Barking, Havering and Redbridge University Hospitals NHS Trust

Annual Report and Accounts

2011/12

Introduction from the Chief Executive and Chairman

This report comes at the end of a very difficult period for our patients and staff.

The Care Quality Commission investigation into the Trust highlighted issues with staff behaviour and attitude, the need to improve systems and processes and problems in particular services such as Maternity and the Accident and Emergency Departments. We have been shocked and disappointed by the evidence of poor care at the Trust but determined to make substantial and sustainable improvements for the future.

The views of patients and staff in national surveys have also identified many areas where we need to improve. Patient and public confidence in our staff and services has been badly affected.

We want to win back the trust of our patients and local community, in our commitment to the best services and standards of care from our staff.

Because the Trust has such a clear picture of its shortcomings, from the in-depth work of the Care Quality Commission (CQC), scrutiny from our stakeholders and the assurance process of our commissioners, we believe we are now in a strong position to improve and deliver excellent care for the future.

We have been able to identify the actions needed to address the CQC's recommendations to fully meet the standards that we have agreed with them – standards which every patient should experience when they enter our care. The whole programme of improvement needed across the Trust will take some time to be fully embedded and for patients to feel the difference.

Despite this, there are some positive early signs, including an increase in compliments being received about the maternity care we provide. We are now providing one of the best levels of midwifery and obstetric care in the NHS, with a midwife to birth ratio of 1:29, and 98 hours of consultant obstetric cover a week at Queen's Hospital.

Another pleasing sign is the Department of Health's new quality indicator - the summary hospital mortality indicator (SHMI) - showing lower mortality during or after admission to our hospitals than would be expected.

The Trust has a number of services – such as oncology - which have strengthened their reputation for excellence over the last year. The National Lung Cancer Audit found that lung cancer patients treated at Queen's or King George hospitals have a better chance of survival than those cared for by similar organisations, and more patients benefiting from active treatment. Last year, the Trust introduced Intensity-Modulated Radiation Therapy for cancer treatments, reducing side-effects for our patients. And we are planning more investments to strengthen our cancer service in the year ahead.

During 2011/12 we introduced management changes to restructure the Divisions into clinically-led directorates. This will ensure that clinical care will be at the very heart of all decisions and developments at the Trust.

We accept that this has been a difficult year for our patients, their relatives and carers, and we want to give our commitment to making the improvements they deserve. We also recognise that it has been an unsettling and challenging time for our staff and we would wish to thank those who have given their commitment to the further improvements we need to make.

Whilst I am pleased to report progress over the last year, there remains a huge programme of improvement to be delivered. Together with our staff, the support of our non-executive directors and our stakeholders as well as the valued input from our patients, we can move steadily forward to provide the highest standards of care our patients rightfully expect.

Averil Dongworth
Chief Executive

George Wood
Interim Chairman

Key Statistics

Serving 750,000 people from a variety of backgrounds and across a wide area, this Trust is one of the largest in the country.

We deliver services from two large district general hospitals – Queen's in Romford and King George in Goodmayes.

Our staff work hard to ensure that patient care is at the heart of everything we do – despite the extremely high numbers of people we treat every day of the year.

Between April 2011 and March 2012, the Trust recorded the following activity:

Outpatients

The Trust handled **184,777** new outpatient appointments, and another **494,595** follow-up appointments.

That is a total of 679,372 outpatient appointments across all the sites where we operate clinics.

A&E attendances

King George Emergency Department and Urgent Care Centre dealt with **101,942** attendances over the year, with Queen's seeing **131,906** through A&E.

That is a total of **233,848** attendances at our Accident and Emergency departments.

Births

Midwives at King George delivered **1,652** babies, with another **7,407** being born at Queen's.

Including home births, the total number of babies born was **9,059**.

Inpatients

Inpatient admissions across the Trust totalled **123,359**.

Hitting the targets

Like all Trusts, we work to meet, and where possible exceed, performance targets set down by the Department of Health and our commissioners. These cover a wide range of services, and include the maximum amount of time people should wait to be treated.

We have worked extremely hard this year to improve waiting times, although this is still an issue in some areas – particularly in our emergency access pathway (often known as A&E waits).

The table below sets out our performance over the year.

	2011/12 Target	Performance		
		2009/10	2010/11	2011/12
A&E waiting times 4-Hour max. wait in A&E from arrival to admission, transfer or discharge	95%	97.31%	95.30%	93.63%
Access to genito-urinary medicine (GUM) clinics	98%	99.93%	99.06%	**99%**
Cancer urgent referral to first outpatient appointment waiting times. 2-week GP referral to first outpatient appointment	93%	99.75%	96.65%	**97.38%**
Cancelled operations Cancelled operations not re-admitted within 28 days	5%	2.33%	2.65%	**1.36%**
Cancer diagnosis to treatment waiting times 31 day diagnosis to treatment – all cancers	96%	96.89%	99.90%	**98.99%**
Cancer urgent referral to treatment waiting times 62 day urgent referral to treatment – all cancers	85%	81.62%	83.69%	**87.62%**
Clostridium Difficile Infections The maximum numbers shown are those allowed under Department of Health targets	See individual targets	82 Max.No. of cases: 145	110 Max.No. of cases: 128	**45** Max. No. of cases: 81
Delayed transfers of care Percentage of patients with delayed transfer of care	3.5%	3.78%	4.28%	4.32%

Engagement in clinical audits Local National	No targets	347 44	384 49	322 40
Ethnic coding data quality Ethnicity recorded for all inpatients	95%	96.34%	97.74%	**98.13%**
MRSA bacteraemias The maximum numbers shown are those allowed under Department of Health targets	See individual targets	28 Max. No. of cases: 39	15 Max. No. of cases: 11	10 Max. No. of cases: 8
Participation in heart disease audits	N/A	Yes	Yes	**Yes**

New Developments

Capital Investments

In 2011/12 the overall Capital Resource Limit (CRL) was £16.57m. £15.30m was spent during the year with £1.27m carried forward to 2012/13. Of the site-specific investments that have been made, £4m has been invested at King George Hospital and £1.1m at Queen's (excluding the managed equipment service refresh).

During the course of 2011/12 the Trust received additional capital funding in respect of the SAN Virtualisation (£850k), Pathology Modernisation/Centralisation (£2.0m), Midwifery Led Unit (MLU) (£320k) and Access Monies (£334k) amounting to £3.50m for the elements applicable to 2011/12.

During 2011/12 replacement theatre instruments were purchased as well as a Urology stack/video scopes and theatre trolleys, the Savience automated outpatients system was installed at KGH, a patient experience real time survey system was installed, the paediatric ward at KGH was reconfigured and the fire alarm at KGH was replaced.

Patients Benefit from New Radiotherapy

Cancer patients are now benefitting from a new form of radiotherapy at Queen's Hospital.
Edwin Jones (pictured right), who is being treated for prostate cancer, was the very first to be given Intensity-Modulated Radiation Therapy (IMRT) to drastically cut the side effects he could suffer.

Lead Radiographer Jackie Hartigan explained: "This equipment means we can deliver radiotherapy to the tumour very accurately. It reduces the dose that the sensitive organs receive so that there are far less long-term side effects for the patient."

Edwin, 72, has been delighted with the treatment so far. "It really is incredibly clever," he said. "It is space age by my standards and I am so privileged to be receiving it. "Everything has been explained to me thoroughly, and all the staff here have been marvellous.
"Everyone at Queen's has a smiling face and is so

professional, and all of the other oncology patients here seem to be of the same opinion."
He added: "Of course, hospitals are not my favourite place, but I can't speak highly enough of the whole experience. There is no way I could have been cared for better, even if I had paid for the most expensive private treatment available."

Around 30 per cent of cancer patients treated by the Trust are suitable for the treatment.
"We are looking to extend the number of patients that we offer it to over the next 18 months," said Jackie.
"By reducing long-term side effects, it will improve patients' subsequent quality of life."

Cancer Patients Offered Complementary Therapies

A new service has started at Queen's Hospital – offering cancer patients a range of therapies to help ease any suffering.
Patients can now access therapies such as aromatherapy, reflexology and Indian head massage on-site.

People being treated for cancer can often feel stressed and anxious, as well as experiencing pain and nausea.
Complementary therapies are known to help alleviate these.

The therapy room in the oncology department has now been officially opened.
The service was made possible thanks to a donation from Georgia's Teenage Cancer Appeal (GTCA) – a charity set up in memory of 14-year-old Georgia Cordery who died at the age of 14. She was treated at Queen's Hospital.

Therapist Julie Campbell is running the service, and has recruited trained volunteers to help her carry out as many treatments as possible.
"I have been working with cancer patients for a long time, and it is astonishing to see the difference that therapies can make," said Julie.
"It can reduce stress, help people sleep and reduce the symptoms of cancer. It's hugely rewarding to see how much it means to people."

Julie also spends time in the cancer day unit, offering reflexology to people as they are receiving their chemotherapy.

Divisional Nurse Judith Douglas said: "This service means an awful lot to our patients. The therapy room is an oasis of calm and extremely well used."

Visiting Hours Extended

A major change has taken place on our wards
New visiting times have been introduced to make it much easier for people to come and see their loved ones.

Visiting hours used to be restricted to two hours in the afternoon, and a further two in the evening.
Now, on the majority of wards, you can come to visit your friends or family any time between 10.30am and 7.30pm.

This will is a huge improvement for patients and visitors alike.

Patients can have the support of visitors throughout the day, helping to relieve any stress or boredom.
And visitors can spend much more time with their loved one – and play a greater role in caring for them.
With visiting hours now stretching over meal times, patients can also eat with a friend or family member, and be supported by them if they need help with feeding.

Whereas previously visiting times had varied from ward to ward, leading to confusion, having set hours across the Trust makes it much clearer.
There are a few exceptions to the visiting times in areas where more flexibility is needed, such a maternity, paediatrics and critical care.
The change came about following discussions with patients, visitors and staff.

Hourly Care Checks

Our patients were benefiting from “hourly rounding” long before the Prime Minister backed the practice last year.
David Cameron called for nurses to change the way they work - making sure they see patients every hour.
He also called for senior nursing staff to spend more time on the wards, and for local people to come in to hospitals to check standards of care.

All of these had already been put in place at Queen’s and King George hospitals, and the improvements have been clear to see.
The Trust introduced a system last summer where nurses carry out regular care checks on patients.

The most vulnerable – including those who are very ill, have dementia or learning difficulties – are seen by a nurse at least once every hour while they are awake.
Those who are recovering well and are soon to be discharged are given the option of whether they would like a nurse to check on them every hour or every other hour. No patient goes more than two hours without being seen.
This system works across all the wards at the Trust – including Accident and Emergency where every patient is checked on every hour, 24-hours a day.

Director of Nursing Deborah Wheeler said: “We have had really good feedback from patients. They like to know that they will be seen regularly by a nurse and that we are keeping a close eye on them and the care they are receiving.”

The Trust also put a Visible Leadership scheme in place almost two years ago which sees the senior nursing team back in uniform and back on the wards.
They spend one day a week on a ward – making an unannounced visit.

As well as checking on all aspects of care on the wards, they focus on one specific area each week such as nutrition, hygiene, IV line care, falls or pain control.

Deborah Wheeler said: “There has been very positive feedback from the matrons and the ward staff to the programme. We see this as a key way for us to ensure that patient care is of a consistent, high standard across all of our wards.”

A Care Quality Commission national report into nutrition and dignity for elderly patients proved that the work taking place at the Trust is paying dividends. It was named as one of the organisations meeting both of the essential standards.

The Trust also actively encourages members of the public to feedback on standards of care and be involved in service developments.
It has an Improving Patient Experience Group and Maternity Services Liaison Committee made up of patients and carers who regularly come onto the wards and work with staff to ensure services are up to scratch.
The Trust also works closely with the Local Improvement Networks, who carry out regular visits to our hospitals.

Patient feedback surveys have been introduced on all wards so that people have the opportunity to tell us how they felt about the care they received.

All of this patient involvement and feedback is then used to shape future services, and helps us to determine where we need to concentrate our efforts.

Clinical Fellows

A ground-breaking scheme has been launched to improve care at our hospitals.

The pilot project has seen experienced doctors and midwives brought in to spearhead work to improve the quality of care in the organisation.

Ten doctors, who are on the cusp of being appointed as consultants in a variety of different specialties, have joined the Trust on a one-year contract as Clinical Fellows. They spend two days a week carrying out clinical work. But the remainder of their time is spent leading on a range of diverse projects in areas such as surgery, paediatrics, maternity, anaesthetics and general medicine.

The Fellows each have a mentor within the Trust, and work with staff throughout both hospitals, including managers, consultants, nurses and midwives as part of their projects to improve care and patient experience within their speciality.

A similar scheme has seen four senior midwives join the Trust and lead their own projects in the organisation, specifically looking at care for women before, during and after childbirth. Eight of our own midwives and six neonatal nurses are also participating in this scheme

All of the Fellows are also taking part in a leadership development support programme with other Trust staff who will then go on to challenge any poor practice or bad attitude that they encounter on the wards.

Medical Director Stephen Burgess said: “This is an extremely exciting scheme. It will really take the organisation forward, and help us to address some of the issues about quality of care that were raised in the Care Quality Commission’s investigation.
“It will also help to develop the leaders and innovators of tomorrow within the Trust.”
He added: “This should leave us with a legacy of well developed projects embedded in our hospitals which will directly lead to a better experience for our patients. It will also see 60 staff acting as champions for change, and leading on work to address poor care and attitudes in the organisation.”

The ten doctors and four midwives will be analysing the outcomes of their projects to measure the impact they have had on the quality and safety of the care provided by the Trust.
The scheme has been developed with NHS London and London Deanery and, if it successful, it could be rolled out to other Trusts.

- The Clinical Fellows are pictured above with Chief Executive Averil Dongworth, Medical Director Stephen Burgess and Medical Director of NHS London Andy Mitchell.

Intensive Care Clinic

People who have been critically ill are being given support to return to a normal life thanks to a new service.

A clinic has been introduced, seeing patients who have spent time in Intensive Care. The follow-up clinic sees people after they have been discharged from hospital to see if they are suffering any long-term effects from their illness.

Some patients can spend months in the Trust’s three Intensive Care Units – one at King George and a general and specialist neuro ICU at Queen’s.

Gonzalo de la Cerda, a consultant in neurocritical care, is leading the project.
He explained: “People can suffer long-term effects after they have had a critical illness. There can be physical issues such as muscular problems, or respiratory problems because of being intubated. Patients who have been on a lot of drugs can also experience delirium.
“But even more serious is people who are suffering post traumatic stress disorder. People who have had a near death experience can have similar problems to people who have been to war.
“Their behaviour can change enormously, including becoming aggressive. There are a wide range of problems which can affect their jobs and their personal lives once they leave hospital.”

Patients who have been intubated and spent at least three days in the Trust’s Intensive Care Units are now given an appointment to come back three months after their discharge from hospital to see how they are doing.

The National Institute for Clinical Excellence recommends that all hospitals with an ICU offer this service. But so far only 30 per cent do so.

Mr de la Cerda said: “It used to be that we would see a patient come into the ICU, they survive and then we don’t see them again.
“But this clinic is good for us as well. It’s great for us to see the patients again, and important for us to understand that our job doesn’t finish when the patient leaves the ICU.”

At the follow-up clinic the patients are assessed to find out if they are experiencing any physical or emotional difficulties.

Mr de la Cerda and Critical Care Outreach Sister Julie Phillips will then refer them on to other specialities such as physiotherapists, speech and language therapists of clinical psychologists if necessary.
If they feel the patient may need different care or treatment they will liaise with their GPs to ensure they are getting the attention they need.

The clinic also allows patients to visit to the ICU if they wish, and see the staff who treated them. Some will have very little memory of their time in the unit, and it can be therapeutic to return.

The follow-up clinic will continue to see former patients from the Intensive Care Units until they are confident that any long-term issues are being addressed.

“It is not enough that people survive a critical illness. We want to ensure that they go on to have a good quality of life,” said Mr de la Cerda

Patient Experience

The Trust puts patient care at the heart of everything that it does, and work is on-going to improve the experience of people using our services.
There were several successes during 2011/12, including receiving national praise for the dignity and nutrition we provide to our elderly patients and impressive Patient Environment Action Team scores.
We also opened the Lavender Garden at Queen's – funded by BHR Hospitals Charity - to provide patients and carers with a relaxing environment to escape the sometimes stressful experience of being in hospital.
We have a very active Improving Patient Experience Group and a Maternity Services Liaison, with members made up of patients and carers keen to be involved with developments at our hospitals.
We have also introduced Real Time patient surveys, giving people the opportunity to leave feedback on their experience either on a hand-held computer or at a number of kiosks around our hospitals.
During a difficult year when there was regular negative publicity about the Trust, we were not surprised to see an increase in the number of complaints received.
While the volume of complaints increased significantly, it was pleasing to note that this reduced towards the end of 2011/12, particularly with regards to concerns about maternity care
Major work has taken place to improve our complaints handling processes to ensure that people receive a prompt and full response to any concerns they raise.

The table below sets out how many complaints have been handled by the organisation.

	Performance		
	2009/10	2010/11	2011/12
Number of formal complaints	566	660	1,139
Number of Patient Advice and Liaison Service enquiries	9,988	7,218	4,790

A three-year Patient Experience and Involvement Strategy has now been drawn up detailing how we will work to improve services and address the areas of concern which have been highlighted in patient surveys.

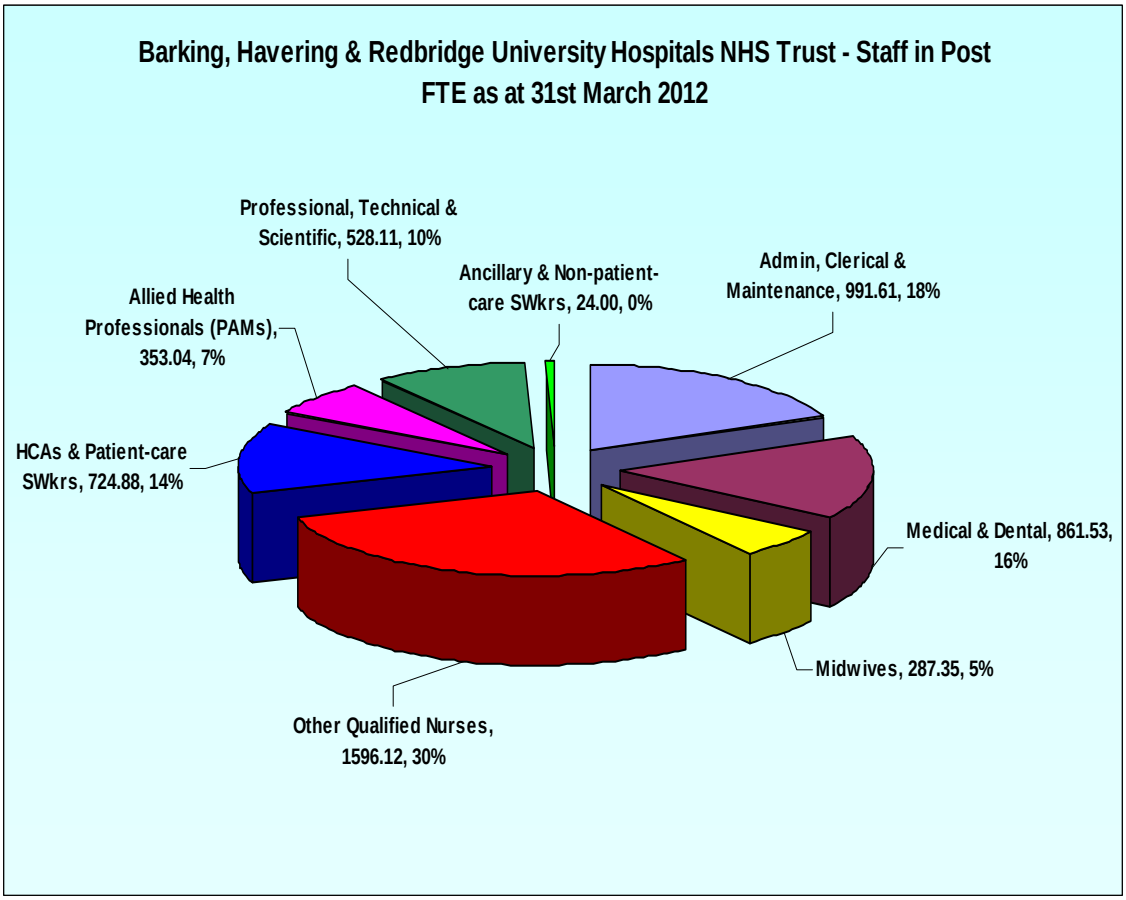
Our Staff

The Trust employs more than 5,300 Full Time Equivalent (FTE) staff, who are our most important resource. Around 72% work in direct clinical care with a further 10% in clinical support roles.

Without our skilled and dedicated workforce we could not continue to make a difference to the people who need to use our services.

From 1 April 2011 to 31 March 2012 the number of FTE staff in post increased by more than 209. The change is due to successful recruitment campaigns designed to increase the number of front-line staff working directly with patients on our wards.

As a result we have been able to reduce agency and locum usage which will also have contributed to improvements in quality and continuity of patient care.



Sickness absence

Trust-wide sickness absence for 2011/12 was 4.92% - an increase of 0.39% on the previous year. More accurate reporting of absence with the continued roll out of HealthRoster partly explains the upward trend.

In line with national, regional and local requirements to improve workforce productivity and efficiency, we have reviewed our sickness absence target and revised this to 3.6% - an improved level than the London average. Although this is a stretch target we believe it should be achievable within the coming year.

Sickness Absence Management was a key element of training delivered for managers in 2011.

National Staff Survey

BHRUT recognises the importance of staff surveys in helping review and improve the work experiences of staff so they in turn can provide better care to patients. The Trust participates in the annual National NHS Staff Survey.

With the findings of the 2010 staff survey, published in April 2011, the Trust decided to invest in a major piece of work with staff across the organisation, to draw up a staff engagement strategy. This involved meetings, discussions and focus groups involving over 600 staff. To launch this and discussions on the improvements needed following the CQC investigation, an initiative called the Big Conversation was launched on 28 October 2011.

To help give staff more support, the Trust has investigated and procured an Employee Assistance Programme, which will go live from June 2012. A staff engagement taskforce set up to help champion staff feedback and input across the organisation. Executive Directors have also been going 'back to the floor' to spend time with staff at work across the organisation in a 'walking in your shoes' initiative. This has helped senior management better understand the challenges facing front-line staff and identify support they need to implement improvements.

Bank, Agency, Recruitment

Recruitment remains a high priority. Several centralised and bulk recruitment campaigns including overseas, open days, focussed advertising and university-targeting, have reduced the number of vacancies within nursing, midwifery and operating department practitioners. This remains an ongoing process especially for difficult to recruit areas such as A&E, theatres and midwives. During the period September 2011 to March 2012, an accelerated recruitment project was established and successfully reduced the Trust vacancy from 10 to 7%.

Recruitment for specific staff groups throughout 2011/12 focused on Health Care Assistants for Medicine and the Emergency Department, European-wide campaign to recruit midwives with particular focus on Italy, Ireland and Portugal, and A&E doctors.

Management and control arrangements for recruitment have been reviewed and a more streamlined process put in place with appropriate internal controls. An internal audit concluded recruitment processes were sound and significant improvements had been made on recruitment timescales.

Recruitment remains an ongoing priority especially for difficult to recruit areas such as A&E, theatres and midwifery where the specialist skills required remain in high demand. In house development into the experienced posts will be continued into 2012/13 with backfill into the vacated internal promotions creating opportunity and fresh ideas.

National Medical staff shortages have an impact in certain specialities, most notably Paediatrics, A&E and critical care. This is reflected, in part, in the poor allocation of trainees in areas such as Paediatrics, and Accident and Emergency. The Director of Medical Education has been working on relationships between the Trust and Deanery. Staff surveys show improved satisfaction from staff with their education at the Trust.

Since the launch of the Trust's In-House Bank in July 2010, there have been further improvements in the use of temporary staff achieving overall fill rates of 90% across all staff groups The flexibility offered by bank and agency usage is recognised and

usage is closely monitored with monthly reports. A fast-track registration process is in place for current Trust employees who wish to join the Bank.

Since the bank came in-house, preferential rates with agency suppliers have been negotiated especially amongst medical staff where the temporary fill is predominantly via an agency. The pool of bank workers, especially nursing posts, has increased so that In house fill for Nursing and Midwifery is 86%. The overall use of temporary administrative and clerical staff and nursing staff has reduced owing to permanent recruitment and more efficient rostering. However, medical staff and national shortage staff groups remain a challenge.

Weekly reviews of bank and agency usage, aligned to the progress on appointing to vacancies, are helping drive down the use of temporary staff. This review is also able to identify the hotspot recruitment areas thus promoting a proactive approach to forecasting future recruitment requirements within each Directorate. HR has restructured to align management and support to the new business units with effect from January 2012.

Workforce Planning and Information

The Trust has piloted the Workforce Assurance Tool (developed by NHS London) which aligns workforce, activity and finance.

At a department level workforce data is extracted from the Trust's eRostering system (Healthroster) and centrally collated to generate a wider eRostering dashboard. Key Performance Indicators (KPIs) recorded and monitored via this report include roster effectiveness, safety, establishment, staff unavailability due to leave. Accompanied with temporary staff data extracted from the Trust's In House Bank this reporting mechanism provides a robust tool for identifying individual departments workforce efficiency and effectiveness.

The KPIs are fundamental to management of the workforce. These ensure the focus is on actual rather than perceived issues. They serve to highlight progress against goals and ensure underperformance is corrected.

The KPIs are regularly benchmarked against previous performance, other organisations across London and also NHS standards.

At Directorate monthly performance reviews workforce KPIs can be considered in relation to service performance, quality and finance indicators.

Partnership working

Achieving and maintaining a positive employee relations environment is fundamental to achieving our HR plan and wider Trust aims.

Openness and transparency are key – a commitment actively demonstrated though BHRUT's range of policies and practice.

Underpinning this approach are recognition arrangements with trade unions and established communications and consultation processes via the monthly Joint Staff Committee (JSC) and a partnership forum of staffside and management representatives.

HR have adopted a more mediated approach to employee relations during 2011/12 to resolve issues and concerns amicably, informally and speedily. This is based on mediation principles which ACAS and the Department of Health have jointly worked on.

Throughout 2011 partnership working with staffside has been strengthened. A partnership event was held on the 29 July 2011 with the Chief Executive, Director of HR and key HR staff and managers. This has led to a revised and updated Partnership Agreement which is in draft form for discussion and approval.

Equality and Diversity

The Trust benefits from a rich diversity in its workforce, reflecting both the local population and the composition of the wider national and international healthcare workforce. Equality of opportunity for all parts of the workforce remains a central tenet of the Trust's overall policies on employment and is a key issue in making the most of the skills, knowledge and experience of the workforce.

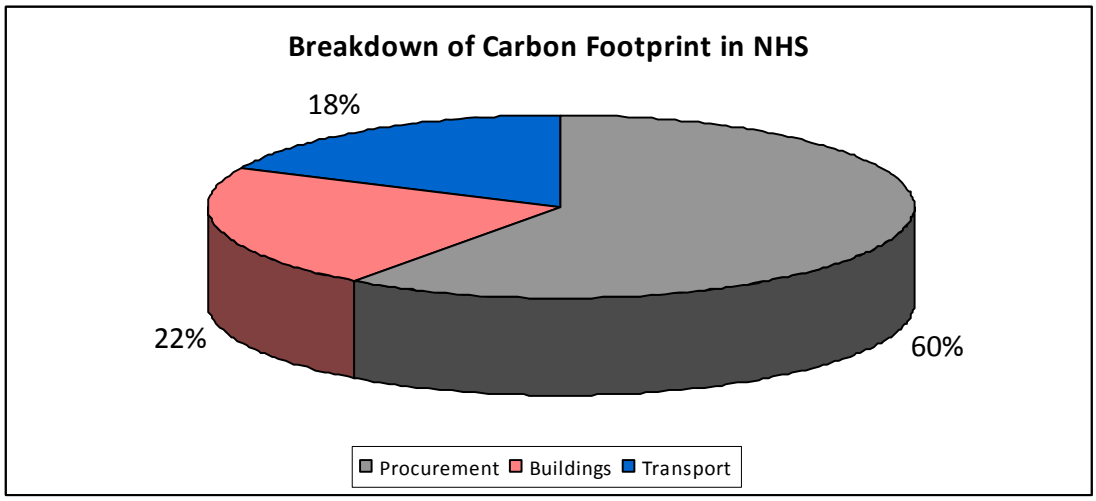
Throughout 2011/12 the Trust prepared for the adoption of the NHS Equality Delivery System (EDS). Key to local implementation is our representation on the Equality Partnership Group (EPG). This was established three years ago and is made up of Equality and Diversity leads from the NHS organisations within the outer north east London cluster, and associate members from London Ambulance Service and NHS South West Essex.

Sustainability

The Department of Health in response to government requirements to cut carbon emissions in the UK, has set the following targets for the NHS;

- 10% reduction in CO_2 by 2015
- 34% reduction in CO_2 by 2020

These targets do not relate just to building energy use but to the entire carbon footprint of all NHS organisations. The NHS Sustainable Development Unit has identified three main sources of carbon emissions across the NHS with the following percentage breakdown shown below.



Update on Progress

During 2011/12 the Trust emitted approximately 25,000tnCO_2 from Trust operated buildings and fleet. This is a reduction of approximately 3% on the previous year's figure. The figure is more impressive due to the fact that there is greater usage of existing buildings, resulting in a greater demand for energy. The energy use figures show that more energy efficient initiatives being put in place, including LED and boiler modifications, are starting to reduce carbon emissions. A much more detailed plan has been produced to target energy reductions across the Trust and is now being implemented.

This Carbon Management Plan has identified the main sources of carbon emissions and listed specific actions to incorporate the wider sustainability agenda. The plan emphasises the importance of understanding what the Trust's carbon footprint is made up of and supports further improvements made to the current methodology, such as procurement and transport.

The main focus to date has been carbon emissions from buildings. This has identified the main areas and has resulted in an ambitious plan to reduce carbon emissions by 30% by 2015 which, if fully implemented, will mean the Trust will reach the 2020 target of 34% in just three years. A mix of both major capital and smaller projects has been produced which will target increasing electricity use and carbon intensive fuel sources across the Trust. Projects that have already started are resulting in carbon reductions, but the planned projects will lead to much more pronounced reductions in building energy use and associated carbon emissions.

The Sustainable Development Committee has a clear responsibility to integrate its activities with all key parts of the Trust's operations and our key partners. Working with the London Boroughs in the area and NHS North East London and the City, we are now establishing links with sustainability strategies supported throughout the region.

The Trust has also signed up to the Good Corporate Citizenship Assessment, which provides the Framework the Trust follows.

Our approach to sustainability over the long term must be to see this as core behaviour for the Trust and to influence all aspects of the Trust's business to ensure that we act as a responsible corporate citizen.

The Trust Board members

Interim Chairman: George Wood
George worked for Ford for 33 years, and joined the Trust in 2010.
He held various senior positions with the organisation including Managing Director of Ford Credit Brazil and later Vice President of the South America region. More recently he was Director of the UK Customer Service Centre.

Chief Executive: Averil Dongworth
Averil was appointed as Chief Executive in February 2011.
She was previously the Chief Executive of Barnet and Chase Farm Hospitals based in North London. She led the Trust from February 2004 having joined from Barnet

Primary Care Trust, where she was also Chief Executive. Prior to that Averil was Chief Executive at City and Hackney Community Services NHS Trust.

Medical Director: Stephen Burgess

Stephen joined the Trust as a consultant in Obstetrics and Gynaecology in 1989 at King George Hospital. He has a special interest in colposcopy.

He chaired the Senior Medical Staff Committee at King George Hospital from 1993 to 1998, when he was appointed as the Trust's Medical Director. He was instrumental in the merger of Redbridge Health Care and Havering Hospitals Trust into the current BHR Hospitals Trust.

He stood down from the post in March 2006, returning to full time clinical practice. In September 2008 he took up the role of Divisional Director of Surgery and became Medical Director in May 2011, having been acting Medical Director since December 2010.

Director of Nursing: Deborah Wheeler

Deborah joined the Trust as Director of Nursing in January 2010 from the Whittington NHS Trust where she held the post of Director of Nursing and Clinical Development.

Deborah trained as a nurse at St Bartholomew's Hospital, and spent her clinical career in orthopaedic nursing. She subsequently held a variety of management posts at the Royal National Orthopaedic Hospital, Stanmore.

Deborah has lived in the Barkingside area for the last 25 years. Her children were born in Barking Hospital and King George Hospital.

Director of Finance: David Wragg

David joined the Trust in April 2009 after nine years as Finance Director at the Queen Elizabeth Hospital NHS Trust in Woolwich, SE London, where he also looked after estates and facilities management.

David had a leading role in the project to merge the Queen Elizabeth Hospital NHS Trust with Bromley Hospitals NHS Trust and Queen Mary's Hospital NHS Trust to form South London Healthcare NHS Trust.

He has also contributed financial leadership to the Picture of Health project, which has made important and far reaching recommendations for the reorganisation of acute hospital services in outer SE London.

Before joining Queen Elizabeth, David spent 15 years working in health service financial management, management consultancy and audit.

Director of Human Resources: Ruth McAll

Ruth McAll joined the Trust in December 2008. She has 15 years experience as an HR Director with a variety of NHS Trusts, including mental health, community and Foundation Trusts.

Ruth works to develop a structure and function for HR that helps staff and managers deliver good practices in people management.
Ruth was a member of the national pensions review, lead in HR networks and NHS conference.

Director of Planning and Performance: Neill Moloney
Neill Moloney joined BHR in May 2008 from Barts and the London NHS Trust where he was Head of Information and Performance. Prior to this he was a General Manager for four years at Mid Essex Hospitals NHS Trust in Chelmsford and Birmingham Heartlands and Solihull NHS Trust, managing a range of clinical and non clinical services.

As a Commissioning Manager for Birmingham Health Authority, Neill led on development of the winter and emergency plans and was responsible for commissioning specialised services.

With a background in business planning, information provision and operational management, Neill's priorities are to ensure plans and enabling strategies are in place to support the delivery of the Trust's clinical services.

Director of Strategy and Planning: Robert Royce
Robert joined the Trust in January 2010.

Previously, Robert was Director of Operations, Planning, Estates and Facilities in a large acute trust in Wales. He has also been Interim Director of Operations, Division of Emergency Care and Specialist Medicine at South London Healthcare NHS Trust. Robert is working towards achieving our agenda of improving the quality of our services and our patients' experience, meeting our financial targets and implementing our clinical strategy.

Director of Operations: Mark Ogden-Meade
Mark provided interim support from October 2011 until the end of the financial year.

Non-executive directors

Keith Mahoney was appointed from December 2008 and has 30 years' experience with major retail organisations. In his role as Head of Logistics (Food) for Marks and Spencer, he managed a budget of £200 million. Keith Chairs the Trust's Finance and Charities Committees.
He is also a volunteer for many charities.

Anthony Warrens was appointed in June 2011. He is the Dean for Education, Professor of Renal and Transplantation Medicine and Consultant Physician at Barts and The London School of Medicine and Dentistry.
Anthony Co-Chairs the Trust's Quality Committee along with Caroline Wright, below.

Caroline Wright was appointed in July 2011.
Caroline is a communications expert with over 15 years' experience in Public Sector communications.

After starting her career as a journalist at the Barking and Dagenham Post and other local newspapers Caroline moved into public sector PR and held a range of senior Board and communications roles in major Government Departments including the Department for Education, Cabinet Office, Department for Trade and Industry, Ofsted and Partnerships for Schools.

Caroline divides her time between offering communications consultancy and advisory services and caring for her two young children.

William Langley was appointed as a Non-Executive Director and Chair of the Audit Committee in July 2010.

He is a qualified accountant with more than 30 years experience working for major organisations in electronics, the food Industry, publishing and travel. He has held directorships of businesses operating in Japan, South East Asia, South Africa and the UK.

He now works on consultancy projects, and carries out work as a charity trustee and as a member of voluntary sector committees and lives in Havering.

Cllr Michael White joined the Conservative Party in 1982 and has been involved in politics ever since. He has been a Member of Havering Council since 1994 and in 1998 he became Deputy Leader of the Conservative Group on Havering Council and Deputy Leader of the Council in 2002. His responsibilities were e-government and communications but he later took on responsibility for the Council's drive to improve its Comprehensive Performance Assessment (CPA) score.

In May 2004 he became Leader of the Council and was re-elected leader in 2010. Michael is also a member of the London Thames Gateway Development Corporation Board, he is Vice-Chair of Thames Gateway London Partnership; and from 2008 to 2010 was Deputy Leader of London Councils.
He joined the Trust in November 2010.

Farewell
During this year we bid farewell to former Interim Chairman Edwin Doyle, and Non-Executive Director Professor Raymond Playford.

Operating and Financial Review 2011/12

The requirement for NHS bodies to prepare an Operating and Financial Review (OFR) as part of the annual report was introduced in 2005/6. The OFR seeks to provide information on the developments, trends, performance and business position of the Trust in terms both of the year in question and future development.

The Trust agreed a Plan with NHS London for 2011/12 for an Income & Expenditure (I&E) deficit of £39.8m, excluding the technical impact of asset impairments and International Financial Reporting Standards (IFRS). This position compared with a deficit of £33.0m in 2010/11. The key movements bridging the Plan with the previous year's outturn position included; £8.3m of full-year effect cost pressures or non-recurrent benefits in 2009/10; £3.5m reduction in income due to Payment by Results (PbR) tariff reduction and non-recurrent income support in 2009/10; £5.2m adverse impact from planned activity reductions; £18.4m cost pressures (including generic cost pressures, inflation and VAT increases); partially mitigated by a £28.6m Cost Improvement Programme (CIP) target.

By Month Six in 2011/12, it was apparent that the Trust would not fully achieve its CIP target and a revised forecast deficit of £49.9m was agreed with NHS London.

The Trust finished the year with a deficit of £49.9m, in line with the revised forecast, but £10.1m worse than the original plan. This was principally due to a final CIP shortfall of £14.4m, partly mitigated by other net favourable movements of £4.3m. The Trust exceeded its income plan by £20.4m, primarily due to over-performance against Primary Care Trust (PCT) contracts, but also due to additional non-recurrent income received in the latter part of year, for example to fund quality pressures, transitional costs and Access initiatives. These were largely offset, however, by the high cost over the over-performance (often undertaken at high cost premium pay or agency staff rates) and quality pressures, for example in Midwifery, Paediatrics and A&E, again often entailing premium pay rates. Although marginally down, high levels of temporary staffing remains a key issue for the Trust (£40.3m in 2011/12, 13.8% of total pay, compared with £41.3m (14.7%) in 2010/11), although action has been taken to reduce both price and usage.

The Trust was able to marginally increase its cash balances, although this was primarily due to an injection of £55.2m additional Public Dividend Capital by the Department of Health, to fund the cash impact of the in year revenue deficit and £4m to improve working balances carried forward in to the year.

The difficulty in managing the cash consequences of the I&E deficit during the year manifested itself in a poor performance against the Better Payment Practice Code, with only 64% non-NHS invoices (by value) paid within the target 30 day period, although this is up from 57% the previous year.

The Trust achieved its other financial performance targets, in meeting its External Financing Limit (EFL) and Capital Resource Limit (CRL) and a capital cost absorption rate of 3.5%

The 2011/12 deficit increased the Trust's cumulative deficit, as measured against the breakeven duty, to £199.8m, incurred over the seven year period to 31 March 2012.

The Trust is currently planning for a deficit of £39.7m in 2012/13 (again excluding the impact of impairments and IFRS), an improvement of £10.2m from the 2011/12 position. This primarily through a planned further CIP of £23.1m (5.5%, compared with a national tariff assumption of 4%), although this is partially offset by forecast cost pressures of £17.9m and an adverse impact of £8.0m reduced activity (primarily non-elective and out-patients). These are further mitigated however, by £4.3m income support from the PCTs, other tariff / price increases of £5.5m and full-year benefit from 2011/12 of £3.2m.

Going forward, as part of its aim to achieve Foundation Trust status by 2015 the Trust is planning to get to a sustainable in year balanced budget over the same timeframe. The Trust is currently reviewing its longer-term financial strategy and modelling, with external support, with a view to agreeing a robust programme by the autumn. This will be linked to the wider re-configuration of services within North-east London as part of the Health for North East London review.

Financial Governance

The Trust's financial situation is monitored by the Trust Board and in detail by its Finance Committee, which is chaired by Non Executive Director Keith Mahoney. The Trust Audit Committee, which is chaired by William Langley, monitors the Trusts governance arrangements.

The Trust's current external auditors are the Audit Commission. The cost of their work performed amounted to £305k for the year.

Pension liabilities have been accounted for in accordance with note 1.7 of the Accounts.

Remuneration Report

The remuneration package and conditions of service for Executive Directors is agreed by the Trust Remuneration Committee, a Committee of the Board of Directors consisting of all of the Non-Executive Directors, including the Chairman of the Trust.

The remuneration for certain Executive Directors does include performance related bonuses and none of the Executives receives 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 functions of the post as defined in the current job description and as foreseen for the future. This is carried out in parallel with a review of the individual's career development and potential opportunities for progression. 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 arrangements for termination payments or compensation for early termination of contract.

Non-Executive Directors, including the Chairman, are appointed by The Appointments Committee for specified terms subject to re-appointment thereafter at intervals of no more than four years and to the relevant laws relating to the removal of a Director. The Constitution currently requires Non-Executive Directors to retire after eight years' service.

The Remuneration Committee met five times during 2011/12

Remuneration Committee Members

Keith Mahoney NED (current Chair of the Remuneration Committee)
William Langley NED
Caroline Wright NED
Michael White NED
Anthony Warrens NED
George Wood (Chair of the Trust Board)
Barbara Liggins (Acting Chair of Trust Board)
Edwin Doyle (Interim Chair of Trust Board)

In Attendance:
Mrs Ruth McAll, Executive Director of HR and OD
Mrs Averil Dongworth, Chief Executive

In determining Directors' pay and conditions, the Remuneration Committee took into account comparative information available from NHS Partners survey and the IDS Boardroom Pay Report.

The level of remuneration for non-executive Board Members is based on an average expected workload of 2 to 3 days a month for Non-Executive Directors 3 days a week for the Chairman.

The contracts of Directors who served during the year are summarised in the table below.

[Directors' salary table]

'This is audited'

			2011/12			2010/11		
	From	Until	Salary	Bonus Payments	Benefits in Kind	Salary	Bonus Payments	Benefits in Kind
All Figures in £'000s			(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(to nearest £100)
Chairman								
G. Wood	November 2011		10 - 15	-	-			
E. Doyle	August 2010	October 2011	15 - 20	-	-	20 - 25	-	-
Sir David Varney		June 2010				0 - 5	-	-
B. Liggins (Shown in Non Executive Directors)	June 2010	August 2010				-	-	-
Non-Executive Directors								
M. Hicks		May 2010				0 - 5	-	-
S. Cruickshank		June 2010				0 - 5	-	-
B. Liggins		July 2011	0 - 5	-	-	5 - 10	-	-
K. Mahoney			5 - 10	-	-	5 - 10	-	-
R. Playford		June 2011	0 - 5	-	-	5 - 10	-	-
G. Wood	August 2010	November 2011	10 - 15	-	-	0 - 5	-	-
W. Langley	July 2010		5 - 10	-	-	0 - 5	-	-
M. White	November 2010		5 - 10	-	-	0 - 5	-	-
Carolyn Wright	July 2011		0 - 5	-	-			
A Warrens	June 2011		0 - 5	-	-			
Chief Executive								
J Goulston		January 2011				180-185		
A. Dongworth Started 1st Feb 2011	February 2011		225	-	-	35 - 40	-	-
Medical Director								
Ian Abbs (Interim)		December 2010				135 - 140		
S. Burgess	January 2011		160-165			40 - 45	-	-
Director of Human Resources								
R. McAll			110 - 115	-	-	110 - 115	-	-
Director of Finance								
D.Wragg			150 - 155	-	-	150 - 155	-	-
Director of Nursing								
D. Wheeler			95 - 100	-	-	100 - 105	-	-
Director of Performance and Planning								
N. Moloney			115 - 120	-	-	115 - 120	-	-
Director of Strategy								
R. Royce			140 - 145	-	-	140 - 145	-	-

- Benefits-in-kind means the taxable value of benefits provided. The values are calculated in accordance with Inland Revenue rules and relate to leased cars less the contribution made by the employee.

[Directors' pensions table]

'This is audited'

Pension Benefits								
Name and title				Lump sum	Cash	Cash	Real	Employer's
	Real	Real increase in	Total accrued	at age 60	Equivalent	Equivalent	increase in	contribution
	increase in	pension	pension at age	related to	Transfer	Transfer	Cash	to stakeholder
	pension at	lump sum	60 at 31	accrued	Value at 31	Value at 31	Equivalent	pension
	age 60	at aged 60	March 2012	pension at 31	March 2012	March 2011	Transfer	
	(bands of	(bands of	(bands of	March 2012			Value	
	£2,500)	£2,500)	£5,000)	(bands of £5,000)				
	£k	£k	£k	£k	£	£	£	£
S Burgess	2.5-5.0	10-12.5	65-70	205-210	1,507,342.52	1,338,606.68	90,941.37	0
Medical Director								
D Wheeler	0-2.5	0-2.5	35-40	115-120	677,378.79	588,812.05	50,043.83	0
Director of Nursing & Clinical Governance								
R Royce	-0-2.5	-0-2.5	40-45	125-130	800,665.47	733,785.95	31,919.81	0
Director of Strategy & Planning								
N Moloney	0-2.5	0-2.5	25-30	85-90	413,182.97	319,284.31	59,247.59	0
Director of Delivery								
R McAll	0-2.5	2.5-5	40-45	120-125	809,323.25	714,381.36	51,957.38	0
Director of HR								
D Wragg	5-7.5	17.5-20	35-40	105-110	611,834.61	440,815.64	110,764.72	0
Director of Finance								
A Dongworth	20-22.5	60-65	100-105	310-315	2,251,262.48	1,684,519.38	362,524.43	0
Chief Executive								

As Non Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for them.

The Government Actuary Department ("GAD") factors for the calculation of Cash Equivalent Transfer Factors ("CETVs") assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

A cash equivalent transfer value ("CETV") is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. Where individuals have left the Trust during the year the cash equivalent transfer values provided by the NHS Business Services Authority (NHS Pensions) at 31 March 2012 are reported and not at the date of leaving.

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 include the value of any pension benefits in another scheme or arrangement that 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 within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

The Trust has not made any contributions to Stakeholder Pensions for senior managers during the year.

Highest and Median Salaries 2011/12

	£	MULTIPLE
Chief Executive	225000.00	
Band 5	27866.04	
Difference	197133.96	8.07

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.

The banded remuneration of the highest paid director in Barking, Havering and Redbridge NHS Trust in the financial year 2011-12 was £225k (2010-11 £221k).

This was 8 times (2010-11, 8) the median remuneration of the workforce, which was £28k (2010-11, £27k).

In 2011-12, 0 (2010-11, 0) employees received remuneration in the excess of the highest-paid director. Remuneration ranged from £16k to £225k (2010-11 £15k to £221k)

Total remuneration includes salary, non-consolidated performance-related pay, benefits in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Notes

1. The Number of staff 2011-12 5798 (2010-11 5574) this is an increase of 224 or 4%.

2. The increase of salary from 2010/11 to 2011/12 is 4k.This is due to the Appointment of a new Chief Executive in late 2010/11.

3. There was no pay increase for the two years.

Annual Governance Statement

1.0 Scope of responsibility

The Trust Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible, as set out in the Accountable Officer Memorandum.
As designated Accountable Officer I have overall accountability for risk management in the Trust. The Medical Director and Director of Nursing lead on clinical risk management issues, whilst the Finance Director is responsible for financial risk management at Trust Board level. The operational responsibility for risk management at corporate level is assigned to the Clinical Governance Director in the Trust's Clinical Governance Directorate.
The Trust has engaged with and participates in the work of its Health and Social Care Partners across North East London using established networks and communication systems. The Trust meets regularly with NHS London. Close working exists with Outer North East London (ONEL), NHS Barking & Dagenham, NHS Havering, NHS Redbridge and NHS South West Essex in order to take forward the delivery of healthcare; this takes place through regular commissioning, operational and strategy meetings.

The Head of Internal Audit has commented in his overall opinion in 2011-12 that he can contribute only **Limited Assurance** to the assurances available to the Accounting Officer and the Board, in addition to the Board's own assessment of the effectiveness of the organisation's system of internal control. Limited assurance can be given as weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisation's objectives at risk in a number of the areas reviewed.

2.0 The governance framework of the organisation

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

It is confirmed that the system of internal control has been in place in Barking, Havering and Redbridge University Hospital NHS Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.
In the opinion of the Head of Internal Audit, the Assurance Framework in operation does not currently meet the 2011 – 12 Annual Governance Statement requirements and provides only limited assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. It does however recognise that the work achieved within the presentation of the Quarter 4 BAF is rigorous in its approach.

2.1 Trust Board

The Trust Board is collectively responsible for the quality of healthcare delivery and financial performance, and is held to account for the stewardship of public money and the delivery of services to our local population as laid down by the Department of Health and locally by

NHS London. The Trust Board is made up of an interim Chairman, the Chief Executive plus five Non Executive Directors and six Executive Directors. The Board meets publically every two months, with internal Board meetings/seminars on alternate months.
The key functions of the Board are detailed within the Trust's *Corporate Governance Manual* and include the organisation's *Standing Or*ders, *Standing Financial Instructions* and *Scheme of Delegation.* The Trust is able to decide how best to meet these key functions and obligations by setting and implementing an Annual Plan, to include objectives relating to:

- Governance
- Financial Turnaround
- Clinical Services
- Infection Control
- Infrastructure

A committee structure is in place which exists to assure the Trust Board of compliance with the Annual Plan. These function as sub-committees of the Trust Board and have delegated responsibility for monitoring risks and escalating through exception reports any high level clinical risks. The Trust Board also receives the minutes of these sub-committees. The Trust Board agenda is structured to review data and information relating to governance, quality and patient standards, finance, workforce and activity provided via the Performance & Quality Dashboard, as well as information for noting. Membership attendance at the Trust Board meetings is good and in excess of the Terms of Reference membership requirements. There is also regular attendance by members of the public.

2.2 Audit Committee

The Audit Committee has been convened in line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability and the Higgs Report. Its purpose is to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. It oversees performance of the risk management systems in place in the Trust, via the Finance Director and the Clinical Governance Director with key risks highlighted to and reviewed by the Audit Committee and the Trust Board on a regular basis through the Assurance Framework and Risk Register.

Independent scrutiny is provided through representation from the Trust's appointed internal auditors, Parkhill Audit Agency, and from the external Auditors, the Audit Commission. Other attendees of the Committee include the Director of Finance and Head of Financial Operation and three Non Executive Directors (one acting as the Committee's Chair) constitute the Committee's membership. Regular attenders include the Local Counter Fraud Service Manager and the Manager for Local Security Management Systems and the Trust's Divisional Directors who are asked to present their high level risks as part of a rolling programme of review.

The Committee meets not less than four times a year, with an additional meeting held annually in private with the External and Internal Auditors. The agenda includes the review of governance, risk management and internal control, the internal audit function and the work and findings of external audit, as well as financial reporting. Other assurance functions such as any reviews by the Department of Health or Arms Length Bodies or Regulators / Inspectors including the Trust's Care Quality Commission Registration and risks escalated from the Statutory Safety Committee or the Major Incident Planning Group.

The Chairman of the Committee is tasked with drawing to the attention of the Trust Board any issues or significant risks that require disclosure to the full Board, or require executive action. This is achieved through the sharing of the confidential minutes of the Audit Committee with the Trust Board.

The Audit Committee received an annual report from the Trust's Head of Internal Audit at its meeting in April 2012. Fifteen reports were made to the Audit Committee in the course of 2011/12, and nine of these provided substantial assurance, two adequate assurance and four limited assurance. The areas of limited assurance were: Budgetary control; mandatory training; asset verification; and compliance with IT standards.

The Committee also met in April 2011, June 2011, September 2011, November 2011 and February 2012. The bulk of its agenda is taken up in the consideration of internal audit and Audit Commission reports, and reports from its Local Counter Fraud & Security Management Specialists. Each of the Clinical Divisions has presented key clinical and financial risks to the Committee, and the Committee also oversees the processes behind the production of the Board Assurance Framework.

The Audit Committee is also the committee to which waivers of Standing Financial Instructions and Standing Orders are routinely reported, so that Committee members are aware of departures from the Trust's normal arrangements for governance. Rules for waiver are clearly specified and principally in the procurement of goods and services when speed is of the essence or sole supplier arrangements exist.

2.3 Quality & Safety Committee

The Quality and Safety Committee oversee the regular and routine monitoring of detailed clinical performance. The meeting is chaired jointly by two Non Executive Directors. Membership includes the Chief Executive, Medical Director, Director of Nursing, Clinical Governance Director, Divisional Directors, Chief Pharmacist, Director of Communications, Medical Education Director and Director of Education, together with a third Non Executive Director. External members include a representative from NHS Outer North East London and the Chair of the Trust's Improving Patient Experience Group.

The Committee's purpose is to make recommendations to the Board in relation to the Board's objectives whilst developing strategies and plans; ensuring the clinical risks receive high level monitoring and review to facilitate improvement in patients' safety, outcomes and experiences.

The Committee takes exception reports from a range of feeder committees to ensure mortality, external accreditation, patient experience, clinical effectiveness and outcomes, the Quality Account, complaints, legal claims, incidents, serious incidents and Never Events are scrutinised; the feeder committees are:

- Clinical Risk Committee
- Patient Experience Committee
- Evidence Based Practice Committee
- Clinical Audit Committee
- Drugs & Therapeutic Committee
- Safeguarding Adults Committee
- Safeguarding Children Committee
- Infection Control Committee
- Nursing & Midwifery Board.

Attendance and contribution to discussions at the Quality & Safety Committee by members is good and in line with the Terms of Reference. The minutes of both parts of the Committee are sent to the Trust Board for review together with formal highlight reports escalating issues

and concerns; these started in June 2011 and detailed below is a brief summary of those issues:

February 2012

Part I

- Concerns about the reputational and financial damage being experienced by the Trust as a result of the delayed endorsement by NHS London for bringing planned C-sections back to the Trust.
- Complaint response times have improved to 30%, but there was a 50% increase in complaints received in January. The current bed pressures are likely to be the reasons for the increase.

Part II – Confidential

- None

December 2011

Part I

- None

Part II - Confidential

- As of the 5.12.11 there were just over 300 complaints awaiting a response, 60 resolution meetings to be arranged and approximately 20-25 complaints coming in each week. There was concern that the flow of complaint responses from the Divisions was not happening. Discussions have been held with NHS London and an offer of assistance has been made.

October 2011

Part I

- The Dr Foster mortality statistics should be escalated to Trust Board as it demonstrates the improvements that are continuing to be made. The re-based position at the end of July showed the Trust as an outlier with an HSMR of 105; an improvement on the March re-based figure of 108, and a significant improvement on the November 2010 position of 115.
- Data on complaints and compliments provided to the QSC in the Quality Dashboard.

Part II - Confidential

- The inquest touching the maternal death of patient TA is boarded to be heard in mid-November. The process is described and highlights the risks to the Trust's reputation during the next 5-6 months in relation to maternity cases in the public domain. The action plan covering all the recent maternal deaths has been reviewed and whilst understanding changing culture can be difficult to achieve, there was a unique opportunity to take some practical steps and promote effective managers to champion the changes in the local area. The Committee noted that the maternal deaths action plan formed part of the larger maternity action plan being directed and monitored by the Project Management Office.
- Concerns relating to the capping of births at both Queen's and King George Hospitals , the diverting of elective caesarean sections to the Homerton and the requirement to ensure supervision of all new staff that could have serious repercussions on staff availability and ultimately patient safety.

August 2011

Part I

- The Policy for Carers and Visitors has been released and provides guidance for patient visiting, it aims to balance the therapeutic effect of patients spending time with relatives, carers and friends with the patient's need for care and rest and for clinical staff to manage the ward and deliver care safely and efficiently.
- The Patient Experience Strategy for delivering the patient experience elements of the Trust's vision of being a healing, caring and serving organisation is structured around the individual patient experience headings defined by Southampton University Hospitals NHS Trust which received approval in November 2010.

Part II

- None

June 2011

- Agreement to change the name of the meeting to the Quality and Safety Committee. As part of the governance of the Committee, it is required that timely escalation of items of interest to the Trust Board need to occur as soon as possible, therefore this and subsequent summaries will include the escalation of agreed items either for review or for information.

2.4 Operational Governance

Operationally risks have been considered through the Divisional Boards and, following management restructuring, by the Directorates from February 2012 and the Trust Executive Committee that replaced the Productivity, Efficiency and Quality Programme Board in July 2011. The Trust's Performance Team produce a monthly Quality & Patient Standards Performance Report that provides a range of information on:

- Quality & Safety
- Operational Performance
- Financial Performance
- Human Resource Performance

Bi-monthly the quality and safety elements from the Trust Board approved Performance Report feed into a Quality Dashboard for the Quality & Safety Committee with additional data added relating to CQUINs, incidents, mortality, patient experience and risks to reputation. This data is aggregated with MRSA and Clostridium difficile data from the NHS London weekly performance reports and data from the Acute Trust Quality Dashboard produced by East Midlands Quality Observatory. The Quality Dashboard requires the Divisions to provide local narrative on the data to aid understanding. This process ensures a wide range of data is available to senior staff within the organisation to aid decision making.

The Care Quality Commissions' Quality Risk Profiles are shared with the Divisional Directors and following the Management Changes, with the Clinical Directors. They have been provided with guidance on how to use the Quality Risk Profile and highlights of the key changes are drawn to their attention. The Quality Risk Profile has been referred to at the June, August, October and December Quality & Safety Committee meetings. The Quality Risk Profile has also been shared with the Divisional Boards through the clinical governance leads.

2.5 Quality Account 2011/12

The Trust in its preparation of the Quality Account has engaged with the public and stakeholders from the beginning of the process. This has been achieved through consultation on what the public see as the Trust's priorities; involvement with the Trust's Improving Patient Experience Group whose membership consists of patients, carers and interested parties. The Quality Account is in the process of being circulated in full to all stakeholders who are required to comment on the accuracy of the account and data accuracy audits are being undertaken by the Trust's external auditors, the Audit Commission.

The additional requirements from the Department of health have been incorporated into the Quality Account with the Statement of Limited Assurance from the Auditors providing additional guarantees on the content.

3.0 Risk Assessment

The overall strategy of the Trust is to maintain systematic and effective arrangements for managing risks throughout the organisation, whether clinical or non-clinical, financial or organisational, so as to ensure they are reduced to a minimum practicable level. These arrangements are described in the Trust's corporate governance manual approved by the Trust Board that includes the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

A Risk Management Strategy and Policy was implemented in 2004, against which the Trust reviews progress annually, and updates the strategy accordingly. Amendments and additions to the Strategy are approved by the Trust Board.

The risk and control framework existing within the Trust has continued to develop over the year using key performance indicators to enable a more accurate level of risk prediction and assessment. These systems are central to informing the decision making process in the provision of a safe and secure environment for patients, staff and visitors. The corporate risk framework is comprised of the following elements:

The Risk Management Strategy and Policy is in line with and accredited by the NHS Litigation Authority's Risk Management Standards level 1 accreditation. It recognises the impact that local, corporate and extreme risks may have on the finances, reputation or both of the organisation and provides guidance on measuring, mitigating and managing the residual risks.

The Board Assurance Framework (BAF) is a cohesive document populated by the identified risks to the Trust potentially not meeting its objectives, the extreme risks identified through the risk register and any risks to the Trust's reputation through poor publicity or external accreditation shortfalls. Identified gaps in control following risk assessment are mitigated via action plans which are monitored through the most appropriate committee structure.

A project to substantially improve the flows of risk information and increase the rigour of the underpinning risk analysis process that supports the BAF has been on-going over the year to ensure clear statements are made in relation to the risks faced by the Trust Board.

The Board Assurance Framework is presented to the Audit Committee at each meeting and the Committee receives a presentation of Divisional extreme and high risks along with mitigating action plans via a rolling programme of presentation. It is also presented on a

rolling programme to the Trust Executive Committee, the Quality and Safety Committee and the Trust Board.

The Risk Register is maintained as the focal point of risk evaluation and is maintained as a "live "document. Over the year, each Division has received an electronic copy of their risk register on a monthly basis. New risks identified through changes in service, serious incidents, incident and complaint investigation, safety alerts and changes in control measures or resources are added to the risk register as they arise, supported by a risk assessment to ensure accurate and reflective grading. Where decreed as an extreme risk a detailed and timed action plan is required to progress risk mitigation. There is also an annual programme of risk assessment, which includes health and safety risk assessment carried out at a local and corporate level to identify new risks.

The high and extreme components of the risk register are transferred to the BAF and their associated action plans are monitored through, the Audit Committee, the Quality and Safety Committee and ultimately the Trust Board for final decisions by exception. The Trust Executive Committee monitor the medium to extreme risks and other levels of risk are managed at Directorate/Divisional level. During Quarter 4 preparations have been made to develop risk registers in line with the organisational change to Clinical Directorates. At the same time the opportunity has been taken to strengthen the process of risk assessment and analysis across the Trust.

The Audit Committee as a sub-committee of the Trust Board holds delegated responsibility for the monitoring and inquisition of the risk register and the BAF. The Committee continues an established programme of risk review. The process examines the risks, the mitigating actions and future action plans for appropriateness and strength seeking to identify any further weakness or threat to patient safety, finance or reputation. In this way the Audit Committee can provide assurance to the Trust Board of the robustness of the control systems in place.

3.1 Financial Control
The Trust did not meet its financial control total for income and expenditure in the course of 2011/12. A deficit control total of £40.0M was originally agreed with NHS London, but ultimately the Trust delivered a deficit of £49.9M, a movement more than accounted for by the shortfall in the Trust's cost improvement programme of £14.9M against a £28.3M target for the year.

3.2 Counter Fraud Systems of control are in place to reduce and investigate incidents of fraud through Parkhill Counter Fraud Services. A rolling programme of staff training is in place to assist staff in identifying potential fraudulent situations and identify weaknesses in current systems. The systems of control have led to high impact outcomes protecting Trust assets, and a strengthening of employment procedures to detect bogus documentation which may be used by potential employees to secure employment fraudulently. Since 2008/09, the Trust has been assessed at Level 3 (performing well) on the Qualitative Assessment (QA) submitted to NHS Protect, and retained this rating in 2010/11. NHS Protect suspended the QA process for all Trusts in 2011/12.

3.3 Data Security at the Trust utilises the N3 network and NHS standards to manage and control data security and maintain confidentiality. The NHS standard for encryption is the cipher AES256. The Trust do encrypt all PC's and laptops, enforcing policies which prevent the copying of data to unsecure and non encrypted portable devices, in order to give greater security to patient data and other NHS specific data.

The Trust's primary responsibility is that the delivery of patient care should remain the highest priority and unaffected where possible by encryption. A balance of risk to patient

care against risk to personal data security is used in determining whether the use of unencrypted devices should continue as an interim measure. Where it is felt that continued reliance upon unencrypted data is necessary for the benefit of patients, a risk assessment must be undertaken and the outcome of the assessment must be reported to the Information Governance Board.

All electronic external routes to and from the Trust are managed through firewalls. In addition to this appliances manage the incoming email and also protect users from viruses and malware. Servers which store data are maintained within a locked and secure environment, which has additional protection against environmental factors, such as water and fire.

3.4 Liberating the NHS – Equity & Excellence - the Trajectory to FT status is currently red rated in the BAF which reflects the current position of BHRUT as one of the most challenged Trust's in England. To move to green BHRUT will need to provide evidence of considerable, sustained improvements in operational performance, finances, clinical quality and patient satisfaction. In addition the Trust is currently working towards a long term financial Management (LTFM) plan that can demonstrate that BHRUT can attain FT status in its current organisational form. The importance of FT trajectory is such that it is a standing item on the Trust Board agenda. Reporting against the FT milestones is in place and both the Trust Board and NHS London review progress on a monthly basis. External support from McKinsey's and Ernst Young has been provided by the Cluster to assist in the LTFM production and to improve operational performance.

3.5 Engagement with Public Stakeholder's in Managing Risk is through interaction with a range of different bodies and groups as detailed below:

The Trust provides reports and Executives and Senior Managers attend relevant meetings of the three local authority Health Scrutiny Committees and that of Essex County Council, together with their emerging Shadow Health and Wellbeing Boards. These committees seek reassurance on the Trust's performance across a range of topics such as complaints, individual services, Quality Accounts and CQC compliance with Registration standards.

The Improving Patient Experience Group (IPEG) set up in 2008 provides the Trust with feedback on a range of patient related topics as well as participating in surveys, sitting on the Quality and Safety Committee and providing information on issues that impact on how patients perceive and experience care and treatment given by the Trust. The group is confident in challenging Trust practices where necessary in an open and constructive forum.
The Trust engages with the local Involvement Networks (LINks) for the outer north east London boroughs and Essex County Council (the West Essex locality), which during 2012 are expected to form new Healthwatch bodies. The LINks have undertaken a number of Enter and View visits to the Trust over the last year, including visits without notice. These visits are to observe and assess the nature and quality of services and obtain the views of the people using those services. In carrying out these 'Enter and View' visits the LINks have sought to validate the information received from members of the public. During 2011, the LINks held an inquiry into the Trust's maternity services and the wider concerns of the CQC. The Trust has sought the views of both the LINks and IPEG members in its work and planned improvements, for example, through a tasting session of new menus introduced for patients. Recommendations from the LINks made through its published Enter and View reports feed into the Trust's action planning, and are published by the LINks.

To complement the regular CQC-organised patient surveys, the Trust has introduced a new system for monitoring patient experience. This includes an analysis of real-time surveys, complaints received, compliments received, PALS inquiries, feedback and suggestions given, which are analysed and reported to the Quality and Safety Committee.

The real time survey was introduced during 2011. Feedback given through these handheld devices, and via kiosks around the hospitals, will be provided to staff in the relevant areas, as well as informing Trust-wide actions by the Executive and providing assurance to the Quality and Safety Committee and Trust Board. After an initial low usage rate, the survey questions have been redesigned, and in 2012, patients will have an expanded range of feedback opportunities, through further kiosks throughout the hospitals and wide introduction of a new feedback card. Patients' views on their care, concerns they highlight or praise offered will be assessed and used to monitor and improve patient experience and reduce risk on an ongoing basis.

The Trust has a range of Committees in which external stakeholders, patients and commissioners participate.

It is important to note that serious concerns about the Trust during 2011-12, including cases leading to adverse media coverage and the CQC investigation, have led to increased adverse stakeholder interest in BHRUT and a red rating for the Trust's reputation in the Board Assurance Framework. The confidence of patients and the public in the Trust's delivery of services and organisational assurance as a whole remains low.

Through taking an open and transparent approach to working with public stakeholders, the Trust has obtained valuable input about their concerns which can then be addressed through the Trust's action plans. The Trust has shared detailed information about the progress being made to improve services at BHRUT and address the CQC's recommendations. For example, the Trust has published updates on its CQC action plan each month to stakeholders and the wider public, met regularly with all the groups set out above and is organising a joint meeting between stakeholders and the CQC regarding BHRUT. This work is aiming to rebuild public confidence in line with the Trust's success in managing risk, and identifying residual risk that requires further action, where appropriate in partnership with other organisations.

3.6 Compliance with Equality, Diversity and Human Rights, control measures are in place to ensure that the organisation is compliant with all its obligations under equality, diversity and human rights legislation. The Trust has worked closely with its local health partners to fully implement the approved Single Equality Scheme. All Trust policies have been equality impact assessed and these also apply to any changes in service requirements.

3.7 Compliance with the NHS Pension Scheme regulations is in place. As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

3.8 Compliance with the Climate Change Act 2008 – the Trust has undertaken a climate change risk assessment and developed a Carbon Management Plan, to achieve national reduction targets as based on the UK Climate Projections 2009 (UKCP09), to ensure compliance with this organisation's obligations under the Climate Change Act.

3.9 High and Extreme Risks Identified during 2011/12 – the following items have been risk rated and added to the BAF where the residual risk is deemed to be high or extreme, in accordance with policy.

Finance – potential inability of Clinical Directorates to achieve financial target and CIP

deliveries (risk no 282; page 22 Q4 BAF)

Emergency Department Medical Workforce – inability to maintain recruitment to consultant and staff grade posts (risk no 315; page 25 Q4 BAF).

Women and Children (maternity) – risk that workforce plans to support Obstetric cover are not fulfilled (risk no 311; page12 Q4 BAF).
Women and Children – the inability of the Directorate to achieve financial balance (risk no 321; page 13 Q4 BAF).

Women and Children – risk of adverse impact on profitability of services due to introduction of GU and FP tariff from April 2012 (risk no 323; page 15 Q4 BAF).

Sexual Health – inability to recruit medical staff to the walk in clinics to support business plan to provide a safe service to high risk, complex clients (risk no 320; page 24 Q4 BAF).

Complaint Management – risk of inability to respond to patients complaints in agreed timescales (risk no 339; page 20)

Risk Management Standards –potential inability to achieve level 2 accreditation for Risk Management Standards (risk no 298; page 21 Q4 BAF).

Partnership Working – risk that pace of change affects partnership working and co-creation of solutions (risk no 331; page 26 Q4 BAF).

Foundation Trust status – failure to achieve Foundation Trust status (risk no 332; page 27 Q4 BAF).

The risk and control framework

The components of the Board Assurance Framework are based on the five ambitions of the Trust's Principal Objectives, which are: Patient Safety, Finance, Workforce, Partnership Working and obtaining Foundation Trust status. The BAF directly underpins the Annual Governance Statement and is the subject of annual enquiry by its host commissioning body and Internal and External Audit. Each Division had individual live risk registers which are reviewed and updated quarterly.

The BAF aligns principle risks, key controls and assurances on controls alongside each objective. Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the Board to develop and subsequently monitor a Board Assurance Action Plan for closing gaps. The Direction of the Board in these matters ensures appropriate allocation of resources to improve the effectiveness of management.

The process and purpose of the BAF may be summarised as:

- Description of the risks which present a major threat to achievement of any of the objectives and are not well controlled.
- Identify and evaluate the design of key controls intended to manage these principle risks, underpinned by self assessment against the Care Quality Commission regulated standards.
- All significant risks whether to the objectives or otherwise are also described on the Trust Risk Register. Those risks are identified initially through review of the objectives themselves. Alternatively they may initially be identified by Directorates as

operational risks.

- The BAF and the Risk Register will provide confirmation that there are action plans to put in place controls for the risks they contain and that there is assurance that plans and controls are robust.
- Those risks which present a major threat to any of the objectives and are not well controlled are defined and graded as Extreme (red). By definition all the Trust's Extreme risks appear on the BAF.
- Significant risks which require high level attention but do not present a major threat to any of the objectives are defined and graded as High (orange) and are described on the Risk Register but not on the BAF unless a potential for major threat.. Oversight of their control and assurance is allocated to the responsible Directorate.
- Extreme risks that threaten any of the objectives which achieve increased controlled and are subsequently deemed to be either High or Moderate risk will be relegated from the BAF to the Risk Register alone and oversight of their control will be allocated to the responsible Directorate.
- The Framework will be reviewed by the Audit Committee at each meeting and by the Board quarterly.
- Fraud is controlled, reduced and deterred by the Trust's following, and demonstrating that it follows Secretary of State Directions.
- The induction programme was delivered to 913 new starters in the course of the year, and helps to create an anti-fraud culture.
- Deterrence is fostered by the production of publicity materials.
- Fraud prevention is strengthened through the circulation of information notices and fraud alerts, the LCFS's attendance at NHS Protect Regional meetings, fraud proofing and policy reviews and protocol development.
- Detection occurs as the result of risk assessments into areas such as staff ID, over-payments reviews, illegal working checks, and a range of other proactive reviews.
- A range of specific investigations are carried out into allegations of fraud raised by staff, patients and members of the public.

Significant Issues

Care Quality Commission

Trustwide Review

The CQC carried out a whole hospital review in July/August 2011 and, as a result, their report listed 81 separate recommendations relating to the quality and safety standards, capacity, leadership, strategy and maternity, when it was published on the 27th October. In summary the CQC felt that although there had been some positive developments, patients remained at risk of poor care, particularly in maternity services where poor clinical care, abusive behaviour, lack of learning from incidents and disengaged staff were identified. The CQC felt there was a need for improvement in patient experiences, the management of complaints and the Trust's governance systems, and that there were difficulties in achieving the 4 hour maximum waits in the A&E department. The Trust has taken the investigation's findings extremely seriously and has used the CQC's reports as a tool to work with all the Trust staff; taking the opportunity to explain they all have a role to play in ensuring we learn from the poor practice identified and to make the necessary changes at an individual, team or departmental level if we are to change the reputation and public perception of the organisation.

In order to root out the unacceptable poor care described in the report, a whole hospital action plan was developed and shared with the CQC and partner organisations. The action plan also captured the outstanding Warning Notice recommendations to ensure all CQC concerns were addressed and monitored through a single rigorous process.

A Project Management Office was established, with the appropriate skills, and the actions prioritised to ensure those affecting patient safety were tackled as a priority. The project team are responsible for driving forward the implementation and for ensuring robust governance arrangements. A Project Management Board, meeting fortnightly, reviews progress and reports to the Trust Executive Committee; sharing the minutes of the Project Management Board meetings with NHS London and Outer North East London NHS (ONEL) to ensure transparency and close working with our Commissioners. These reports are also presented to a range of internal committees and the Trust Board.

Warning Notices

Maternity

On the 1st March 2011 the Trust was issued with 3 Warning Notices relating to maternity and midwifery services. One was in relation to Outcome 1, Care and Welfare of People who use Services, one relating to staffing and the final one related to equipment. These concerns were replicated in their report issues in February 2012.

The Trust challenged the equipment Warning Notice and this was subsequently withdrawn. However, as a result a full review of our equipment was carried out in conjunction with our Private Finance Initiative (PFI) Partners, Sodexo, who maintains a managed equipment service on our behalf. Where minor shortfalls in equipment were identified, largely because staff had failed to report breakages or missing items, these were rectified and staff reminded of the correct procedures to follow.

The concerns detailed in the remaining two Warning Notices were constructed into a comprehensive action plan with implementation closely monitored by the Trust Board and externally by NHS London, ONEL and the CQC. The composite action plan is managed via the Programme Management Office and has four projects underpinning the Maternity Improvement Plan, these are:

- Governance
- Clinical Pathways
- Demand and Capacity
- Workforce

The Trust has put in place a new maternity management team to strengthen leadership and has invested in providing 1:29 midwife to birth ratio, thus ensuring 1:1 care in labour, which is one of the best midwife to birth ratio's in London. Good progress has been made with recruiting additional midwives. New midwives have a detailed induction and are supported by the Maternity Education Team.

The Trust has performed a training needs analysis of the midwifery workforce to ensure right skill mix on the maternity wards and staff rosters have been enhanced to ensure every shift has a high level of experienced midwives available.

Until such time as the CQC revisit the maternity department to assess the improvements, this Warning Notice remains in place.

Staffing

Following ongoing concerns into staffing levels on the general wards a Warning Notice was issued against the Trust by the CQC on the 20th June 2011. A number of assumptions made by the CQC were challenged by the Trust and substantiating evidence provided; a revised Warning Notice was issued by the CQC on the 26th July.

It is fully acknowledged that at the time of the CQC's visits, staffing on the wards visited was not optimum. To address the CQC's concerns the Trust immediately instigated a new staffing monitoring form that the Duty Matron completes on a daily basis with staff shortages discussed at each bed meeting. The Matron and Senior Nurses assess the impact of any shortages each day and, where possible, deploy staff to areas most in need. If a situation occurs where there is only one Registered Nurse on a shift this is escalated immediately by the Duty Matron / Site Manager to the Senior Nurse on Call for staffing, and staff are deployed appropriately.

The In-House Bank update the Duty Matron and Senior Nurse on-Call on 'fill rates' to assist in identifying potential 'hot spots' in the coming shifts in order that the Senior Nurse can authorise the use of outside agency staff. Where an area has a high percentage of agency / temporary staff on duty, the Duty Matron moves staff around to ensure appropriate levels of substantive staff are available to ensure continuity and safety of care.

The Trust has also rolled out the use of e-rostering in all ward areas. This allows senior nursing staff to oversee all rosters to ensure appropriate rostering practices are taking place and that all Ward Managers are managing their staffing appropriately. The Trust continues to recruit, and vacancy rates are monitored by the Matrons for each area.

The Trust has now registered with the NHS Institute to implement the safer nursing care tool (SNCT) which will be rolled out across all ward areas over the next 18 months. The data collected from this tool will provide information on patient dependency and will support the allocation of appropriate staffing to all areas and identify areas where allocated resource may not be sufficient to meet patient dependency. The Trust now feels confident that not only staffing levels, but skills mix of staff deployed in clinical areas, is rigorously monitored and where needed, action taken.

This warning notice was removed on the 21st December 2011.

A&E

A further Warning Notice was issued on the 20th June 2011 concerning the Trust's A&E department that highlighted the CQC's concerns about the long patient waits and delays in offloading ambulances.

The CQC's latest reports, published in February 2012, highlight their ongoing concerns around Outcome 4, Care & Welfare of People who use services.

Over the intervening period, the Trust has taken various actions with the aim of tackling the problems identified the Emergency Department (ED). In June 2011, the 'Rapid Access and Treatment' (RATing) process was introduced. The process was successful in bringing down waiting times and an extension of the RATing facilities and operational hours, which also incorporates a 'See and Treat' model.

RATing allows the movement of patients more quickly through the ED by moving resources, decision-making responsibilities and treatments to the 'front door' when patient's first arrive. In essence this means that patients are given the appropriate care and treatment in a timely manner and greatly assists in the achievement of the emergency access quality indicator targets the Trust has to meet.

The 'See and Treat' area helps by generating additional off-loading space for ambulances, which aides patient flow to cope with any sudden influx of ambulances carrying sick patients needing urgent care. However, in order to get the full benefit from this model it is essential to

have improved flow throughout the rest of the Trust. Other steams of work are underway such as improving discharge arrangements to ensure a consistent, whole-system approach underpins the improvements in A&E.

Further action is planned to improve on the time patients wait for treatment, aiming to do this within 60 minutes by setting new targets for our Specialists to respond to calls in the ED. This is a key workstream that was agreed at our Senior Leaders Event and is supported by the Medical Director.

The Trust has also started rolling out real-time tracking of emergency access targets via new additions to our electronic handover system (e-Handover). Tracking will provide all Specialties with a real-time tool to monitor performance from ED referral to patient referral by a Registrar and Consultant for admission or discharge. The e-Handover system will empower medical teams to accurately track patients' progress and doctors' performance, with an overall benefit of increased quality of care and improved patient flow.

To ensure that the ED is appropriately staffed with an effective and efficient workforce a recruitment strategy has been written and agreed, which also includes the creation of Clinical Fellow posts[1], an increase of 6 training grade posts as agreed with the Deanery

In order to ensure sufficient availability of trolleys to RATing teams, and prevent patients being handed over on ambulance trolleys, 16 new trolleys have been procured (6 for Queen's and 10 for King George Hospital.

In addition, the Trust launched the first phase of ambulatory care pathways during January 2012, building on the good work already undertaken through our Virtual Ward. The first two phases have been rolled out and cover respiratory conditions such as pneumothorax, pneumonia, pleural effusion and pulmonary embolism. The next phase, due to be launched during March 2012, includes the transfer of the DVT and cellulitis pathways to the ambulatory care service, as well as including pathways for cardiac chest pain and low risk upper GI bleeds. The ultimate benefits of the ambulatory care service include improved patient flow, reduction in length of stay, reduction in readmissions and increased patient satisfaction.

The work in A&E is supported by additional radiologists that have been employed to ensure diagnostic scans are reviewed promptly by expert clinicians.

Until such time as the CQC complete a return visit, the Warning Notice remains in place.

Conditions

Following the submission of evidence to the Care Quality Commission the following Conditions were removed during 2011/12:

- Resuscitation Training (all locations) – April 2011
- Appraisal (all locations) – April 2011
- Pressure damage (Queen's & King George Hospital) – June 2011

Apart from Staffing in maternity, all other Conditions were removed in 2010/11.

[1] Clinical Fellows are doctors, who are on the cusp of being appointed as Consultants but who have been appointed on a one-year contract at the Trust to lead on a range of diverse projects.

Serious Incidents.
There were 7 cases reported within the time frame 2011/12 which require reporting within the Governance Statement. 2 Never Events and 5 maternal deaths. Each incident has the potential to harm the trust's reputation and the maternal deaths which have been or will be subject to inquest will attract high levels of media attention resulting in a loss of public confidence.

Never Events:

Neurosurgery

1. A patient needed to undergo a stealth guided craniotomy for excision biopsy of a right side lesion. There was also a lesion on the left side. The operation was commenced on the wrong (left) side. The error was noticed after the skin incision and bone flap had been raised but before the dura (protective covering of the brain) was opened. The procedure was immediately discontinued. The patient was re-prepared for the correct site surgery which was undertaken without incident. The patient did not suffer harm beyond an unnecessary scar and bone flap and subsequently made a good recovery. Immediate actions were taken to improve systems and ensure staff were less reliant on technical equipment. A full investigation was conducted with an external assessor and the recommendations implemented.

Interventional Radiology

2. The patient required a procedure to clear blocked blood vessels on the right leg. The right leg was marked and the patient was turned around on the table in the opposite direction to facilitate ultrasound access. The consultant inserted the steering wire into the marked side but did not take into consideration the re-positioning of the patient for cross over which resulted in the left procedure being carried out on the left leg. A full investigation was conducted with an external assessor and the recommendations implemented.

Maternal Deaths

3. Pregnant client self referral from home with history of pain ?appendectomy. Operation to remove appendix carried out and sepsis found with necrotic tissue thought to be the appendix but histology found it to be an ovary. Patient extremely ill due to sepsis and she underwent further surgery during which she died. A full investigation by external assessors completed and recommendations implemented.
4. Patient had an emergency LSCS at 31 weeks and 6 days for pre-eclampsia. Live male infant transferred to NICU. Patient subsequently deteriorated later on in the day, had a cardiac arrest, and transferred to theatre for a laparotomy. The oatient suffered a cardiac arrest from which she could not be resuscitated and she subsequently died. A full investigation by external assessors completed and recommendations implemented
5. A woman post delivery of a health baby, was brought in by ambulance after feeling unwell at home 13 days post delivery - cause of death intracerebral haemorrhage. Cause of death established by the Coroner as natural causes.
6. Patient brought into A&E department by ambulance after suffering a cardiac arrest at home – despite resuscitation attempts patient died in department. Cause of death established by the Coroner as natural causes.
7. 20 year old women who delivered baby in King George Hospital on 2nd April 2011, admitted to A&E on 7th June 2011 following an overdose of mixed tablets taken with wine, patient was discharged home on 8th June and re-admitted on 9th June complaining of abdominal pain – subsequently transferred to Royal Free Liver Unit where she died on 18th June 2011. A full investigation with an external assessor completed.

The Trust did not meet its financial control total for income and expenditure in the course of

2011/12. A deficit control total of £40.0M was originally agreed with NHS London, but ultimately the Trust delivered a deficit of £49.9M, a movement more than accounted for by the shortfall in the Trust's cost improvement programme of £14.9M against a £28.3M target for the year.

Accountable Officer:

Averil Dongworth, Chief Executive Officer

Organisation:

Barking, Havering & Redbridge University Hospitals NHS Trust

Signature:

Date: 8/6/12

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

Issue of audit opinion on the financial statements

In my audit report for the year ended 31 March 2012 issued on 8 June 2012 I reported that, in my opinion, the financial statements:

- gave a true and fair view of the financial position of Barking, Havering and Redbridge University Hospitals NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and
- had been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Issue of adverse value for money conclusion

In my audit report for the year ended 31 March 2012 issued on 8 June 2012 I reported an adverse value for money conclusion in the following terms:

Basis for adverse conclusion

In considering the Trust's arrangements for securing financial resilience, I identified the following:

- the Trust set a deficit budget for 2011/12 and incurred a deficit for the year of £49.9 million and has yet to agree a plan to recover its historic deficit of £199.8 million; and
- the Trust has set a £40 million deficit budget for 2012/13.

In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness, I identified the following:

- the level of cost improvements achieved in 2011/12 (£14.9 million) did not meet the target set for the year (£28.3 million);
- the Trust did not yet have fully operational service line reporting and management arrangements;
- in August 2011 the Care Quality Commission conducted a special investigation into the care received by patients from the Trust across emergency care, elective care and maternity care, reporting in October 2011 that 'despite some signs of improvement in recent months, patients remain at risk of poor care in this trust, particularly in maternity services'. 81 improvement recommendations were made relating to quality and safety standards, capacity, leadership, strategy and maternity services;
- two warning notices issued in by the Care Quality Commission on the Trust's maternity services and A&E department remain in force; and
- one condition relating to maternity staffing placed on the Trust's Care Quality Commission registration during 2010/11 has not been lifted.

Adverse conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, the matters reported in the basis for adverse conclusion paragraph above prevent me from being 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 ending 31 March 2012.

Certificate

In my report dated 8 June 2012, I explained that I could not formally conclude the audit on that date until I had completed the work to provide assurance on the Trust's annual quality accounts. I have now completed this work. No matters have come to my attention since that date that would have a material impact on the financial statements on which I gave an unqualified opinion or a significant impact on my conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness.

I certify that I have completed the audit of the accounts of Barking, Havering and Redbridge University Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Jon Hayes
District Auditor
Audit Practice, Audit Commission
1st Floor
Millbank
London SW1P 4HQ

Date: 26th June 2012

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers 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; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Signed.....A. L. Dongworth.....Averil Dongworth

Date 8/6/12

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of 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 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

8/6/12 Date  Averil Dongworth
Chief Executive

8/6/12 Date  David Wragg
Finance Director

Year ended 31 March 2012

SUMMARISATION SCHEDULES (TRUs) FOR THE Barking, Havering & Redbridge Hospitals University NHS Trust

Director of Finance Certificate

I certify that the attached summarisation schedules have been compiled from and are in accordance with the financial records maintained by the trust and with the accounting standards and policies for the NHS approved by the Secretary of State.

8/6/12 Date  David Wragg
Director of Finance

Chief Executive Certificate

I acknowledge the attached summarisation schedules, which have been prepared and certified by the Director of Finance, as the summarisation schedules which the trust is required to submit to the Secretary of State

8/6/12 Date  Averil Dongworth
Chief Executive

Entity name:	Barking, Havering And Redbridge University Hospitals NHS Trust
This year	2011-12
Last year	2010-11
This year ended	31 March 2012
Last year ended	31 March 2011
This year commencing:	1 April 2011

Statement of Comprehensive Income for year ended 31 March 2012

	NOTE	2011-12 £000	2010-11 £000
Employee benefits	10.1	**(291,010)**	(280,981)
Other costs	8	**(151,148)**	(127,857)
Revenue from patient care activities	5	**388,459**	376,900
Other Operating revenue	6	**30,662**	30,110
Operating surplus/(deficit)		**(23,038)**	(1,828)
Investment revenue	12	**754**	820
Other gains and (losses)	13	**35**	0
Finance costs	14	**(23,800)**	(21,157)
Surplus/(deficit) for the financial year		**(46,049)**	(22,165)
Public dividend capital dividends payable		**(3,613)**	(3,368)
Retained surplus/(deficit) for the year		**(49,662)**	(25,533)
Other Comprehensive Income			
Impairments and reversals		**0**	0
Net gain/(loss) on revaluation of property, plant & equipment		**422**	1,753
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Net gain/(loss) on other reserves		**0**	0
Net gain/(loss) on available for sale financial assets		**35**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Reclassification adjustment on disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**(49,205)**	(23,780)

Financial performance for the year	
Retained surplus/(deficit) for the year	**(49,662)**
Prior period adjustment to correct errors	**0**
IFRIC 12 adjustment (including impairments from IFRIC 12)	**53**
Non IFRIC 12 Impairments	**(180)**
Adjustments from donated asset/gov't grant reserve elimination	**(124)**
Adjusted retained surplus (deficit)	**(49,913)**

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following:-

a) Indexation to Fixed Assets caused a reversal of the impairment charged to the Statement of Comprehensive Income in 2011/12. An impairment charge is not considered part of the organisation's operating position, therefore the reversal of impairments should also be removed.

b) The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position.

PDC dividend: balance receivable/(payable) at 31 March 2012	**29**

The notes on pages 1 to 46 form part of this account.

Statement of Financial Position as at 31 March 2012

	NOTE	31 March 2012 £000	31 March 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets:				
Property, plant and equipment	15	**365,635**	362,738	354,787
Intangible assets	16	**2,760**	2,685	3,529
investment property		**0**	0	0
Other financial assets	24	**0**	0	0
Trade and other receivables	22.1	**19,076**	23,467	26,337
Total non-current assets		**387,471**	388,890	384,653
Current assets:				
Inventories	21	**5,818**	6,988	6,033
Trade and other receivables	22.1	**35,588**	29,716	33,284
Other financial assets	24	**0**	0	0
Other current assets	25	**0**	0	0
Cash and cash equivalents		**4,343**	2,830	2,098
Non-current assets held for sale	27	**0**	0	0
Total current assets		**45,750**	39,534	41,415
Total assets		**433,220**	428,424	426,068
Current liabilities				
Trade and other payables	28	**(43,691)**	(48,220)	(48,322)
Other liabilities	29	**0**	0	0
Provisions	35	**(2,710)**	(1,780)	(2,140)
Borrowings	30	**(5,977)**	(5,277)	(5,021)
Other financial liabilities		**0**	0	0
Working capital loan from Department		**0**	0	0
Capital loan from Department		**0**	0	0
Total current liabilities		**(52,378)**	(55,277)	(55,483)
Non-current assets plus/less net current assets/liabilities		**380,842**	373,147	370,585
Non-current liabilities				
Trade and other payables	28	(4,916)	(4,916)	(5,342)
Other Liabilities	31	0	0	0
Provisions	35	(5,014)	(5,048)	(5,312)
Borrowings	30	(258,720)	(260,151)	(264,019)
Other financial liabilities		0	0	0
Working capital loan from Department		0	0	0
Capital loan from Department		0	0	0
Total non-current liabilities		**(268,650)**	(270,115)	(274,673)
Total Assets Employed:		**112,192**	103,032	95,912
FINANCED BY:				
TAXPAYERS' EQUITY				
Public Dividend Capital		365,675	307,275	276,375
Retained earnings		(263,787)	(215,571)	(190,057)
Revaluation reserve		10,304	11,328	9,594
Other reserves		0	0	0
Total Taxpayers' Equity:		**112,192**	103,032	95,912

The financial statements on pages *1 to 4* were approved by the Board on 6th June 2012 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2012

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000	£000
Balance at 1 April 2011	307,275	(215,571)	11,328	0	**103,032**
Opening balance adjustments	0	0	0	0	**0**
Adjustments for Transforming Community Services transactions	0	0	0	0	**0**
Restated balance at 1 April 2011	307,275	(215,571)	11,328	0	**103,032**
Changes in taxpayers' equity for 2011-12					
Retained surplus/(deficit) for the year	0	(49,662)	0	0	**(49,662)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	422	0	**422**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	**0**
Impairments and reversals	0	0	0	0	**0**
Movements in other reserves	0	0	0	0	**0**
Transfers between reserves	0	1,446	(1,446)	0	**0**
Release of reserves to SOCI	0	0	0	0	**0**
Transfers to/(from) other bodies within the Resource Account boundary	0	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
New PDC Received	58,400	0	0	0	**58,400**
PDC Repaid In Year	0	0	0	0	**0**
PDC Written Off	0	0	0	0	**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements in PDC In Year	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	58,400	(48,216)	(1,024)	0	9,160
Balance at 31 March 2012	**365,675**	**(263,787)**	**10,304**	**0**	**112,192**
Included above:					
Transfer from revaluation reserve to retained earnings in respect of impairments		0	0		0
Changes in taxpayers' equity for 2010-11					
Balance at 1 April 2010	276,375	(190,057)	9,594	0	95,912
Retained surplus/(deficit) for the year	0	(25,533)	0	0	(25,533)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	1,753	0	1,753
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	0	0	0
Movements in other reserves	0	0	0	0	0
Transfers between reserves	0	19	(19)	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New PDC Received	30,900	0	0	0	30,900
PDC Repaid In Year	0	0	0	0	0
PDC Written Off	0	0	0	0	0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0	0	0	0	0
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	0
Net recognised revenue/(expense) for the year	30,900	(25,514)	1,734	0	7,120
Balance at 31 March 2011	**307,275**	**(215,571)**	**11,328**	**0**	**103,032**
Included above:					
Transfer from revaluation reserve to retained earnings in respect of impairments		0	0		0

Other reserves equals the donatated asset reserve which is required to be transferred to retained earnings.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2012

	2011-12 £000	2010-11 £000
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**(23,038)**	**(1,828)**
Depreciation and Amortisation	**14,033**	**13,120**
Impairments and Reversals	**(1,133)**	**(8,670)**
Other Gains / (Losses) on foreign exchange	**0**	**0**
Donated Assets received credited to revenue but non-cash	**(213)**	**0**
Government Granted Assets received credited to revenue but non-cash	**0**	**0**
Interest Paid	**(23,721)**	**(20,865)**
Dividend paid	**(3,735)**	**(3,401)**
Release of PFI/deferred credit	**0**	**0**
(Increase)/Decrease in Inventories	**1,170**	**(955)**
(Increase)/Decrease in Trade and Other Receivables	**(1,425)**	**6,295**
(Increase)/Decrease in Other Current Assets	**0**	**0**
Increase/(Decrease) in Trade and Other Payables	**(5,555)**	**(97)**
(Increase)/Decrease in Other Current Liabilities	**0**	**0**
Provisions Utilised	**(762)**	**(1,068)**
Increase/(Decrease) in Provisions	**1,519**	**299**
Net Cash Inflow/(Outflow) from Operating Activities	**(42,860)**	**(17,170)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**754**	**820**
(Payments) for Property, Plant and Equipment	**(9,251)**	**(8,333)**
(Payments) for Intangible Assets	**0**	**(1)**
(Payments) for Investments with DH	**0**	**0**
(Payments) for Other Financial Assets	**0**	**0**
(Payments) for Financial Assets (LIFT)	**0**	**0**
Proceeds of disposal of assets held for sale (PPE)	**100**	**0**
Proceeds of disposal of assets held for sale (Intangible)	**0**	**0**
Proceeds from Disposal of Investment with DH	**0**	**0**
Proceeds from Disposal of Other Financial Assets	**0**	**0**
Proceeds from the disposal of Financial Assets (LIFT)	**0**	**0**
Loans Made in Respect of LIFT	**0**	**0**
Loans Repaid in Respect of LIFT	**0**	**0**
Rental Revenue	**0**	**0**
Net Cash Inflow/(Outflow) from Investing Activities	**(8,397)**	**(7,514)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(51,257)**	**(24,684)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	58,400	30,900
Public Dividend Capital Repaid	0	0
Loans received from DH - New Capital Investment Loans	0	0
Loans received from DH - New Working Capital Loans	0	0
Other Loans Received	0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	0	0
Loans repaid to DH - Working Capital Loans Repayment of Principal	0	0
Other Loans Repaid	0	(470)
Cash transferred to NHS Foundation Trusts	0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	(5,636)	(5,014)
Capital grants and other capital receipts	6	0
Net Cash Inflow/(Outflow) from Financing Activities	**52,770**	**25,416**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**1,513**	**732**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	2,830	2,098
Opening balance adjustment - TCS transactions	0	
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	2,830	2,098
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	4,343	2,830

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Trusts Manual for Accounts 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 NHS Trusts 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 Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.3 Care Trust designation

The Trust is not designated as a Care Trust due to joint activities.

1.4 Pooled Budgets

The Trust has no pooled budgets.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the 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 11). 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 liabilties due under this policy, in line with information provided by the NHS Litigation Authority. Uncertainty in estimation may relate to the timing of potential settlements, although the liability to the Trust will be limited to the level of the excess.

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

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

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

The management make judgements in terms of approving new capital investment and variations to the PFI Assets to maintain or enhance its

Non-current building and land assets are valued at market values. The property market has continued to demonstrate volatility during the period, and continues to be subject to uncertainty in the medium term.

The Trust has a number operating leases and a Private Finance Initiative (PFI) Agreement where the Trust is the lessee. The PFI assets are held on-balance sheet, and are valued at current value, either by obtaining market valuations from appropriately qualified independent valuers, or on a depreciated replacement cost basis (see note 1.9). Valuations are therefore subject to market fluctuation, which could result in unforeseeable increases or decreases in valuation in future periods. Any known impairments which are not likely to be reversed in the near term are accounted for in the period in which they arise. Operating leases are expensed in accordance with IAS 17 on a straight-line line basis

Provisions are reviewed by management on a regular basis using a combination of information provided by appropriate third party sources. Any change in circumstances related to these provisions is reflected in the period in which it is identified.

1.6 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 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 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

1.7 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the 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.

1.8 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.

1.9 Property, plant and equipment

Recognition

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 of at least £5,000; or
- Collectively, a number of items have a 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; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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.

Notes to the Accounts - 1. Accounting Policies (Continued)

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. 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

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 subsequent accumulated depreciation and impairment losses. 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

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.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value

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.

Subsequent expenditure
Where subsequent expenditure enhances an 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.

1.10 Intangible assets

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 fair value. Software that is integral to the operating 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 demonstrated:
● 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

Notes to the Accounts - 1. Accounting Policies (Continued)

- 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 to be able to sell or use it
- 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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. 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 their estimated useful lives

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, 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.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, 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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 Donated assets

Following the accounting policy change outlined in the Treasury Financial Reporting Manual (FREM) for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.14 Government grants

The Trust has no Government Grants.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.14 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. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then 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.

1.15 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 on 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. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The trust as lessor

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

1.16 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use 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 IFRIC 12. The Trust therefore recognises PFI assets as property, plant and equipment together with a liability to pay for them. The services received under the contract are recorded as operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 assets, 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 in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

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 fair 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.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

The Trust pays a contribution to the lifecycle replacement costs of building assets requiring replacement through the annual unitary payment. In return, the PFI operator maintains a contractual obligation to maintain the facility to an agreed standard, but is under no direct obligation to spend the lifecycle funds at pre determined intervals. The Trusts receives no financial benefit for any lifecycle savings derived during the duration of the PFI agreement. Conversely, the Trust does not bear the 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 varied by agreement. The lifecycle replacement of these assets effectively results in a series of finance leases in accordance with the individual replacement cycles.

1.17 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 to fair value due to the high turnover of stocks.

1.18 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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

1.19 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. The discount rates used were 2.2%, in real terms (2.8% 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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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.

1.20 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 trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.21 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 NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 EU Emissions Trading Scheme

The Trust is not part of the EU Emissions Trading Scheme. However the Trust has recognised a liability

of £180,000 in 2011/12 in respect of the Carbon Reduction Commitment (CRC). The CRC is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations. Further details can be found on the Department of Energy and Climate Change website.

http://www.decc.gov.uk/en/content/cms/emissions/crc_efficiency/crc_efficiency.aspx

1.23 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence 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.

1.24 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. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

Loans and receivables

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.

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 through a provision for impairment of receivables.

Notes to the Accounts - 1. Accounting Policies (Continued)

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.

1.25 Financial liabilities

The Trust has no other financial liabilities.
The Trust has no financial liabilities held at fair value through profit and loss.

1.26 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.

1.27 Foreign currencies

The Trust's functional currency and presentational 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/deficit in the period in which they arise.

1.28 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 41 to the accounts.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS 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 real 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 Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.3 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 NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 Subsidiaries

The Trust currently has no Subsidiaries.

For 2010-11 and 2011-12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.32 Associates

The Trust has no associates.

1.33 Joint ventures

The Trust has no joint ventures.

1.34 Joint operations

The Trust has no joint operations.

1.35 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 Operating Cost Statement 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.

1.36 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12 - Income Taxes (amendment) - subject to consultation
IAS 19 Post-employment benefits (pensions) - subject to consultation
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled budget

The Trust has no pooled budget arrangements.

3. Operating segments

The Trust has only one operating segment, that of Healthcare.

4. Income generation activities

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

Summary Table - aggegate of all schemes	**2011-12**	2010-11
	£000	£000
Income	**2,892**	1,948
Full cost	**2,486**	1,353
Surplus/(deficit)	**406**	595

The above relates to income generated through rental of space and provision of medical services to a private healthcare contractor in respect of Oncology.

5. Revenue from patient care activities	**2011-12**	2010-11
	£000	£000
Strategic health authorities	**31**	231
NHS trusts	**98**	95
Primary care trusts - tariff	**236,023**	230,927
Primary care trusts - non-tariff	**96,061**	91,569
Primary care trusts - market forces factor	**49,855**	48,710
Foundation trusts	**743**	193
Local authorities	**0**	0
Department of Health	**0**	0
NHS other	**56**	158
Non-NHS:		
Private patients	**276**	341
Overseas patients (non-reciprocal)	**1,035**	892
Injury costs recovery	**3,245**	3,141
Other	**1,036**	643
	388,459	376,900

Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection.

6. Other operating revenue	**2011-12**	2010-11
	£000	£000
Recoveries in respect of employee benefits	**0**	0
Patient transport services	**0**	0
Education, training and research	**15,140**	15,547
Charitable and other contributions to expenditure	**633**	469
Receipt of donations for capital acquisitions	**213**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**1,442**	1,470
Income generation	**10,500**	8,278
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**766**	758
Other revenue	**1,968**	3,588
	30,662	30,110
Total operating revenue	**419,121**	407,010

7. Revenue	**2011-12**	2010-11
	£000	£000
From rendering of services	**417,960**	405,974
From sale of goods	**1,161**	1,133

Revenue is almost totally from the supply of services. Revenue from the sale of goods mainly relates to the sale of locally manufactured pharmacy products.

8. Operating expenses	**2011-12**	2010-11
	£000	£000
Services from other NHS trusts	**1,369**	923
Services from PCTs	**634**	361
Services from other NHS bodies	**176**	2,805
Services from foundation trusts	**1,432**	570
Purchase of healthcare from non NHS bodies	**243**	1,096
Trust chair and non executive directors	**67**	61
Supplies and services - clinical	**62,488**	56,429
Supplies and services - general	**11,000**	10,137
Consultancy services	**1,709**	1,546
Establishment	**3,941**	3,332
Transport	**4,077**	3,808
Premises	**18,208**	14,540
Impairments and Reversals of Receivables	**3,328**	(324)
Inventories write down	**0**	0
Depreciation	**13,237**	12,275
Amortisation	**796**	845
Impairments and reversals of property, plant and equipment	**(1,133)**	(8,680)
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	10
Impairments and reversals of investment properties	**0**	0
Audit fees	**305**	306
Other auditor's remuneration	**18**	0
Clinical negligence	**11,080**	9,755
Research and development	**0**	0
Education and Training	**693**	547
Other	**17,481**	17,515
	151,148	127,857

The majority of the "other" expenditure is the service element of the Queens' PFI contract.

Employee benefits		
Employee benefits excluding Board members	**289,809**	279,952
Board members	**1,201**	1,029
Total employee benefits	**291,010**	280,981
Total operating expenses	**442,158**	408,838

9 Operating Leases

Significant leases are laundry, linen and sterile services.

9.1 Trust as lessee

	Land £000	Buildings £000	Other £000	2011-12 Total £000	2010-11 £000
Payments recognised as an expense					
Minimum lease payments	**0**	**0**	**550**	**550**	1,064
Contingent rents	**0**	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	**0**	0
Total				**550**	1,064
Payable:					
No later than one year	**0**	**0**	**288**	**288**	632
Between one and five years	**0**	**0**	**539**	**539**	932
After five years	**0**	**0**	**0**	**0**	559
Total	**0**	**0**	**827**	**827**	2,123
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

The Trust has entered into a number of commercial agreements as part of its operations. In two instances, the Trust acts as an operating lessor.

In 2006, the Trust entered into a 60 year lease for land at King George Hospital to allow for an independent sector treatment centre (ISTC) for NHS patients.

In 2009, the Trust entered into a 10 year lease for facilities at Queens Hospital for private treatment of cancer patients.

	2011-12 £000	2010-11 £000
Recognised as income		
Rents	696	726
Contingent rents	70	32
Total	**766**	758
Receivable:		
No later than one year	793	796
Between one and five years	3,260	3,184
After five years	4,084	4,827
Total	**8,137**	8,807

10 Employee benefits and staff numbers

10.1 Employee benefits

	Total £000	Permanently employed £000	Other £000
Employee Benefits 2011-12 - gross expenditure			
Salaries and wages	246,692	207,672	39,020
Social security costs	21,166	20,183	983
Employer contributions to NHS Pensions scheme	23,312	22,980	332
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	399	399	0
Total employee benefits	291,569	251,234	40,335
Less recoveries in respect of employee benefits (table below)	0	0	0
Total - Net Employee Benefits including capitalised costs	291,569	251,234	40,335
Employee costs capitalised	559	559	0
Net Employee Benefits excluding capitalised costs	291,010	250,675	40,335

Employee Benefits 2011-12 - income			
Salaries and wages	0	0	0
Social Security costs	0	0	0
Employer Contributions to NHS BSA - Pensions Division	0	0	0
Other pension costs	0	0	0
Other Post Employment Benefits	0	0	0
Other Employment Benefits	0	0	0
Termination Benefits	0	0	0
TOTAL excluding capitalised costs	0	0	0

	Total £000	Permanently employed £000	Other £000
Net expenditure - 2010-11			
Salaries and wages	239,705	198,410	41,295
Social security costs	17,973	17,973	0
Employer contributions to NHS Pensions scheme	22,136	22,136	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	1,613	1,613	0
Total employee benefits	281,427	240,132	41,295
Employee costs capitalised	446		
Net Employee Benefits excluding capitalised costs	280,981		

10.2 Staff Numbers

	2011-12			2010-11
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	880	802	79	880
Ambulance staff	0	0	0	0
Administration and estates	1,064	975	89	1,091
Healthcare assistants and other support staff	1,179	1,019	160	470
Nursing, midwifery and health visiting staff	2,303	2,015	289	2,688
Nursing, midwifery and health visiting learners	0	0	0	200
Scientific, therapeutic and technical staff	913	862	52	894
Social Care Staff	0	0	0	1
Other	52	0	52	0
TOTAL	6,392	5,672	720	6,224
Of the above - staff engaged on capital projects	9	9	0	9

10.3 Staff Sickness absence and ill health retirements

	2011-12 Number	2010-11 Number
Total Days Lost	**53,316**	**43,773**
Total Staff Years	**146**	**120**
Average working Days Lost	10	9

	2011-12 Number	2010-11 Number
Number of persons retired early on ill health grounds	**0**	0
	£000s	£000s
Total additional pensions liabilities accrued in the year	**0**	0

10.4 Exit Packages agreed in 2011-12

	2011-12			2010-11		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	**0**	2	**2**	4	0	**4**
£10,001-£25,000	**1**	1	**2**	0	7	**7**
£25,001-£50,000	**2**	1	**3**	3	5	**8**
£50,001-£100,000	**2**	1	**3**	12	6	**18**
£100,001 - £150,000	**0**	0	**0**	1	0	**1**
£150,001 - £200,000	**0**	0	**0**	0	0	**0**
>£200,000	**0**	0	**0**	0	0	**0**
Total number of exit packages by type (total cost	**5**	**5**	**10**	**20**	**18**	**38**
Total resource cost (£000s)	229	170	**399**	993	620	1,613

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change Scheme.**Exit costs in this note are accounted for in full in the year of departure**. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Pension costs
Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Full actuarial (funding) valuation

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

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

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 the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2011-12 Number	2011-12 £000	2010-11 Number	2010-11 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**76,971**	**187,984**	75,328	181,554
Total Non-NHS Trade Invoices Paid Within Target	**32,402**	**120,125**	18,408	103,791
Percentage of NHS Trade Invoices Paid Within Target	42.10%	63.90%	24.44%	57.17%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,493**	**22,311**	2,605	27,392
Total NHS Trade Invoices Paid Within Target	**1,160**	**4,404**	869	9,006
Percentage of NHS Trade Invoices Paid Within Target	46.53%	19.74%	33.36%	32.88%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2011-12 £000	2010-11 £000
Amounts included in finance costs from claims made under this legislation	**17**	13
Compensation paid to cover debt recovery costs under this legislation	**2**	23

12 Investment Income

	2011-12 £000	2010-11 £000
Rental Income		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest Income		
LIFT: equity dividends receivable		
LIFT: loan interest receivable		
Bank interest	**52**	51
Other loans and receivables	**702**	769
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**754**	820
Total investment income	**754**	820

13 Other Gains and Losses

	2011-12 £000	2010-11 £000
Gain/(loss) on disposal of property, plant and equipment	**35**	0
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**35**	0

14 Finance Costs

	2011-12 £000	2010-11 £000
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Provisions - unwinding of discount	**141**	145
Interest on obligations under PFI contracts:		
- main finance cost	**19,573**	19,744
- contingent finance cost	**4,067**	1,127
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**17**	13
Other interest expense	**2**	128
Total interest expense	**23,800**	21,157
Other finance costs	**0**	0
Total	**23,800**	21,157

15.1 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 31 March 2011	29,227	272,322	9,484	3,061	69,158	57	17,262	2,969	**403,540**
Cumulative dep'n adjustment following revaluation	2,327	1,756	363	0	0	0	0	0	**4,446**
Merger adjustments	0	0	0	0	0	0	0	0	**0**
At 1 April 2011 restated	31,554	274,078	9,847	3,061	69,158	57	17,262	2,969	**407,986**
Additions Purchased	0	0	0	10,398	4,905	0	0	0	**15,303**
Additions Donated	0	173	0	0	40	0	0	0	**213**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	2,939	0	(9,313)	3,573	0	1,894	36	**(871)**
Reclassifications as Held for Sale	0	0	0	0	(65)	0	0	0	**(65)**
Disposals other than for sale	0	0	0	0	(2,259)	0	0	(8)	**(2,267)**
Upward revaluation/positive indexation	0	372	49	0	0	0	0	0	**421**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from NHS Bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**31,554**	**277,562**	**9,896**	**4,146**	**75,352**	**57**	**19,156**	**2,997**	**420,720**
Depreciation									
At 31 March 2011	(2,327)	(1,756)	(363)	0	35,415	43	8,421	1,369	**40,802**
Cumulative dep'n adjustment following revaluation	2,327	1,756	363	0	0	0	0	0	**4,446**
Merger adjustments	0	0	0	0	0	0	0	0	**0**
At 1 April 2011 restated	0	0	0	0	35,415	43	8,421	1,369	**45,248**
Reclassifications		0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(2,259)	0	0	(8)	**(2,267)**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	18	0	0	0	**18**
Reversal of Impairments	(157)	(994)	0	0	0	0	0	0	**(1,151)**
Charged During the Year	0	4,384	230	0	6,578	4	1,718	323	**13,237**
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	**0**
At 31 March 2012	**(157)**	**3,390**	**230**	**0**	**39,752**	**47**	**10,139**	**1,684**	**55,085**
Net book value at 31 March 2012	31,711	274,172	9,666	4,146	35,600	10	9,017	1,313	**365,635**
Purchased	31,711	273,407	9,666	4,146	35,406	10	9,017	1,313	**364,676**
Donated	0	765	0	0	194	0	0	0	**959**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2012	**31,711**	**274,172**	**9,666**	**4,146**	**35,600**	**10**	**9,017**	**1,313**	**365,635**
Asset financing:									
Owned	31,711	73,642	9,666	4,146	19,156	10	9,017	1,313	**148,661**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	200,530	0	0	16,444	0	0	0	**216,974**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total	**31,711**	**274,172**	**9,666**	**4,146**	**35,600**	**10**	**9,017**	**1,313**	**365,635**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
At 31 March 2011	0	8,038	68	3,222	0	0	0	**11,328**
Prior period adjustments	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	0	0	**0**
At 1 April 2011 restated	0	8,038	68	3,222	0	0	0	**11,328**
Movements (specify)	0	184	46	(1,254)	0	0	0	**(1,024)**
At 31 March 2012	0	8,222	114	1,968	0	0	0	**10,304**

15.2 Property, plant and equipment

2010-11	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2010	29,227	267,398	9,417	3,462	65,293	57	15,344	2,828	**393,026**
Additions - purchased	0	3	0	7,610	2,196	0	0	0	**9,809**
Additions - donated	0	0	0	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	3,211	0	(8,011)	1,887	0	2,772	141	**0**
Reclassified as held for sale	0	0	0	0	(16)	0	0	0	**(16)**
Disposals other than by sale	0	0	0	0	(202)	0	(854)	0	**(1,056)**
Revaluation & indexation gains	0	1,710	67	0	0	0	0	0	**1,777**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
At 31 March 2011	**29,227**	**272,322**	**9,484**	**3,061**	**69,158**	**57**	**17,262**	**2,969**	**403,540**
Depreciation									
At 1 April 2010	0	0	0	0	29,697	40	7,538	964	**38,239**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(202)	0	(854)	0	**(1,056)**
Upward revaluation/positive indexation	0	24	0	0	0	0	0	0	**24**
Impairments	0	0	0	0	30	0	24	0	**54**
Reversal of Impairments	(2,327)	(5,815)	(592)	0	0	0	0	0	**(8,734)**
Charged During the Year	0	4,035	229	0	5,890	3	1,713	405	**12,275**
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	**0**
At 31 March 2011	(2,327)	(1,756)	(363)	0	35,415	43	8,421	1,369	40,802
Net book value	**31,554**	**274,078**	**9,847**	**3,061**	**33,743**	**14**	**8,841**	**1,600**	**362,738**
Purchased	31,554	273,461	9,847	3,061	33,528	14	8,841	1,600	**361,906**
Donated	0	617	0	0	215	0	0	0	**832**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2011	31,554	274,078	9,847	3,061	33,743	14	8,841	1,600	**362,738**
Asset financing:									
Owned	31,554	71,998	9,847	3,061	18,729	14	8,841	1,600	**145,644**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	202,080	0	0	15,014	0	0	0	**217,094**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
	31,554	274,078	9,847	3,061	33,743	14	8,841	1,600	**362,738**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
At 1 April 2010 restated	0	6,305	0	3,242	0	0	0	**9,547**
Movements (specify)	0	1,669	68	(20)	0	0	0	**1,717**
At 31 March 2011	0	7,974	68	3,222	0	0	0	**11,264**

15.3 Property, plant and equipment

There were no additional capital items donated in the current year.

The Trust's accounting policy for Asset lives is as follows:-

Life	**Yrs**	**Yrs**
Category	**Min**	**Max**
Building (non dwelling)	15	70
Dwelling	15	50
Plant and Machinery	7	15
Information Technology	4	10
Intangible	3	5

Land and Buildings were last revalued on 31st March 2010 by professional valuers, DTZ Debenham Tie Leung Limited (an independent third party valuer). The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Professional revaluations of Land and Buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices. These indices were historically provided from the Treasury, but as of 2009/10 this service has been withdrawn. For Financial Year 2011/12 indices were obtained from the Land Registry.

Non Property based assets including Equipment and Fixtures, are held at depreciated historic cost as this is not considered to be materially different from fair value.

Gains arising from indexation and revaluation are taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.
Losses arising from indexation and revaluation are recognised as price/market movement impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset. Losses in excess of that amount are charged to the current year's Statement of Comprehensive Income.
Diminution in value when newly constructed assets are brought into use are charged in full to the Statement of Comprehensive Income. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

The Trust leases out the following items of property, plant and equipment on an operating lease basis.

	HCA	**ISTC**
	£000	£000
· Gross carrying amount	2,832	889
· Accumulated depreciation	-	-
· Accumulated impairment loss	124	321
· Depreciation charge for the period	36	-
· Impairment losses recognised for the period	-	-
· Impairment losses reversed for the period	13	3

16.1 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 31 March 2011	4,260	0	263	0	0	**4,523**
Prior period adjustments	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	**0**
At 1 April 2011 restated	4,260	0	263	0	0	**4,523**
Additions - purchased	0	0	0	0	0	**0**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	871	0	0	0	0	**871**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(257)	0	0	0	**(257)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Transfers to Foundation Trusts	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluatio	0	0	0	0	0	**0**
At 31 March 2012	5,131	(257)	263	0	0	**5,137**
Amortisation						
At 31 March 2011	1,575	0	263	0	0	**1,838**
Prior period adjustments	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	**0**
At 1 April 2010	1,575	0	263	0	0	**1,838**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	(257)	0	0	0	**(257)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	796	0	0	0	0	**796**
Transfers to Foundation Trusts	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluatio	0	0	0	0	0	**0**
At 31 March 2012	2,371	(257)	263	0	0	**2,377**
NBV at 31 March 2012	2,760	0	0	0	0	2,760
Net book value at 31 March 2012 comprises:						
Purchased	2,760	0	0	0	0	**2,760**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2012	2,760	0	0	0	0	**2,760**

Revaluation reserve balance for intangible non-current assets						
	£000's	£000's	£000's	£000's	£000's	£000's
At 31 March 2011	0	0	0	0	0	**0**
Prior period adjustments	0	0	0	0	0	**0**
Merger adjustments						
At 1 April 2011 restated	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2012	0	0	0	0	0	0

16.2 Intangible non-current assets

2010-11	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 1 April 2010	4,488	0	263	0	0	**4,751**
Additions - purchased	1	0	0	0	0	**1**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	0	0	0	0	**0**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	(229)	0	0	0	0	**(229)**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Transferred to Foundation Trusts	0	0	0	0	0	**0**
At 31 March 2011	4,260	0	263	0	0	**4,523**
Amortisation						
At 1 April 2010	959	0	263	0	0	**1,222**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	(229)	0	0	0	0	**(229)**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	845	0	0	0	0	**845**
Transfers to Foundation Trusts	0	0	0	0	0	**0**
At 31 March 2011	1,575	0	263	0	0	**1,838**
Net book value at 31 March 2010	2,685	0	0	0	0	**2,685**
Net book value at 31 March 2010 comprises:						
Purchased	2,685	0	0	0	0	**2,685**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2011	2,685	0	0	0	0	**2,685**

16.3 Intangible non-current assets

Intangible non-current assets include software where not dependant on, or part of, assets held within Tangible Fixed assets - Information Technology, or where computer software has been internally generated or implemented.

All intangible assets are held at depreciated historic cost, as this is not considered to be material different from fair value, and are amortised over their finite, useful economic lives.

The assets are recognised, whether purchased or self created, at cost, if:
- it is probable that the future economic benfits that are attributable to the asset will flow to the entity, and
- the cost of the asset can be reliably measured.

If the recognition criteria are not met, the expenditure on this item will be recognised as an expense when it is incurred.

17 Analysis of impairments and reversals recognised in 2011-12

	2011-12 Total £000
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	(1,133)
Total charged to Annually Managed Expenditure	(1,133)
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	0
Over Specification of Assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for PPE charged to reserves	0
Total Impairments of Property, Plant and Equipment	(1,133)
Total Impairments charged to Revaluation Reserve	0
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	(1,133)
Overall Total Impairments	(1,133)
Of which:	
Impairment on revaluation to "modern equivalent asset" basis	0
Donated and Gov Granted Assets, included above	
Donated Asset Impairments: amount charged to SOCI - DEL	0
Donated Asset Impairments: amount charged to SOCI - AME	0
Donated Asset Impairments: amount charged to revaluation reserve	0
Total Donated Asset Impairments	0
Government Granted Asset Impairments: amount charged to SoCI - DEL	0
Government Granted Asset Impairments: amount charged to SoCI - AME	0
Government Granted Asset Impairments: amount charged to revaluation reserve	0
Total Gov Granted asset Impairments.	0
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	0

18 Investment property

There are no investment properties.

19 Commitments

19.1 Capital commitments

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

	31 March 2012	31 March 2011
	£000	£000
Property, plant and equipment	**3,160**	6,859
Intangible assets	**0**	0
Total	**3,160**	6,859

19.2 Other financial commitments

The trust has not entered into any non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

20 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	20,662	1,467	10,795	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,512	0	2,658	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	14,043	17,609	39,589	4,916
At 31 March 2012	**36,217**	**19,076**	**53,042**	**4,916**
prior period:				
Balances with other Central Government Bodies	18,023	1,737	14,417	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,059	0	3,426	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	10,634	21,730	30,377	4,916
At 31 March 2011	**29,716**	**23,467**	**48,220**	**4,916**

21 Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000
Balance at 1 April 2011	2,390	4,429	169	0	0	0	**6,988**
Prior period adjustment	0	0	0	0	0	0	**0**
Merger adjustment	0	0	0	0	0	0	**0**
Restated at 1 April 2011	2,390	4,429	169	0	0	0	**6,988**
Additions	32,996	35,545	5	0	0	0	**68,546**
Inventories recognised as an expense in the period	(33,118)	(36,170)	0	0	0	0	**(69,288)**
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**
Reversal of write-down previously taken to SoCI	0	0	0	0	0	0	**0**
Transfers (to)/from other bodies	0	(428)	0	0	0	0	**(428)**
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**
Balance at 31 March 2012	2,268	3,376	174	0	0	0	**5,818**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
NHS receivables - revenue	**8,648**	18,517	**1,467**	1,737
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**12,897**	0	**0**	0
Non-NHS receivables - revenue	**3,857**	4,489	**0**	0
Non-NHS receivables - capital	**0**	6	**0**	0
Non-NHS prepayments and accrued income	**5,364**	3,078	**0**	0
Provision for the impairment of receivables	**(2,468)**	(2,423)	**0**	0
VAT	**1,218**	726	**0**	0
Current part of PFI and other PPP arrangements prepayments and a	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**6,072**	5,323	**17,609**	21,730
Total	**35,588**	29,716	**19,076**	23,467
Total current and non current	**54,664**	53,183		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired

	31 March 2012 £000	31 March 2011 £000
By up to three months	**3,982**	4,218
By three to six months	**497**	388
By more than six months	**808**	2,521
Total	**5,287**	7,127

22.3 Provision for impairment of receivables

	2011-12 £000	2010-11 £000
Balance at 1 April 2011	**(2,423)**	(2,747)
Adjustments	**0**	0
Restated balance at 1 April 2011	**(2,423)**	(2,747)
Amount written off during the year	**3,283**	0
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(3,328)**	324
Transfer to NHS Foundation Trust	**0**	0
Balance at 31 March	**(2,468)**	**(2,423)**

Every invoice has been analysed through a dunning level method in asertaining the impairment of receivables figures.

We do not have any collateral on bad debt provisions.

23 NHS LIFT investments

The Trust has no NHS LIFT investments.

24 Other financial assets

The Trust has no other financial assets.

25 Other current assets

The Trust has no other current assets.

26 Cash and Cash Equivalents

	31 March 2012 £000	31 March 2011 £000
Opening balance at	**2,830**	2,098
Opening balance adjustment	**0**	0
Merger adjustments	**0**	0
Restated	**2,830**	2,098
Net change in year	**1,513**	732
Closing balance	**4,343**	2,830
Made up of		
Cash with Government Banking Service	**4,323**	2,804
Commercial banks	**21**	26
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**4,343**	2,830
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**4,343**	2,830
Patients' money held by the Trust, not included above	0	0

27 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	0	0	0	0	**0**
Restated at 1 April 2011	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	65	0	0	0	0	**65**
Less assets sold in the year	0	0	0	0	(65)	0	0	0	0	**(65)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other bodies	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2012	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2010	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	16	0	0	0	0	**16**
Less assets sold in the year	0	0	0	0	(6)	0	0	0	0	**(6)**
Less impairment of assets held for sale	0	0	0	0	(10)	0	0	0	0	**(10)**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2011	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2011	0	0	0	0	0	0	0	0	0	0

28 Trade and other payables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Interest payable	**0**	0	**0**	0
NHS payables - revenue	**2,184**	8,985	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,918**	0	**0**	0
Family Health Services (FHS) payables	**-**	-	**-**	-
Non-NHS payables - revenue	**10,314**	14,371	**0**	0
Non-NHS payables - capital	**1,406**	258	**0**	0
Non_NHS accruals and deferred income	**18,072**	17,003	**4,916**	5,129
Social security costs	**2,924**	2,683		
VAT	**0**	0	**0**	0
Tax	**3,429**	3,373		
Payments received on account	**0**	0	**0**	0
Other	**3,444**	1,334	0	0
Total	**43,691**	48,007	**4,916**	5,129
Total payables (current and non-current)	**48,607**	**53,136**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	0	0		
number of Cases Involved (number)	0	0		
outstanding Pension Contributions at the year end	0	0		

29 Other liabilities

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
PFI/LIFT deferred credit	**0**	0	**0**	**0**
Lease incentives	**0**	0	**0**	**0**
Other	**0**	0	**0**	**0**
Total	**0**	0	**0**	0
Total other liabilities (current and non-current)	**0**	**0**		

30 Borrowings

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**0**	0	**0**	0
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**5,977**	5,277	**258,720**	260,151
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**5,977**	**5,277**	**258,720**	**260,151**
Total other liabilities (current and non-current)	**264,697**	**265,428**		

Loans - repayment of principal falling due in:

	31 March 2012		
	DH £000	**Other £000**	**Total £000**
0-1 years	0	5,977	5,977
1 - 2 Years	0	6,194	6,194
2 - 5 Years	0	20,049	20,049
Over 5 Years	0	232,477	232,477
TOTAL	0	264,697	264,697

31 Other financial liabilities

The Trust has no other financial liabilities.

32 Deferred income

The Trust has no deferred income.

33 Finance lease obligations as lessee

The Trust has no finance lease obligations other than PFI (note 37).

34 Finance lease receivables as lessor

The Trust has no Finance Lease receivable as lessor.

35 Provisions

Comprising:

	Total	Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Equal Pay	Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at "01/04/11"	6,828	0	5,772	583	0	0	0	473	0	0
Prior period adjustment	0	0	0	0	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0	0	0	0
Restated Balance 01/04/11	6,828	0	5,772	583	0	0	0	473	0	0
Arising During the Year	1,527	0	0	20	0	0	0	827	680	0
Utilised During the Year	(762)	0	(707)	(55)	0	0	0	0	0	0
Reversed Unused	(10)	0	0	(10)	0	0	0	0	0	0
Unwinding of Discount	141	0	141	0	0	0	0	0	0	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts *(for Trusts becoming FTs only)*	0	0	0	0	0	0	0	0	0	0
Balance as at "31/03/12"	**7,724**	**0**	**5,206**	**538**	**0**	**0**	**0**	**1,300**	**680**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**2,710**	0	692	**538**	**0**	**0**	**0**	**1,300**	**180**	**0**
Later than One Year and not later than Five Years	**2,682**	0	2,182	**0**	**0**	**0**	**0**	**0**	**500**	**0**
Later than Five Years	**2,332**	0	2,332	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at "31/03/12"	85,057,521
As at "31/03/11"	73,710,000

Legal claims include provisions for employer's liability, public liability, injury benefits and employment tribunal cases.

Employer's liabilty and public liabilty provisions are the product of the best estimates of the NHS Litigation Authority's claim managers. It is assumed that the cases will complete in the timescale and costs forecast. However, cases do change in value and timing depending on the litigation process and the complexity of the case.

Other Provisions include provisions for Agenda for Change. The agenda for change provision is for salary arrears due to ex-employees, whose posts had been assimilated to Agenda For Change subsequent to their leaving. These provisions have been determined after making an assessment of the likely eventual outcome.

The expected reimbursement from commissioners (Primary Care Trusts) for provisions covered by back-to-back arrangements is £1,621,715 (2011: £1,644,968). This amount is included within NHS debtors Note. £85,057,521 is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the NHS Trust (2011: £73,710,000).

36 Contingencies

The Trust has no Contingencies for 11/12. For the year 10/11 this was £72k.

37 Private Finance Initiative (PFI) Schemes - additional information

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

The PFI project relates to Queen's Hospital in Romford, which was built by Catalyst Healthcare (Romford) Ltd, (CHRL), completed in October 2006 and fully operational by December 2006. CHRL is a consortium comprising Bovis Lend Lease Limited (the constructor and infrastructural lifecyle provider), Sodexo Ltd, (providing a broad range of facilities management services including "living-space" lifecycle) and Uberior Investments, formerly part of HBOS, now part of the Lloyds Banking Group. Bovis, Sodexo and Uberior were original equity holders in CHRL. Bovis sold their CHRL equity interest in 2009 to Infrastructure Investments Ltd, a division of, HSBC.

The PFI Project Agreement, with Catalyst comprises a design and build contract which provides Queen's Hospital, a 930 bedded multi-specialty acute hospital in Romford, supported by 16 operating theatres, an Accident and Emergency department, ITU/ HDU facilities, a renal dialysis unit with accompanying diagnostic services such as pathology and radiology.

Siemens Healthcare Services Ltd provides a managed equipment service to the Trust as part of the unitary payment, but is not part of the CHRL consortium; however Siemens is a sub-contractor to CHRL.

CHRL provides a full range of facilities management services for the Trust in consideration for the Service Payment, which includes cleaning, portering, catering and building maintenance. Clinical services continue to be provided directly by the Trust's own staff. At the end of the Project Term, January 2040, CHML's interest in the facility ceases and no further payments are due to them. CHRL are obliged to maintain the hospital to a required standard throughout the project timescale, and there is an agreed handover commitment requiring this standard to be maintained or made good at the end of the contract.

Within the contract, there is provision for the Trust to elect to either benchmark or market-test certain facilities management services, which may affect the price of services provided by the consortium.

From 1 April 2009, and the adoption of International Financial Reporting Standards, the PFI hospital comes onto the Statement of Financial position. Assets have been recognised for the building and equipment under the scope of the Managed Equipment Service, which are depreciated in accordance with the Trust's accounting policies. The substance of the contract is that the Trust has a financial liability which is similar to a finance lease over the Project term. Payments comprise two elements - imputed finance lease charges and service charges. The financial liability covers the financing cost of the building and equipment, (as distinct from service costs); the timing of these obligations is disclosed below:-

The annual payment is subject to an RPI-based indexation in common with most other PFI schemes. Apart from inflationary increases, any increases or decreases in payments are determined by upward or downward service variations, determined by the Trust.

	2011-12	2010-11
	£000	£000
Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**21,848**	21,459
Total	**21,848**	21,459
Payments committed to the service element of on SOFP PFI		
No Later than One Year	**22,175**	21,646
Later than One Year, No Later than Five Years	**94,385**	92,135
Later than Five Years	**767,337**	792,265
Total	**883,897**	906,046

The estimated annual payments in future years are not expected to be materially different from those which the Trust is committed to make during the next year. The annual payment is subject to an RPI-based indexation in common with most other PFI schemes. Apart from inflationary increases, any increases or decreases in payments are determined by upward or downward service variations, determined by the Trust.

Imputed "finance lease" obligations for on SOFP PFI contracts due

No Later than One Year	**25,376**	24,748
Later than One Year, No Later than Five Years	**99,002**	91,617
Later than Five Years	**480,652**	507,609
Subtotal	**605,030**	623,974
Less: Interest Element	**(340,333)**	(358,546)
Total	**264,697**	265,428

38 Impact of IFRS treatment - current year

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

	Total
	£000
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)	
Depreciation charges	6,032
Interest Expense	19,573
Impairment charge - AME	0
Impairment charge - DEL	(953)
Other Expenditure	21,848
Revenue Receivable from subleasing	0
Impact on PDC dividend payable	(2,368)
Total IFRS Expenditure (IFRIC12)	44,132
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease income)	(44,079)
Net IFRS change (IFRIC12)	53
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2011-12	4,905
UK GAAP capital expenditure 2011-12 (Reversionary Interest)	2,977
Revenue costs of IFRS: all other expenditure associated with IFRS (e.g. finance leases)	
Depreciation charge	0
Interest expense	0
Impairment charge - AME	0
Impairment charge - DEL	0
Other expenditure	0
Impact on PDC dividend payable	0
Total IFRS expenditure (non IFRIC12)	**0**
Revenue consequences under UK GAAP	0
Net IFRS change (non IFRIC12)	**0**
Capital consequences of IFRS all other expenditure associated with IFRS	
Capital expenditure 2011-12	0
Net assets relating to non-IFRIC12 IFRS - IFRS basis	0
Net assets relating to non-IFRIC12 IFRS - UKGAAP basis	0
UK GAAP capital expenditure 2011-12 (Reversionary Interest)	0

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS 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 NHS 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 NHS 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 agree by the board of directors. Trust 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.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 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 primary care trusts, which are financed from resources voted annually by Parliament The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	0
Receivables - NHS	0	22,645	0	22,645
Receivables - non-NHS	0	26,655	0	26,655
Cash at bank and in hand	0	4,343	0	4,343
Other financial assets	0	0	0	0
Total at 31 March 2012	0	53,643	0	53,643
Embedded derivatives				
Receivables - NHS		18,328		**18,328**
Receivables - non-NHS		31,777		**31,777**
Cash at bank and in hand		2,830		**2,830**
Other financial assets		0		**0**
Total at 31 March 2011		**52,935**	**0**	**52,935**

39.3 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	0
NHS payables	0	4,102	4,102
Non-NHS payables	0	38,516	38,516
Other borrowings	0	0	0
PFI & finance lease obligations	0	264,697	264,697
Other financial liabilities	0	0	0
Total at 31 March 2012	0	307,315	307,315
Embedded derivatives	0	0	0
NHS payables		8,985	8,985
Non-NHS payables		37,304	37,304
Other borrowings		0	0
PFI & finance lease obligations		265,428	265,428
Other financial liabilities	0	0	0
Total at 31 March 2011	**0**	**311,717**	**311,717**

40 Events after the end of the reporting perioc	£000
There are no events after the reporting period.	0