407). Total remuneration includes salary and nonconsolidated performance-related payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff costs have been outlined in detail in note 10 of the accounts. In 2016/17, the Trust spent a total of £565m of which staff costs accounted for £357m (63%).

**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.
The table below gives the gender breakdown within the Trust (as at 31 March 2017).

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Level Director</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Non Executive Director / Chair</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>281</td>
<td>132</td>
</tr>
<tr>
<td>All Other Employees</td>
<td>4665</td>
<td>1373</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4950</strong></td>
<td><strong>1512</strong></td>
</tr>
</tbody>
</table>

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

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

Our expert staff work across the following disciplines:

**PROFESSIONAL TECHNICAL & SCIENTIFIC**

- Admin, Clerical & Maintenance: 1366 (21.1%)
- Allied Health Professionals (PAMs): 507 (7.8%)
- Ancillary & Non-patient-care SWkrs: 23 (0.4%)
- HCas & Patient-care SWkrs: 854 (13.2%)
- Medical - Career Grades: 585 (9.1%)
- Medical - Training Grades: 369 (5.7%)
- Midwives: 318 (4.9%)
- Other Qualified Nurses: 1786 (27.6%)

**HCAs & PATIENT-CARE SWKRS**

- Medical - Career Grades: 585 (9.1%)
- Medical - Training Grades: 369 (5.7%)
- Midwives: 318 (4.9%)
- Other Qualified Nurses: 1786 (27.6%)

**Table 1- For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:**

- Number of existing engagements as of 31 March 2017: 12
- Of which, the number that have existed:
  - for less than one year at the time of reporting: 10
  - for between 1 and 2 years at the time of reporting: 0
  - for between 2 and 3 years at the time of reporting: 1
  - for between 3 and 4 years at the time of reporting: 0
  - for 4 or more years at the time of reporting: 1

**Table 2- For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:**

- Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017: 10
- Number of new engagements which include contractual clauses giving BH&R University Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations: 10
- Number for whom assurance has been requested: 10
- Of which: assurance has been received: 10
- assurance has not been received: 0
- engagements terminated as a result of assurance not being received: 0

**Table 3- Off-payroll engagements with significant financial responsibility**

- Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year: 2
- Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements: 19

**Expenditure on consultancy**

In 2016/17 the Trust spent £2,676k on Consultancy services.

**Exit Packages**

There were no exit package costs.

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

We have audited the financial statements of Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2017 on pages 90 to 128 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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.

RESPECTIVE RESPONSIBILITIES OF DIRECTORS, THE ACCOUNTABLE OFFICER AND AUDITOR

As explained more fully in the Statement of Directors’ Responsibilities set out on page 64, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

As explained in the statement of the Chief Executive’s responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust’s resources. We are required under section 21(3)(e), 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

SCOPE OF THE AUDIT OF THE FINANCIAL STATEMENTS

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

SCOPE OF THE REVIEW OF ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN THE USE OF RESOURCES

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2016, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Emphasis of Matter - Financial position

In forming our opinion on the financial statements, which is not qualified, we have considered the adequacy of the disclosure made in Note 1.2 to the financial statements concerning the Trust’s financial position. The Trust incurred a deficit of £10.9m during the year ended 31 March 2017. This was delivered through the receipt of loan funding together with one-off in year transactions.

The requirement placed on public sector bodies require that judgements on going concern are reached with reference to the continuance of service provision by the public sector and measured with reference to public confirmation of funding for those services.

These conditions and the other matters explained in Note 1.2 indicate the existence of a material uncertainty which may place significant doubt on the Trust’s ability to achieve long term financial stability.

OPINION ON OTHER MATTERS

In our opinion:

• the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and

• the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Opinions on individual financial statements

In respect of each financial statement:

• the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust’s expenditure and income 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 relevant to NHS Trusts in England.
specifically in terms of sustainable resource deployment, we identified the points above relating to the in-year and cumulative deficit. In addition, the Trust has not yet succeeded in addressing the underlying deficit.

The Trust is putting the necessary arrangements in place to address the deficit and remains committed to delivering its operational plan in line with its long term financial model.

Qualified conclusion
On the basis of our work, having regard to the guidance issued by the C&AG in November 2016, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Barking, Havering and Redbridge University Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Neil Thomas for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
Canary Wharf
London E14 5GL
26 May 2017
SECTION THREE: FINANCIAL STATEMENTS AND NOTES
### Statement of Comprehensive Income for year ended 31 March 2017

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other operating costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue from patient care activities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Operating deficit</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investment revenue</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other gains and (losses)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Finance costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deficit for the financial year</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Public dividend capital dividends payable</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Retained deficit for the year</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Comprehensive Income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals taken to the revaluation reserve</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant &amp; equipment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total comprehensive income for the year</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Current assets:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inventories</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-total current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total assets</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTE</th>
<th>31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Trade and other receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
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<td>-</td>
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</tr>
<tr>
<td>Trade and other receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-total current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total assets</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Statement of Financial Position as at 31 March 2017**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2017</th>
<th>31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Current assets:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inventories</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-total current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total assets</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Current liabilities**

- Trade and other payables: 23 (57,653) (64,436)
- Provisions: 26 (560) (626)
- Borrowings: 24 (8,271) (8,453)
- DH capital loan: 24 (976) (963)
- Total current liabilities: (67,460) (74,120)
- Total assets less current liabilities: 306,236 301,871

**Non-current liabilities**

- Trade and other payables: 23 (3,851) (4,064)
- Provisions: 26 (2,386) (2,993)
- Borrowings: 24 (237,038) (239,941)
- DH revenue support loan: 24 (64,047) (31,500)
- DH capital loan: 24 (7,201) (8,177)
- Total non-current liabilities: (315,023) (286,675)
- Total assets employed: (9,003) 24,196

**FINANCED BY**

- Public Dividend Capital: 477,076 477,076
- Retained earnings: (488,022) (455,347)
- Revaluation reserve: 1,943 2,467
- Total Taxpayers’ Equity: (9,003) 24,196

The notes on pages 90 to 123 form part of this account.

The financial statements on pages 86 to 89 were approved by the Board on 24th May 2017 and signed on its behalf by Acting Chief Executive:

Jeff Buggle
Acting Chief Executive
24 May 2017

The notes on pages 90 to 123 form part of this account.
### Statement of Changes in Taxpayers’ Equity

For the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>Public Dividend capital</th>
<th>Retained earnings</th>
<th>Revaluation reserve</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Balance at 1 April 2016</td>
<td>477,076</td>
<td>(455,347)</td>
<td>2,467</td>
<td>24,196</td>
</tr>
<tr>
<td>Changes in taxpayers’ equity for 2016-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained deficit for the year</td>
<td>(32,675)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(524)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reclassification Adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary and permanent PDC received - cash</td>
<td>1,500</td>
<td></td>
<td></td>
<td>1,500</td>
</tr>
<tr>
<td>Temporary and permanent PDC repaid in year</td>
<td>(1,500)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net recognised expense for the year</td>
<td>0</td>
<td>(524)</td>
<td>(33,199)</td>
<td></td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>477,076</td>
<td>(488,022)</td>
<td>1,943</td>
<td>(9,003)</td>
</tr>
<tr>
<td>Balance at 1 April 2015</td>
<td>477,076</td>
<td>(392,493)</td>
<td>27,715</td>
<td>112,298</td>
</tr>
<tr>
<td>Changes in taxpayers’ equity for the year ended 31 March 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained deficit for the year</td>
<td>(62,854)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(25,938)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net recognised expense for the year</td>
<td>0</td>
<td>(62,854)</td>
<td>(88,102)</td>
<td></td>
</tr>
<tr>
<td>Balance at 31 March 2016</td>
<td>477,076</td>
<td>(455,347)</td>
<td>2,467</td>
<td>24,196</td>
</tr>
</tbody>
</table>

### Information on reserves

1 **Public dividend capital**

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

2 **Income and expenditure reserve**

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

3 **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.

### Statement of cash flows for the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating deficit</td>
<td>(6,584)</td>
<td>(35,898)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>8</td>
<td>14,623</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>17</td>
<td>21,749</td>
</tr>
<tr>
<td>Donated Assets received credited to revenue but non-cash</td>
<td>6</td>
<td>(126)</td>
</tr>
<tr>
<td>Increase in Inventories</td>
<td>(8,839)</td>
<td>(2,121)</td>
</tr>
<tr>
<td>Increase in Trade and Other Receivables</td>
<td>2,462</td>
<td>(8,780)</td>
</tr>
<tr>
<td>Increase/(Decrease) in Trade and Other Payables</td>
<td>(12,664)</td>
<td>16,437</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>(546)</td>
<td>(946)</td>
</tr>
<tr>
<td>Increase in Movement in non cash provisions</td>
<td>237</td>
<td>292</td>
</tr>
<tr>
<td><strong>Net Cash Inflow from Operating Activities</strong></td>
<td>10,374</td>
<td>13,757</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Received</td>
<td>110</td>
<td>258</td>
</tr>
<tr>
<td>Payments for Property, Plant and Equipment</td>
<td>(10,730)</td>
<td>(10,914)</td>
</tr>
<tr>
<td>Proceeds of disposal of assets held for sale (PPF)</td>
<td>144</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Investing Activities</strong></td>
<td>(10,476)</td>
<td>(10,656)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow/(Outflow) before Financing</strong></td>
<td>(102)</td>
<td>3,101</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross: Temporary and Permanent PDC: Received</td>
<td>1,500</td>
<td>0</td>
</tr>
<tr>
<td>Gross: Temporary and Permanent PDC: Repaid</td>
<td>(1,500)</td>
<td>0</td>
</tr>
<tr>
<td>Loans received from DH - New Capital Investment Loans</td>
<td>0</td>
<td>3,362</td>
</tr>
<tr>
<td>Loans received from DH - New Revenue Support Loans</td>
<td>74,250</td>
<td>62,596</td>
</tr>
<tr>
<td>Loans repaid to DH - Capital Investment Loans/Repayment of Principal</td>
<td>(602)</td>
<td>(602)</td>
</tr>
<tr>
<td>Loans repay to SH - Working Capital Loans/Revenue Support Loans</td>
<td>(41,703)</td>
<td>(31,096)</td>
</tr>
<tr>
<td>Capital Element Payments in Respect of Finance Leases and On-SoFP PR and LIFT</td>
<td>(8,466)</td>
<td>(7,836)</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(24,673)</td>
<td>(26,232)</td>
</tr>
<tr>
<td>PDC Dividend (paid)/refunded</td>
<td>1,726</td>
<td>(2,241)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow/(Outflow) from Financing Activities</strong></td>
<td>532</td>
<td>(2,649)</td>
</tr>
<tr>
<td><strong>NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS</strong></td>
<td>430</td>
<td>452</td>
</tr>
<tr>
<td><strong>Cash and Cash Equivalents at Beginning of the Period</strong></td>
<td>1,118</td>
<td>666</td>
</tr>
<tr>
<td><strong>Cash and Cash Equivalents at year end</strong></td>
<td>21</td>
<td>1,548</td>
</tr>
</tbody>
</table>
NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

The Secretary State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 ACCOUNTING CONVENTION

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

1.2 FINANCIAL POSITION

These accounts have been prepared on the basis that the Trust is a going concern. This year the Trust has continued to meet its financial targets, against a backdrop of increased financial pressure across the NHS. In achieving these, the Trust exceeded its agreed control total by £1.1m in delivering a deficit of £1.23m inclusive of £1.6m core Sustainability and Transformation Funding (STF). In addition, the Trust was awarded a further £1.4m bonus and incentive STF resulting in a reported deficit of £10.9m. This represents an improvement of £22.8m from previous year, and includes £20.7m in savings through our Quality and Cost Improvement (QCI) Programme. Total income has grown from £505.2m to £585.0m as a result of Trust undertaking additional activities, address elective care demand and has operated on a payment by results (cost and volume basis) during the year. The total balance sheet value has significantly reduced into a negative position as a result of the impairment of the Trust’s Land and Buildings values. In accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the Department of Health (DH), the Trust has considered whether its sites’ locations are

1.3 CHARITABLE FUNDS

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

At the end of the financial year the charity held capital and reserves of £1.1m, an increase in year of £0.04m.

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 2016-17 income and total funds are viewed below materiality. The Charity continues to publish a separate set of accounts for 2016/17 in accordance with the Statement of Recommended Accounting Practice “Accounting and Reporting by Charities”, FRS 102.

1.4 CRITICAL ACCOUNTING JUDGEMENTS AND KEY SOURCES OF ESTIMATION UNCERTAINTY

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

1.4.1 CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

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 10.3). 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 market 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 whether 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 1.6. 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 the Treasury guidance. Future revaluations of property may result in further changes to the carrying values of non-current assets.
1.4.2 Key Sources of Estimation Uncertainty
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 2017.
• 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 2016-17 financial year received after 31 March 2017; orders received;

1.5 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of a proxy date compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension’s Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-Term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees*. The cost of leave 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.

Retirement Benefit Costs
Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.7 Other Expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, Plant and Equipment

Recovery
Property, plant and equipment is capitalised if:
• 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 will be supplied to the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably; and
• the item has cost at least £5,000; or

Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous 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, the components are treated as separate assets and depreciated over their own useful economic lives.

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

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
• Land and non-specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost

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

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

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. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent Expenditure
Where subsequent expenditure enhances a asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Intangible Assets

1.9 Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust’s business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.
Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been met:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

**MEASUREMENT**
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

**1.10 DEPRECIATION, AMORTISATION AND IMPAIRMENTS**

**Freehold land, assets under construction or development,** and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible noncurrent assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives. At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible noncurrent assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

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. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

**1.11 DONATED ASSETS**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired in accordance with above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deemed income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

**1.12 GOVERNMENT GRANTS**

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deemed income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

**1.13 NON-CURRENT ASSETS HELD FOR SALE**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

**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.

**THE TRUST AS LESSEE**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust’s surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

**THE TRUST AS LESSOR**

Amounts due from leases 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 so as to reflect a constant periodic rate of return on the trust’s net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

**1.15 PRIVATE FINANCE INITIATIVE (PFI) TRANSACTIONS**

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes according to the requirements of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of FRSIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

**SERVICES RECEIVED**

The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

**PFI ASSET**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

**PFI LIABILITY**

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 initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to ‘Finance costs’ within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
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 predetermined 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. As a result, these lifecycle replacement charges are recognised as an expense in the period they arise.

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 valued by agreement. The lifecycle replacement of these assets effectively results in a series of finance leases in accordance with the individual replacement cycles.

The fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is recognised as a deferred income. 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.

ASSETS CONTRIBUTED BY THE NHS 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 Comprehensive Income.

OTHER ASSETS CONTRIBUTED BY THE TRUST TO THE OPERATOR

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator’s capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment to provide the finance lease liability and is set against the carrying value of the liability.

1.16 INVENTORIES

Inventories are valued at the lower of cost and net realisable value using the first-in-first-out cost formula. This is considered to be a reasonable approximation for fair value due to the high turnover of stocks.

1.17 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.

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 NHS trust’s cash management.

1.18 PROVISIONS

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rate of 0.24% in real terms (1.37% for employee early departure obligations). When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 CLINICAL NEGLIGENCE COSTS

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 27.

1.20 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 the NHSLA. In return the NHSLA provides assistance with the costs of claims arising. The annual membership contributions, and any excess payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 CARBON REDUCTION COMMITMENT SCHEME (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 CONTINGENCIES

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or nonoccurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 FINANCIAL ASSETS

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. The assets are initially recognised at fair value and are derecognised when the contractual rights have expired or the asset has been transferred.

There are no Financial Assets held to maturity, available for sale or held at fair value through the profit and loss.

LOANS AND RECEIVABLES

Loans Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.
1.24 FINANCIAL LIABILITIES
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value. The Trust has no financial liabilities at fair value through profit and loss.

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

1.26 FOREIGN CURRENCIES
The Trust’s functional and presentation currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust’s surplus or deficit in the period in which they arise.

1.27 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 35 to the accounts.

1.28 PUBLIC DIVIDEND CAPITAL (PDC) AND PDC DIVIDEND
Public dividend capital represents taxpayers’ equity in the Trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of 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 (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not reviewed should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.29 LOSSES AND SPECIAL PAYMENTS
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 SUBSIDIARIES, ASSOCIATES AND JOINT ARRANGEMENTS
The only subsidiary of the Trust is the NHS Charity Fund, referred to in Note 1.3 above. The Trust has no other associate or joint venture organisations or legal entities.

1.31 RESEARCH AND DEVELOPMENT
Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.32 ACCOUNTING STANDARDS THAT HAVE BEEN ISSUED BUT HAVE NOT YET BEEN ADOPTED
The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 subject to HM Treasury consideration.

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

1.33 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 unrestrained transfers such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

2 POOLED BUDGETS
The Trust had no pooled budgets during the year.

3 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.

4 INCOME GENERATION ACTIVITIES
The Trust undertakes income generation activities with an aim of achieving profit, which is then reinvested in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

This income generation is rental income for space at Queen’s Hospital from a private healthcare provider performing oncology medical services and the provision of oncology medical services by the Trust to this private provider (KCA-Hospitals). It also includes visitor car parking at King George Hospital, and staff car parking across all sites.

Summary Table - aggregates of all schemes

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£5,282</td>
<td>£5,109</td>
</tr>
<tr>
<td>Full cost</td>
<td>£2,597</td>
<td>£2,579</td>
</tr>
<tr>
<td>Surplus</td>
<td>£2,685</td>
<td>£2,526</td>
</tr>
</tbody>
</table>

5 REVENUE FROM PATIENT CARE ACTIVITIES

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Trusts</td>
<td>£1,285</td>
<td>£2,151</td>
</tr>
<tr>
<td>NHS England</td>
<td>95,686</td>
<td>90,613</td>
</tr>
<tr>
<td>Clinical Commissioning Groups</td>
<td>390,738</td>
<td>367,086</td>
</tr>
<tr>
<td>Foundation Trusts</td>
<td>1,362</td>
<td>2,127</td>
</tr>
<tr>
<td>Department of Health</td>
<td>68</td>
<td>91</td>
</tr>
<tr>
<td>NHS Other (including Public Health England and Prop Co)</td>
<td>739</td>
<td>1,156</td>
</tr>
<tr>
<td>Additional income for delivery of healthcare services</td>
<td>0</td>
<td>1,500</td>
</tr>
<tr>
<td>Non-NHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Authorities</td>
<td>4,332</td>
<td>4,320</td>
</tr>
<tr>
<td>Private patients</td>
<td>159</td>
<td>210</td>
</tr>
<tr>
<td>Overseas patients (non-recipient)</td>
<td>2,717</td>
<td>2,703</td>
</tr>
<tr>
<td>Injury Costs Recovered</td>
<td>3,044</td>
<td>2,549</td>
</tr>
<tr>
<td>Other Non-NHS patient care income</td>
<td>132</td>
<td>131</td>
</tr>
</tbody>
</table>

Total Revenue from patient care activities | £500,262 | £474,939 |
### 6 OTHER OPERATING REVENUE

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recoveries in respect of employee benefits</td>
<td>1,999</td>
<td>1,342</td>
</tr>
<tr>
<td>Patient transport services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>17,320</td>
<td>16,711</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure - NHS</td>
<td>311</td>
<td>263</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure - non-NHS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receipt of charitable donations for capital acquisitions</td>
<td>62</td>
<td>128</td>
</tr>
<tr>
<td>Support from DH for mergers</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receipt of Government grants for capital acquisitions</td>
<td>0</td>
<td>81</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>125</td>
<td>702</td>
</tr>
<tr>
<td>Sustainability &amp; Transformation Fund Income</td>
<td>20,997</td>
<td></td>
</tr>
<tr>
<td>Income generation (Other fees and charges)</td>
<td>5,282</td>
<td>5,195</td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>3,146</td>
<td>3,319</td>
</tr>
<tr>
<td>Other revenue</td>
<td>8,662</td>
<td>8,651</td>
</tr>
<tr>
<td><strong>Total Other Operating Revenue</strong></td>
<td><strong>57,704</strong></td>
<td><strong>30,300</strong></td>
</tr>
<tr>
<td><strong>Total operating revenue</strong></td>
<td><strong>557,966</strong></td>
<td><strong>505,235</strong></td>
</tr>
</tbody>
</table>

### 7 OVERSEAS VISITORS DISCLOSURE

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income recognised during 2016-17 (invoiced amounts and accruals)</td>
<td>2,717</td>
<td>2,703</td>
</tr>
<tr>
<td>Cash payments received in-year (ie receivables at 31 March 2016)</td>
<td>200</td>
<td>92</td>
</tr>
<tr>
<td>Cash payments received in-year (no invoices issued 2016-17)</td>
<td>269</td>
<td>216</td>
</tr>
<tr>
<td>Amounts added to provision for impairment of receivables (ie receivables at 31 March 2016)</td>
<td>833</td>
<td>1,410</td>
</tr>
<tr>
<td>Amounts added to provision for impairment of receivables (no invoices issued 2016-17)</td>
<td>785</td>
<td>1,173</td>
</tr>
<tr>
<td>Amounts written off in-year (irrespective of year of recognition)</td>
<td>0</td>
<td>136</td>
</tr>
</tbody>
</table>

### 8 OPERATING EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from other NHS Trusts</td>
<td>548</td>
<td>1,042</td>
</tr>
<tr>
<td>Services from CCGs/NHS England</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>140</td>
<td>17</td>
</tr>
<tr>
<td>Services from NHS Foundation Trusts</td>
<td>1,040</td>
<td>1,586</td>
</tr>
<tr>
<td>Total Services from NHS bodies*</td>
<td>1,711</td>
<td>2,625</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>5,442</td>
<td>2,460</td>
</tr>
<tr>
<td>Trust Chair and Non-executive Directors</td>
<td>109</td>
<td>119</td>
</tr>
<tr>
<td>Supplies and services - clinical</td>
<td>75,029</td>
<td>76,613</td>
</tr>
<tr>
<td>Supplies and services - general</td>
<td>13,113</td>
<td>10,484</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>2,676</td>
<td>1,957</td>
</tr>
<tr>
<td>Establishment</td>
<td>4,013</td>
<td>3,421</td>
</tr>
<tr>
<td>Transport</td>
<td>4,442</td>
<td>4,252</td>
</tr>
<tr>
<td>Service charges - ON-SOFP PFI and other service concession arrangements</td>
<td>13,757</td>
<td>14,256</td>
</tr>
<tr>
<td>Business rates paid to local authorities</td>
<td>3,483</td>
<td>3,423</td>
</tr>
<tr>
<td>Premises</td>
<td>15,245</td>
<td>13,892</td>
</tr>
<tr>
<td>Hospitality</td>
<td>86</td>
<td>69</td>
</tr>
<tr>
<td>Insurance</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>Legal fees</td>
<td>1,100</td>
<td>895</td>
</tr>
<tr>
<td>Impairments and Reversals of Receivables</td>
<td>228</td>
<td>605</td>
</tr>
<tr>
<td>Depreciation</td>
<td>12,613</td>
<td>13,990</td>
</tr>
<tr>
<td>Amortisation</td>
<td>2,010</td>
<td>1,701</td>
</tr>
<tr>
<td>Impairments and reversal of property, plant and equipment</td>
<td>21,749</td>
<td>29,208</td>
</tr>
<tr>
<td>Internal Audit Fees</td>
<td>140</td>
<td>135</td>
</tr>
<tr>
<td>Audit fees</td>
<td>130</td>
<td>155</td>
</tr>
<tr>
<td>Other auditor’s remuneration</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>27,995</td>
<td>25,499</td>
</tr>
<tr>
<td>Education and Training</td>
<td>260</td>
<td>667</td>
</tr>
<tr>
<td>Change in Discount Rate</td>
<td>139</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1,627</td>
<td>1,758</td>
</tr>
<tr>
<td><strong>Total Operating expenses (excluding employee benefits)</strong></td>
<td><strong>207,181</strong></td>
<td><strong>208,286</strong></td>
</tr>
</tbody>
</table>

#### Employee Benefits

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits excluding Board members</td>
<td>355,579</td>
<td>330,952</td>
</tr>
<tr>
<td>Board members</td>
<td>1,390</td>
<td>1,899</td>
</tr>
<tr>
<td><strong>Total Employee Benefits</strong></td>
<td><strong>357,969</strong></td>
<td><strong>332,851</strong></td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td><strong>564,550</strong></td>
<td><strong>541,137</strong></td>
</tr>
</tbody>
</table>

* Services from NHS bodies does not include expenditure which falls into a category below that line.
9 OPERATING LEASES

9.1 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST AS 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.

9.2 TRUST AS LESSOR

The Trust acts as an operating lessor for the following leases:

1) A 60 year land lease at King George Hospital, Redbridge, granted in 2006 to operate an Independent Sector Treatment Centre.
2) A 10 year space lease at Queen’s Hospital, granted in 2009 for a private healthcare provider to provide oncology medical services.
3) The Trust leases ward space at King George Hospital to an NHS Foundation Trust.
4) The Trust leases space at both hospitals to Barts Health NHS Trust for renal services.
5) The Trust leases space at King George Hospital for GP services.
6) The Trust leases space at King George Hospital to a private provider to operate its Pregnancy Advisory Clinic.
7) 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.

10 EMPLOYEE BENEFITS AND STAFF NUMBERS

10.1 EMPLOYEE BENEFITS

10.2 AVERAGE STAFF NUMBERS

<table>
<thead>
<tr>
<th>Average Staff Numbers</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number</td>
<td>1,031</td>
<td>955</td>
</tr>
<tr>
<td>Permanently Number</td>
<td>995</td>
<td>995</td>
</tr>
<tr>
<td>Other Number</td>
<td>76</td>
<td>55</td>
</tr>
<tr>
<td>Total Number</td>
<td>1,030</td>
<td>0</td>
</tr>
</tbody>
</table>

10.3 STAFF SICKNESS ABSENCE AND ILL HEALTH RETIREMENTS

<table>
<thead>
<tr>
<th>Total working Days Lost*</th>
<th>2016-17 Number</th>
<th>2015-16 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Staff Years</td>
<td>1,015</td>
<td>4862</td>
</tr>
<tr>
<td>Average working Days Lost per member of staff</td>
<td>8.49</td>
<td>8.63</td>
</tr>
</tbody>
</table>

* based on the 2016 calendar year, DH considers these figures to be a reasonable proxy for financial year equivalents.
10.4 RETIREMENTS DUE TO ILL-HEALTH

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>136</td>
<td>396</td>
</tr>
</tbody>
</table>

10.5 PENSION COSTS

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The next actuarial valuation is to be carried out as at 31 March 2017. This will set the employer contribution rate payable from April 2018 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

11.1 MEASURE OF COMPLIANCE

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 a valid invoice, whichever is later.

There has been an overall reduction in the percentage of invoices paid within target for both Non NHS and NHS payables. This has primarily been as a result of delays in agreeing overperformance funding with commissioners and subsequent payments, impacting the Trust’s ability to pay suppliers on time. A lot of work has been undertaken with commissioners to address this and the Trust expects timely settlements with commissioners in 2017/18.

11.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
</tr>
</tbody>
</table>

12 OTHER GAINS AND LOSSES

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
</tr>
</tbody>
</table>

13 FINANCE COSTS

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
</tr>
</tbody>
</table>

Interest

Interest on loans and overdrafts 1,511 976
Interest on obligations under finance leases 0 0
Interest on obligations under PFI contracts:
- main finance cost 17,942 18,644
- contingent finance cost 6,949 6,595
Total interest expense 26,402 26,215
Other finance costs 0 0
Provisions - unwinding of discount (6) 45
Total 26,396 26,260
14 EXTERNAL AUDITOR REMUNERATION

14.1 OTHER AUDITOR REMUNERATION

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
</tbody>
</table>

Other auditor remuneration paid to the external auditor:

1. Audit of accounts of any subsidiary of the trust 4 4
2. Audit-related assurance services 10 10
3. Taxation compliance services 0 0
4. All taxation advisory services not falling within item 3 above 0 0
5. Internal audit services 0 0
6. All assurance services not falling within items 1 to 5 0 0
7. Corporate finance transaction services not falling within items 1 to 6 above 0 0
8. Other non-audit services not falling within items 2 to 7 above 0 0
Total 27 14

14.2 LIMITATION ON AUDITOR’S LIABILITY

There is no limitation on auditor’s liability for external audit work carried out for the financial years 2016/17 or 2015/16.

15.1 PROPERTY, PLANT AND EQUIPMENT

<table>
<thead>
<tr>
<th>Property, Plant and Equipment</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>£000s</td>
</tr>
<tr>
<td>Buildings excluding Dwellings</td>
<td>£000s</td>
</tr>
<tr>
<td>Dwellings</td>
<td>£000s</td>
</tr>
<tr>
<td>Assets under construction &amp; payments on account</td>
<td>£000s</td>
</tr>
<tr>
<td>Plant &amp; Machinery</td>
<td>£000s</td>
</tr>
<tr>
<td>Transport equipment</td>
<td>£000s</td>
</tr>
<tr>
<td>Information technology</td>
<td>£000s</td>
</tr>
<tr>
<td>Furniture &amp; Fittings</td>
<td>£000s</td>
</tr>
<tr>
<td>Total</td>
<td>£000s</td>
</tr>
</tbody>
</table>

Cost or valuation:

- At 1 April 2016 20,586 32,996 101,326 157,203 11,199 369,705
- Additions of Assets Under Construction 0 0 0 0 0 10,129 420,759
- Additions Purchased 0 0 0 0 0 0 7,675
- Additions - Non Cash Donations (i.e. physical assets) 0 0 0 0 0 10 62
- Additions - Purchases from Cash Donations & Government Grants 0 0 0 0 0 0 0
- Reclassifications 0 0 0 0 0 0 0
- Reclassifications as Held for Sale and reversals 0 0 0 0 0 0 0
- Disposals other than for sale 0 0 0 0 0 0 0
- Revaluation 0 0 0 0 0 0 0
- Impairments/reversals charged to operating expenses 0 0 0 0 0 0 0
- Impairments/reversals charged to reserves 0 0 0 0 0 0 0

At 31 March 2017 31,470 210,596 10,129 77,668 0 22,447 392,705

Depreciation:

- At 1 April 2016 0 0 0 0 0 0 0
- Dilapidations 0 0 0 0 0 0 0
- Reclassifications 0 0 0 0 0 0 0
- Reclassifications as Held for Sale and reversals 0 0 0 0 0 0 0
- Disposals other than for sale 0 0 0 0 0 0 0
- Revaluation 0 0 0 0 0 0 0
- Impairments/reversals charged to reserves 0 0 0 0 0 0 0
- Impairments/reversals charged to operating expenses 0 0 0 0 0 0 0

Charged During the Year 0 0 0 0 0 0 0

At 31 March 2017 0 10,173 0 45,984 0 12,274 3,534

Net Book Value at 31 March 2017 31,470 210,596 10,129 77,668 0 10,173 299,171

Asset financing:

- Derived - Purchased 31,470 13,525 19 10,129 16,049 0 10,173 2,019 123,067
- Derived - Donated 0 142 0 0 0 0 0 0 1,008
- Derived - Government Granted 0 0 0 0 0 0 0 0 0
- On SWPPP PH contracts 0 157,203 0 0 0 0 0 0 157,203

Total at 31 March 2017 31,470 210,596 10,129 77,668 0 10,173 2,019 299,171

The total of £10,129 contains intangibles which have not been split out from project costs because these projects are still ongoing.

Revaluation Reserve Balance for Property, Plant & Equipment:

- At 1 April 2016 0 0 0 0 0 0 0 2,467
- Movements (specify) 0 0 0 0 0 0 0 0

At 31 March 2017 0 0 0 0 0 0 0 1,943

Additions to Assets Under Construction in 2016/17

- Land 0
- Buildings and Dwellings 1,195
- Dwellings 0
- Plant & Machinery 6,101
- Balance as at YTD 8,296
15.2 PROPERTY, PLANT AND EQUIPMENT PRIOR-YEAR

<table>
<thead>
<tr>
<th>2015-16</th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction &amp; payments on account</th>
<th>Plant &amp; machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
<td>(£000s)</td>
</tr>
<tr>
<td>32,152</td>
<td>305,447</td>
<td>9,782</td>
<td>1,930</td>
<td>97,415</td>
<td>67</td>
<td>29,059</td>
<td>3,877</td>
<td>403,819</td>
<td></td>
</tr>
<tr>
<td>Additions of Assets Under Construction</td>
<td>8,469</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions: Purchase from Cash Donations &amp; Government Grants</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions: Donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluations</td>
<td>2,800</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redepositions as Held for Sale and Reversals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Disposals other than for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Revaluation</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation</td>
<td>4,060</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32,620</td>
<td>236,529</td>
<td>9,782</td>
<td>4,060</td>
<td>101,326</td>
<td>57</td>
<td>92,996</td>
<td>4,975</td>
<td>420,753</td>
</tr>
</tbody>
</table>

15.3 (CONT). PROPERTY, PLANT AND EQUIPMENT

The Trust’s accounting policy and depreciable lives for categories of non-current assets are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings (other than dwellings)</td>
<td>15</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Dwellings</td>
<td>15</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Plant and Machinery</td>
<td>5</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Information Technology</td>
<td>0</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Computer Hardware and Software</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Furniture and Fixtures</td>
<td>7</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Professional revaluations of Land and Buildings are normally undertaken at least once in every five year period (last undertaken in 2012) and are normally revalued annually, by professional valuers, using indices.

In view of property price changes in the London region Land and Buildings were revalued as at 1st April 2016 by professional valuers. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal & Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any losses arising from indexation and revaluation.

Land and buildings are recorded as an asset at cost (DRC). Specialised buildings – depreciated replacement cost. Non-specialised buildings – market value.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined on the basis 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 revalues 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.

Losses arising from indexation and revaluation are recognised as price/market movement impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset. Losses in excess of that amount are charged to the current year’s Statement of Comprehensive Income.

A valuation on the basis of MEA on an alternative site basis, had the following accounting impacts:

- Asset valuations: A reduction in the value of Trust land and buildings.
- Size of any new asset would be less than the existing total square footage representing economies gained through increased efficiencies in occupation.

Impairment and revaluation reserve: An adjustment to the revaluation reserve and an impairment charge to the Income & Expenditure account arising from the above.

PDC dividends paid: A decrease in the PDC dividends paid equal to 3.5% of the reduction in the value of the asset. Given that the PDC dividend is paid at 3.5% of average relevant net assets, of which the land and buildings form a significant part, there was a reduction in the dividend payable arising any reduction in the asset value.

In 2016-17, in line with Trust policy of valuation based on modern equivalent assets, and reflecting representations from the NHS Improvement, the Trust’s sites were valued by applying the MEA on an alternate site basis. This approach is consistent with HM Treasury and the Royal Institute of Chartered Surveyors (RICS) guidance, and does not represent a change in accounting policy.
### 16.1 Intangible Non-current Assets

#### 2016-17

<table>
<thead>
<tr>
<th></th>
<th>IT - In-house &amp; 3rd party software</th>
<th>Computer Licenses</th>
<th>Licences and Trademarks</th>
<th>Patents</th>
<th>Development Expenditure Internally Generated</th>
<th>Intangible Assets Under Construction</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>At 1 April 2016</strong></td>
<td>14,080</td>
<td>0</td>
<td>263</td>
<td>0</td>
<td>979</td>
<td>0</td>
<td>15,322</td>
</tr>
<tr>
<td><strong>Additions of Assets Under Construction</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Additions Purchased</strong></td>
<td><strong>596</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>596</strong></td>
</tr>
<tr>
<td><strong>Reclassifications</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Disposals other than by sale</strong></td>
<td><strong>(2,206)</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>(2,206)</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2017</strong></td>
<td><strong>11,470</strong></td>
<td><strong>0</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>0</strong></td>
<td><strong>12,712</strong></td>
</tr>
<tr>
<td><strong>Amortisation</strong></td>
<td><strong>At 1 April 2016</strong></td>
<td><strong>6,102</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>6,102</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2017</strong></td>
<td><strong>11,470</strong></td>
<td><strong>0</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>0</strong></td>
<td><strong>12,712</strong></td>
</tr>
<tr>
<td><strong>Net Book Value at 31 March 2017</strong></td>
<td><strong>4,847</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>696</strong></td>
<td><strong>0</strong></td>
<td><strong>5,543</strong></td>
<td><strong>5,543</strong></td>
</tr>
</tbody>
</table>

#### Revaluation reserve balance for intangible non-current assets

<table>
<thead>
<tr>
<th></th>
<th>Purchased</th>
<th>Remaining</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>At 1 April 2016</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Movements during year</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2017</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

### 16.2 Intangible Non-current Assets Prior Year

#### 2015-16

<table>
<thead>
<tr>
<th></th>
<th>IT - In-house &amp; 3rd party software</th>
<th>Computer Licenses</th>
<th>Licences and Trademarks</th>
<th>Patents</th>
<th>Development Expenditure Internally Generated</th>
<th>Intangible Assets Under Construction</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Cost or valuation</strong></td>
<td><strong>At 1 April 2015</strong></td>
<td><strong>13,786</strong></td>
<td><strong>(257)</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>13,792</strong></td>
</tr>
<tr>
<td><strong>Additions - purchased</strong></td>
<td><strong>151</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>151</strong></td>
</tr>
<tr>
<td><strong>Reclassifications</strong></td>
<td><strong>(257)</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>(257)</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Disposals other than by sale</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2016</strong></td>
<td><strong>14,080</strong></td>
<td><strong>0</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>0</strong></td>
<td><strong>15,322</strong></td>
</tr>
<tr>
<td><strong>Amortisation</strong></td>
<td><strong>At 1 April 2015</strong></td>
<td><strong>6,858</strong></td>
<td><strong>(257)</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>6,664</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2016</strong></td>
<td><strong>6,823</strong></td>
<td><strong>0</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>0</strong></td>
<td><strong>6,686</strong></td>
</tr>
<tr>
<td><strong>Disposals other than by sale</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Charged during the year</strong></td>
<td><strong>1,277</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>1,277</strong></td>
</tr>
<tr>
<td><strong>At 31 March 2016</strong></td>
<td><strong>6,823</strong></td>
<td><strong>0</strong></td>
<td><strong>263</strong></td>
<td><strong>0</strong></td>
<td><strong>979</strong></td>
<td><strong>0</strong></td>
<td><strong>7,749</strong></td>
</tr>
<tr>
<td><strong>Net Book Value at 31 March 2016</strong></td>
<td><strong>4,847</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>696</strong></td>
<td><strong>0</strong></td>
<td><strong>5,543</strong></td>
<td><strong>5,543</strong></td>
</tr>
</tbody>
</table>

### 17 Analysis of Impairments and Reversals Recognised in 2016-17

<table>
<thead>
<tr>
<th>Property, Plant and Equipment</th>
<th>Intangible Assets</th>
<th>Financial Assets</th>
<th>Non-current Assets Held for Sale</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Unforeseen obsolescence</strong></td>
<td><strong>680</strong></td>
<td>0</td>
<td>0</td>
<td><strong>680</strong></td>
</tr>
<tr>
<td><strong>Changes in market price</strong></td>
<td>0</td>
<td><strong>21,069</strong></td>
<td>0</td>
<td><strong>21,069</strong></td>
</tr>
<tr>
<td><strong>Total charged to Annually Managed Expenditure</strong></td>
<td><strong>21,749</strong></td>
<td>0</td>
<td>0</td>
<td><strong>21,749</strong></td>
</tr>
<tr>
<td><strong>Total Impairments of Property, Plant and Equipment changed to SoCI - AME</strong></td>
<td>0</td>
<td><strong>21,749</strong></td>
<td>0</td>
<td><strong>21,749</strong></td>
</tr>
<tr>
<td><strong>Total Impairments charged to SoCI</strong></td>
<td>0</td>
<td>0</td>
<td><strong>21,749</strong></td>
<td><strong>21,749</strong></td>
</tr>
<tr>
<td><strong>Overall Total Impairments</strong></td>
<td>0</td>
<td>0</td>
<td><strong>21,749</strong></td>
<td><strong>21,749</strong></td>
</tr>
</tbody>
</table>

### 18 Commitments

#### 18.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

<table>
<thead>
<tr>
<th>31 March 2017</th>
<th>31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Property, Plant and Equipment</td>
<td><strong>4,316</strong></td>
</tr>
<tr>
<td>Intangible assets</td>
<td><strong>233</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,549</strong></td>
</tr>
</tbody>
</table>

### 19 Inventories

<table>
<thead>
<tr>
<th>Ranges</th>
<th>Consumables</th>
<th>Work in Progress</th>
<th>Energy</th>
<th>Loan Equipment</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2016</strong></td>
<td><strong>2,778</strong></td>
<td><strong>6,338</strong></td>
<td>0</td>
<td><strong>114</strong></td>
<td>0</td>
<td><strong>9,230</strong></td>
</tr>
<tr>
<td><strong>Additions</strong></td>
<td><strong>46,824</strong></td>
<td><strong>22,755</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td><strong>69,579</strong></td>
</tr>
<tr>
<td><strong>Inventories recognised as an expense in the period</strong></td>
<td><strong>45,759</strong></td>
<td><strong>24,977</strong></td>
<td>0</td>
<td><strong>46</strong></td>
<td>0</td>
<td><strong>70,740</strong></td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td><strong>3,843</strong></td>
<td><strong>14,116</strong></td>
<td>0</td>
<td><strong>110</strong></td>
<td>0</td>
<td><strong>18,069</strong></td>
</tr>
</tbody>
</table>
### 20.1 Trade and Other Receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2017</th>
<th>Non-Current 31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>NHS receivables - revenue</td>
<td>28,575</td>
<td>36,570</td>
</tr>
<tr>
<td>NHS receivables - capital</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS receivables - revenue</td>
<td>12,265</td>
<td>3,074</td>
</tr>
<tr>
<td>Non-NHS receivables - capital</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>4,441</td>
<td>2,911</td>
</tr>
<tr>
<td>PDC Dividend prepaid to DH</td>
<td>276</td>
<td>2,002</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>(5,223)</td>
<td>(2,995)</td>
</tr>
<tr>
<td>VAT</td>
<td>1,284</td>
<td>562</td>
</tr>
<tr>
<td>Current/non-current part of PR and other PPP arrangements</td>
<td>1,866</td>
<td>1,886</td>
</tr>
<tr>
<td>prepayments and accrued income excluding PR lifecycle</td>
<td>1,961</td>
<td>5,670</td>
</tr>
<tr>
<td>Other receivables</td>
<td>47,565</td>
<td>49,680</td>
</tr>
<tr>
<td>Total</td>
<td>52,095</td>
<td>53,501</td>
</tr>
</tbody>
</table>

The great majority of trade is with CCGs (NHS Clinical Commissioning Groups). As CCGs are funded by Government to purchase NHS patient care services, no credit scoring of them is necessary.

### 20.2 Receivables Past Their Due Date But Not Impaired

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>2,230</td>
<td>5,387</td>
</tr>
<tr>
<td>By three to six months</td>
<td>1,217</td>
<td>3,480</td>
</tr>
<tr>
<td>By more than six months</td>
<td>6,666</td>
<td>7,031</td>
</tr>
<tr>
<td>Total</td>
<td>10,023</td>
<td>15,898</td>
</tr>
</tbody>
</table>

### 20.3 Provision for Impairment of Receivables

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2016</td>
<td>(2,995)</td>
<td>(2,528)</td>
</tr>
<tr>
<td>Amount written off during the year</td>
<td>0</td>
<td>138</td>
</tr>
<tr>
<td>Amount recovered during the year</td>
<td>65</td>
<td>1,160</td>
</tr>
<tr>
<td>Increase/decrease in receivables impaired</td>
<td>(293)</td>
<td>(1,765)</td>
</tr>
<tr>
<td>Transfers to NFTTrust on authorisation as FT</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfers to Other Public Sector Bodies under Absorption Accounting</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>(3,223)</td>
<td>(2,995)</td>
</tr>
</tbody>
</table>

### 21 Cash and Cash Equivalents

<table>
<thead>
<tr>
<th></th>
<th>31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening balance</td>
<td>1,118</td>
<td>666</td>
</tr>
<tr>
<td>Net change in year</td>
<td>430</td>
<td>482</td>
</tr>
<tr>
<td>Closing balance</td>
<td>1,548</td>
<td>1,118</td>
</tr>
</tbody>
</table>

**Made up of**

- Cash with Government Banking Service: 1,548, 1,106
- Cash in hand: 0, 12

Cash and cash equivalents as in statement of financial position: 1,548, 1,118
Cash and cash equivalents as in statement of cash flows: 1,548, 1,118

**Third Party Assets - Bank balance (not included above)**: 0, 0
**Third Party Assets - Monies on deposit**: 4, 5

### 22 Non-current Assets Held for Sale

<table>
<thead>
<tr>
<th></th>
<th>Land £000s</th>
<th>Buildings, excluding dwellings £000s</th>
<th>Dwellings &amp; payments on account £000s</th>
<th>Assets under construction &amp; payments on account £000s</th>
<th>Plant &amp; machinery £000s</th>
<th>Transport &amp; equipment £000s</th>
<th>Information technology £000s</th>
<th>Furniture &amp; fittings £000s</th>
<th>Intangible Assets £000s</th>
<th>Financial Assets £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2016</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Liabilities associated with assets held for sale at 31 March 2017**

- Assets held for sale relating to Mammography equipment no longer required by the Trust following the cessation of the Breast screening service from 31st March 2016. These assets were valued by third party resulting in an impairment write down of £521k.
### 23 TRADE AND OTHER PAYABLES

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
<th>Non-Current 31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables - revenue</td>
<td>8,172</td>
<td>5,321</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS payables - capital</td>
<td>111</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>3,967</td>
<td>3,359</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables - revenue</td>
<td>24,940</td>
<td>36,488</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables - capital</td>
<td>1,220</td>
<td>1,875</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>5,883</td>
<td>6,659</td>
<td>3,851</td>
<td>4,064</td>
</tr>
<tr>
<td>Social security costs</td>
<td>3,738</td>
<td>3,161</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PDC Dividend payable to DH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accrued Interest on DH Loans</td>
<td>193</td>
<td>107</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>3,453</td>
<td>3,401</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3,976</td>
<td>4,065</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total payables (current and non-current)</td>
<td>317,533</td>
<td>222,694</td>
<td>47,668</td>
<td>37,924</td>
</tr>
</tbody>
</table>

Included above:
- Outstanding Pension Contributions at the year-end 4,122 6,567

### 24 BORROWINGS

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
<th>Non-Current 31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans from Department of Health</td>
<td>976</td>
<td>602</td>
<td>71,248</td>
<td>39,677</td>
</tr>
<tr>
<td>PFI liabilities - main liability</td>
<td>8,271</td>
<td>8,453</td>
<td>237,038</td>
<td>239,941</td>
</tr>
<tr>
<td>Total</td>
<td>9,247</td>
<td>9,055</td>
<td>308,286</td>
<td>279,618</td>
</tr>
</tbody>
</table>

Total borrowings (current and non-current) 317,533 288,673

### 25 DEFERRED INCOME

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
<th>Non-Current 31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening balance at 1 April 2016</td>
<td>3,534</td>
<td>4,486</td>
<td>4,064</td>
<td>4,277</td>
</tr>
<tr>
<td>Deferral revenue addition</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer of deferred revenue</td>
<td>433</td>
<td>(952)</td>
<td>(213)</td>
<td>(213)</td>
</tr>
<tr>
<td>Current deferred income at 31 March 2017</td>
<td>3,967</td>
<td>3,534</td>
<td>3,851</td>
<td>4,064</td>
</tr>
</tbody>
</table>

Total deferred income (current and non-current) 7,818 7,598

### 26 PROVISIONS

<table>
<thead>
<tr>
<th></th>
<th>Total £000s</th>
<th>Comprising: £000s</th>
<th>Legal Claims £000s</th>
<th>Restructuring Costs £000s</th>
<th>Continuing Care £000s</th>
<th>Equal Pay (incl. Agenda for Change) £000s</th>
<th>Other £000s</th>
<th>Redundancy £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2016</td>
<td>3,622</td>
<td>2,677</td>
<td>661</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>184</td>
<td></td>
</tr>
<tr>
<td>Arising during the year</td>
<td>253</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>219</td>
<td></td>
</tr>
<tr>
<td>Utilised during the year (546)</td>
<td>421</td>
<td>36</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>588</td>
<td></td>
</tr>
<tr>
<td>Transfers to NHS Foundation Trusts on being authorised as FT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers (to/from other public sector bodies under absorption accounting)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>3,446</td>
<td>2,377</td>
<td>605</td>
<td>0</td>
<td>0</td>
<td>319</td>
<td>145</td>
<td></td>
</tr>
</tbody>
</table>

**Expected Timing of Cash Flows:**
- No Later than One Year: 560 420 100 0 0 0 0 40
- Later than One Year and not later than Five Years: 2,181 1,680 400 0 0 0 0 101
- Later than Five Years: 705 277 105 0 0 0 0 4

Amount included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:
- As at 31 March 2017: 360,540
- As at 31 March 2016: 304,420

### 27 ANALYSIS OF CHARITABLE FUND RESERVES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2017 £000s</th>
<th>31 March 2016 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust has not consolidated its Charitable Funds Account</td>
<td>1,308</td>
<td>1,544</td>
</tr>
<tr>
<td>Restricted / Endowment Funds</td>
<td>786</td>
<td>925</td>
</tr>
<tr>
<td>Non-Restricted Funds</td>
<td>2,104</td>
<td>2,069</td>
</tr>
</tbody>
</table>

Non-restricted funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity’s objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee’s discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.
28 PFI - ADDITIONAL INFORMATION

The information below is required by the Department of Health for inclusion in national statutory accounts.

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £000s</th>
<th>2015-16 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service element of on SOFP PFI charged to operating expenses in year</td>
<td>13,757</td>
<td>14,326</td>
</tr>
<tr>
<td>Total</td>
<td>13,757</td>
<td>14,326</td>
</tr>
<tr>
<td>Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI</td>
<td>2016-17 £000s</td>
<td>2015-16 £000s</td>
</tr>
<tr>
<td>No Later than One Year</td>
<td>23,541</td>
<td>23,103</td>
</tr>
<tr>
<td>Later than One Year, No Later than Five Years</td>
<td>100,198</td>
<td>98,332</td>
</tr>
<tr>
<td>Later than Five Years</td>
<td>590,246</td>
<td>625,909</td>
</tr>
<tr>
<td>Total</td>
<td>719,985</td>
<td>747,344</td>
</tr>
<tr>
<td>Imputed “finance lease” obligations for on SOFP PFI contracts due</td>
<td>2016-17 £000s</td>
<td>2015-16 £000s</td>
</tr>
<tr>
<td>No Later than One Year</td>
<td>26,427</td>
<td>26,523</td>
</tr>
<tr>
<td>Later than One Year, No Later than Five Years</td>
<td>93,134</td>
<td>103,761</td>
</tr>
<tr>
<td>Later than Five Years</td>
<td>592,782</td>
<td>625,909</td>
</tr>
<tr>
<td>SubTotal</td>
<td>712,343</td>
<td>755,293</td>
</tr>
<tr>
<td>Less: Interest Element</td>
<td>(267,034)</td>
<td>(266,853)</td>
</tr>
<tr>
<td>Total</td>
<td>445,309</td>
<td>488,440</td>
</tr>
<tr>
<td>Present Value Imputed “finance lease” obligations for on SOFP PFI contracts due</td>
<td>2016-17 £000s</td>
<td>2015-16 £000s</td>
</tr>
<tr>
<td>No Later than One Year</td>
<td>8,271</td>
<td>8,453</td>
</tr>
<tr>
<td>Later than One Year, No Later than Five Years</td>
<td>15,618</td>
<td>29,341</td>
</tr>
<tr>
<td>Later than Five Years</td>
<td>218,242</td>
<td>210,602</td>
</tr>
<tr>
<td>Total</td>
<td>245,309</td>
<td>248,394</td>
</tr>
<tr>
<td>Number of on SOFP PFI Contracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of on PFI contracts</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number of on PFI contracts which individually have a total commitments value in excess of £500m</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

29 IMPACT OF IFRS TREATMENT - CURRENT YEAR

The information below is required by the Department of Health for budget reconciliation purposes.

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Expenditure £000s</th>
<th>2015-16 Expenditure £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue costs of IFRS: Arrangements reported on SoP under IFRIC12 (e.g PFI / LIFT)</td>
<td>2016-17</td>
<td>2015-16</td>
</tr>
<tr>
<td>Depreciation charges</td>
<td>5,428</td>
<td>6,847</td>
</tr>
<tr>
<td>Interest Expense</td>
<td>17,942</td>
<td>25,255</td>
</tr>
<tr>
<td>Impairment charge - AWE</td>
<td>17,527</td>
<td>20,125</td>
</tr>
<tr>
<td>Other Expenditure</td>
<td>25,916</td>
<td>14,326</td>
</tr>
<tr>
<td>Impact on PDC dividend payable</td>
<td>(3,631)</td>
<td>(3,109)</td>
</tr>
<tr>
<td>Total IFRS Expenditure (IFRIC12)</td>
<td>67,162</td>
<td>63,444</td>
</tr>
<tr>
<td>Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)</td>
<td>58,618</td>
<td>43,983</td>
</tr>
<tr>
<td>Net IFRS change (IFRIC12)</td>
<td>8,564</td>
<td>19,461</td>
</tr>
<tr>
<td>Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12</td>
<td>2016-17</td>
<td>2015-16</td>
</tr>
<tr>
<td>Capital expenditure 2015-16</td>
<td>7,675</td>
<td>1,100</td>
</tr>
<tr>
<td>UK GAAP capital expenditure 2015-16 (Reversionary Interest)</td>
<td>1,629</td>
<td>1,054</td>
</tr>
</tbody>
</table>

2015-16 Expenditure £000s | 2016-17 Income/Expenditure IFRIC 12 YTD £000s | 2016-17 Income/Expenditure IFRIC 12 YTD £000s | 2015-16 Income/Expenditure ESA 10 YTD £000s | 2015-16 Income/Expenditure ESA 10 YTD £000s |

Revenue costs of IFRS12 compared with ESA10 | 2016-17 | 2015-16 |
| Depreciation charges | 5,428 | 6,847 |
| Interest Expense | 17,942 | 25,255 |
| Impairment charge - AWE | 17,527 | 20,125 |
| Other Expenditure | 25,916 | 14,326 |
| Impact on PDC dividend payable | (3,631) | (3,109) |
| Total Revenue Cost under IFRIC12 vs ESA10 | 67,162 | 63,444 |
| Net Revenue Cost/(income) under IFRIC12 vs ESA10 | 58,618 | 43,983 |

Revenue costs of IFRS12 compared with ESA10 | 2016-17 | 2015-16 |
| Depreciation charges | 5,428 | 6,847 |
| Interest Expense | 17,942 | 25,255 |
| Impairment charge - AWE | 17,527 | 20,125 |
| Other Expenditure | 25,916 | 14,326 |
| Impact on PDC dividend payable | (3,631) | (3,109) |
| Total Revenue Cost under IFRIC12 vs ESA10 | 67,162 | 63,444 |
| Net Revenue Cost/(income) under IFRIC12 vs ESA10 | 58,618 | 43,983 |
30 FINANCIAL INSTRUMENTS
The Trust has no other financial liabilities.

30.1 FINANCIAL RISK MANAGEMENT
Financial reporting standard FRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with CCGs/NHS England (Commissioners of healthcare) and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust’s treasury management operations are carried out by the finance department, within parameters defined formally within the Trust’s standing financial instructions and policies agreed by the board of directors. The Trust’s treasury activity is subject to review by the Trust’s internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations, although it should be noted that some equipment and consumables are sourced from overseas and may be subject to price changes fluctuations given market volatility seen the UK’s decision to leave the European Union.

Interest rate risk
The Trust borrows from government for revenue financing and capital expenditure, subject to approval by NHS Improvement and Department of Health. The borrowings are for 1 – 25 years and interest rates are confirmed by the Department of Health. These are fixed for the life of the loan and range between 1.5% and 3.5%. The Trust therefore has low exposure to future interest rate fluctuations.

Credit risk
The majority of the Trust’s revenue comes from contracts with other public sector bodies, so the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust’s operating costs are incurred under contracts with commissioners of healthcare (CCGs/ NHS England), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is, therefore, exposed to significant liquidity risks.

30.2 FINANCIAL ASSETS

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Loans and receivables</th>
<th>Available for sale</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Receivables - NHS</td>
<td></td>
<td>30,682</td>
<td></td>
<td>30,682</td>
</tr>
<tr>
<td>Receivables - non-NHS</td>
<td></td>
<td>24,647</td>
<td></td>
<td>24,647</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td></td>
<td>1,548</td>
<td></td>
<td>1,548</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td></td>
<td>0</td>
<td>56,877</td>
<td>56,877</td>
</tr>
<tr>
<td>Receivables - NHS</td>
<td></td>
<td>44,971</td>
<td></td>
<td>44,971</td>
</tr>
<tr>
<td>Receivables - non-NHS</td>
<td></td>
<td>15,903</td>
<td></td>
<td>15,903</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td></td>
<td>1,118</td>
<td></td>
<td>1,118</td>
</tr>
<tr>
<td><strong>Total at 31 March 2016</strong></td>
<td></td>
<td>0</td>
<td>61,992</td>
<td>61,992</td>
</tr>
</tbody>
</table>

30.3 FINANCIAL LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>At ‘fair value through profit and loss’</th>
<th>Other Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>NHS payables</td>
<td>80,737</td>
<td>80,737</td>
</tr>
<tr>
<td>Non-NHS payables</td>
<td>56,347</td>
<td>56,347</td>
</tr>
<tr>
<td>Other borrowings</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PFI &amp; finance lease obligations</td>
<td>245,309</td>
<td>245,309</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td>0</td>
<td>382,393</td>
</tr>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS payables</td>
<td>46,328</td>
<td>46,328</td>
</tr>
<tr>
<td>Non-NHS payables</td>
<td>62,465</td>
<td>62,465</td>
</tr>
<tr>
<td>Other borrowings</td>
<td>40,279</td>
<td>40,279</td>
</tr>
<tr>
<td>PFI &amp; finance lease obligations</td>
<td>248,394</td>
<td>248,394</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2016</strong></td>
<td>0</td>
<td>397,466</td>
</tr>
</tbody>
</table>

31 EVENTS AFTER THE END OF THE REPORTING PERIOD
There are no reportable events after the end of the reporting period, up to date of signing these statements other than these financial statements were approved at the Board of Directors meeting on 1 June 2017.
32 RELATED PARTY TRANSACTIONS

During the year none of the Department of Health Ministers has taken undertaken any transactions with the Trust, however, the following Trust Board members undertook transactions with the Trust via their limited liability companies.

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Party</th>
<th>Payments to Related Party £000s</th>
<th>Receipts from Related Party £000s</th>
<th>Amounts owed to Related Party £000s</th>
<th>Amounts due from Related Party £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Collins - Acting Director of Finance (Trisett Ltd)</td>
<td>207</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anne Robson - Acting Director of People &amp; Organisation Development (Interim Ltd)</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust also recorded the following transactions with organisations that some members of the board were associated with:

<table>
<thead>
<tr>
<th>Party</th>
<th>Payments to Related Party £000s</th>
<th>Receipts from Related Party £000s</th>
<th>Amounts owed to Related Party £000s</th>
<th>Amounts due from Related Party £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Castells Solicitors LLP</td>
<td>155</td>
<td>88</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Department of Health</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Healthcare People Management Association</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ICNARC</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BM United Kingdom Limited (EUK)</td>
<td>38</td>
<td>1,557</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>London Borough of Barking and Dagenham</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>London Health People Management Association</td>
<td>172</td>
<td>932</td>
<td>112</td>
<td>75</td>
</tr>
<tr>
<td>NHS Confederation</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>112</td>
<td>932</td>
<td>112</td>
<td>75</td>
</tr>
<tr>
<td>Queen Mary University of London</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The Trust has one related party which is non-NHS governmental departmental. It is the Barking Havering University Hospitals NHS Charity which recorded an income of £425k, expenditure of £390k, year end receivables of £3k, and payables of £194k.

33 LOSSES AND SPECIAL PAYMENTS

The total number of losses cases in 2016-17 and their total value was as follows:

<table>
<thead>
<tr>
<th>Losses</th>
<th>Total Value of Cases £s</th>
<th>Total Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>143,602</td>
<td>161</td>
<td></td>
</tr>
</tbody>
</table>

The total number of losses cases in 2015-16 and their total value was as follows:

<table>
<thead>
<tr>
<th>Losses</th>
<th>Total Value of Cases £s</th>
<th>Total Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>245,738</td>
<td>168</td>
<td></td>
</tr>
</tbody>
</table>

Details of cases individually over £300,000

The Trust has no individual losses or special payments above £300,000 (2014-15 - none).
34 FINANCIAL PERFORMANCE TARGETS

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

34.1 BREAK-EVEN PERFORMANCE

<table>
<thead>
<tr>
<th>Turnover</th>
<th>2006-07 £000s</th>
<th>2007-08 £000s</th>
<th>2008-09 £000s</th>
<th>2009-10 £000s</th>
<th>2010-11 £000s</th>
<th>2011-12 £000s</th>
<th>2012-13 £000s</th>
<th>2013-14 £000s</th>
<th>2014-15 £000s</th>
<th>2015-16 £000s</th>
<th>2016-17 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>315,870</td>
<td>245,451</td>
<td>278,460</td>
<td>297,456</td>
<td>407,107</td>
<td>418,121</td>
<td>438,854</td>
<td>457,905</td>
<td>477,893</td>
<td>505,239</td>
<td>507,986</td>
</tr>
<tr>
<td>Adjustments for impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjustments for impact of policy changes (impairments and the removal of the donated asset and government grant reserves)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjustments for impact of policy changes in donated asset and government grant reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjustments for the GVA adjustment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total adjustments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Break-even</td>
<td>-9.33</td>
<td>-25.02</td>
<td>-22.42</td>
<td>-36.83</td>
<td>-47.68</td>
<td>-54.80</td>
<td>-60.57</td>
<td>-65.91</td>
<td>-69.03</td>
<td>-64.46</td>
<td>-64.46</td>
</tr>
</tbody>
</table>

*Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust’s financial performance measurement needs to be aligned with the guidance issued by HM TreasuryDepartment measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to FRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring break-even performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

Also as a result of the accumulated financial deficit a Section 30 referral letter regarding a breach of the break-even duty has been sent to the Secretary of State.

34.2 CAPITAL COST ABSORPTION RATE

The dividend payable on public dividend capital is based on the actual average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

34.3 EXTERNAL FINANCING

The Trust is given an external financing limit which it is permitted to undershoot.

34.4 CAPITAL RESOURCE LIMIT

The Trust is given a capital resource limit which it is not permitted to exceed.

35 THIRD PARTY ASSETS

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.

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.
If you or someone you know cannot read this document, please let us know and we will do our best to provide the information in a suitable format or language. Contact our Patient Advice and Liaison Service:

- Call 01708 435 454
- Email pals@bhrhospitals.nhs.uk
- Visit the main receptions at Queen's or King George hospitals

Queen’s Hospital
Rom Valley Way
Romford
Essex RM7 0AG

King George Hospital
Barley Lane
Goodmayes
Ilford IG3 8YB

These are the main hospitals we run our services from. Our teams also provide services at other clinics and sites across our community.

If you would like any further information please contact us:

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Email communications@bhrhospitals.nhs.uk

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@BHR_hospitals
Barking, Havering and Redbridge University Hospitals NHS Trust