## CONTENTS

4 Message from our Chair  
5 A message from our Chief Executive  
6 Our Year in Pictures

### SECTION ONE: PERFORMANCE REPORT

**Overview**  
10 Delivering our objectives  
14 Delivering high quality care  
24 Running our hospitals efficiently  
32 Becoming an employer of choice  
38 Working in partnership  
42 Managing our finances

**Performance analysis**  
44 Our performance report

### SECTION TWO: ACCOUNTABILITY REPORT

**Corporate governance report**  
54 Directors’ report  
63 Statement of Accountable Officer’s responsibility  
64 Governance statement

**Remuneration and staff report**  
70 Remuneration report  
73 Staff report  
76 Audit opinion

### SECTION 3: FINANCIAL STATEMENTS AND NOTES

82 Accounts 2017-18
A MESSAGE FROM OUR CHAIR

Welcome to our annual report for 2017/18. My first as Chair of Barking, Havering and Redbridge University Hospitals NHS Trust.

Since joining the Trust towards the end of 2017, I have been hugely impressed by the commitment, passion and dedication of all the staff to deliver high quality care to our patients, which has been unwavering, despite the huge pressure which has undoubtedly been felt, particularly across the winter months.

I am absolutely committed towards continuing our journey to achieving our vision of delivering outstanding care to our community, and I know all my colleagues in the Trust feel similarly and there is a huge commitment to keep improving our quality of care and our standards in every field.

It has not been a year without its challenges. It is well known that the past few months have seen systemic financial problems come to light and we are now tackling some significant issues. While these are described elsewhere, I should say that from a Board perspective, we take responsibility for the lack of governance and failure in financial performance of the Trust, and we are sorry.

It is clear that things were not as they should have been for some while. However, I think we responded appropriately, seeking external support, gathering the right intelligence and gaining improved insight to ensure that we were able to diagnose the underlying issues. I believe that we have ended the year stronger and wiser for the experience, and with important lessons having been learned.

The Board itself has seen a period of significant change, with both executives and non-executives, including myself, having joined the Trust. These periods can always throw up challenges as organisations reorder themselves and that has been the case here. I look forward to helping to create a more stable and sustainable leadership into 2018 and beyond.

Ultimately, being placed into financial special measures by NHS Improvement at the very end of 2017 is one example of the cutting edge challenges which face our population, and finding the tools to make sustained, embedded change, improving our efficiency and reducing costs.

This is both in terms of the speed with which we are moving patients through the pathway – we hit the NHS constitutional standard for ensuring that 95% of patients begin treatment within 62 days of referral in eight months of the year.

It’s also about the quality of care. The unveiling of the UK’s first Halcyon radiotherapy machine at the end of 2017 is one example of the cutting edge treatment we are now offering. Over the course of 2018/19 we will continue to invest in our facilities and improve our hospitals, with at least one further new treatment machine on the way.

However, our performance, particularly over the extremely challenging winter months, against the four-hour emergency access target, has been less positive. Our patients are sicker, with multiple concurrent illnesses, meaning we have higher admissions, longer lengths of stay, and one of our most challenging winters ever.

As Joe has already mentioned in his introduction, being placed into financial special measures as a result of significant financial challenges which we have faced, was very disappointing.

I believe that we were up front and honest about the problem when it became fully apparent and we took swift action to address the immediate issues and develop a plan to move forward.

Now the underpinning issues have been identified, it has been an opportunity to reflect and learn that things were not as they should have been, in terms of our approach, our processes, our reporting or our culture.

I have been hugely impressed with the commitment, resilience, passion and dedication of our staff to tackle this challenge – just as they have tackled other challenges before. Every day I find new reasons to be proud of them.

It should also be acknowledged that the picture across the whole of North East London is extremely challenging. Our local Clinical Commissioning Groups are under similar levels of financial strain, so this year will be hugely significant in terms of recognising and dealing with the broader health challenges which face our population, and finding ways to balance the supply and demand for our services, while using our resources wisely.

I am very clear, as are the Board, that while we need to regain tighter control of our finances, we absolutely will not compromise on patient safety or the quality of patient care.

Now, more than ever, we will press on with embedding The PRIDE Way – our improvement methodology forged through our partnership with the Virginia Mason Institute. It will give us the tools to make sustained, embedded change, improving our efficiency and reducing costs.

This will build on our having launched the Leaders’ Agreement last year, which set out our clear expectations of leaders in the Trust to support and develop their teams, to make our Trust a great place to work.

I would like to thank our staff, volunteers and patient partners, our stakeholders and partners, but most importantly, our patients.
Our apprentice, Samantha Misselbrook was named the best apprentice for the north, central and east London region in the National NHS Apprenticeship Celebration Awards. Samantha works in our Education department as a training and development assistant and is passionate about helping young people plan their future, after being unsure of what she wanted to do on leaving school.

A caring seven-year-old visited our NICU to donate premature baby clothes and money he’d raised to help our tiniest patients. Henry O’Keefe had been inspired by a Pampers TV ad.

A miracle mum was about to celebrate the first birthday of the daughter she didn’t think possible. Beatrice Way and husband Alexander celebrated the first birthday of baby Rosemary, and thanked our surgeon, Hu Liang Low, who saved Beatrice’s life with a pioneering operation following a stroke.

We held our annual Long Service and PRIDE Awards, to give thanks and recognition to our dedicated staff and volunteers.

We made it possible for a devoted couple to marry in our hospital after Robert Davies, 52, received the news that his cancer was terminal. Robert married long-term partner Julie on Ocean B ward at Queen’s Hospital watched over by family and friends including their two daughters, Megan and Cerys.

We held special tree lighting ceremonies at both our hospitals in the run-up to the festive season to launch our Treasured Memories appeal. The Avanti School choir brightened the day of visitors to King George Hospital with some festive tunes before a lucky pupil got to switch on the Christmas tree lights.

We held a celebration event to mark the achievements of our trainee nurse associates, a year after we became one of the first trusts to launch the programme. Among those celebrating was Alina Stevens, who discovered a love of helping dementia patients when she spent a summer holidays working in a dementia unit with her stepmother.

We swept the board at the Patient Experience Network National Awards with three awards; for our short film for cancer patients; our bereavement support, including opening the Daisy Centre; and our patient partner Sara Turle won the best networker award. We were also runner-up for our innovative partnership work with critical care patients at the end of their lives.

Our youngest patient partner, Alex Burulea, 17, was interviewed in our local press to encourage other young people to get involved with their local hospital.

Our year in pictures

April

May

June

July

August

September

October

November

December

January

February

March

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March
This section of the Annual Report details our operational performance over the 2017/18 financial year. It is structured into five sections, which align with our five core objectives, as set out in our Operational Plan for 2017-2019. These core objectives, and those which sit beneath them, were led by our staff and volunteers, working in partnership with key local stakeholders and patient representatives.
OUR 2017-18

DELIVERING HIGH QUALITY CARE
• Embed quality and safety systems to respond to quality concerns and reduce harm
• Ensure the highest standards of infection control
• Embed The PRIDE Way, our quality improvement methodology

RUNNING OUR HOSPITALS EFFICIENTLY
• Develop our divisional teams to ensure we are well-led
• Continue to improve delivery of our constitutional standards
• Improve back office productivity, including procurement, IT and clinical support services, and refresh our estates strategy

BECOMING AN EMPLOYER OF CHOICE
• Implement the Leaders’ Agreement to enable our staff to achieve excellence
• Establish new roles and implement our academic and education strategies to develop our staff
• Increase and retain our substantive workforce

OBJECTIVES

WORKING IN PARTNERSHIP
• Work with our partners to deliver the Sustainability and Transformation Plan
• Improve engagement and community development with our partners, patients and public
• Work with our partners to develop services to align with our Clinical Services Strategy

MANAGING OUR FINANCES
• Embed service line reporting and management to improve decision-making and budgetary control
• Make sure we get paid for all the work we do
• Achieve financial balance with the inclusion of transformation funding
OUR HOSPITALS IN 2017/18:
136,000 GP REFERRALS

MATERNITY
99% POSITIVE RECOMMENDATIONS
39% WATER BIRTHS IN OUR BIRTH CENTRE
8,299 BABIES DELIVERED THIS YEAR

PAEDIATRICS
6,202 PAEDIATRIC INPATIENTS (ADMISSIONS)
12,290 PAEDIATRIC OUTPATIENTS

EMERGENCY
239,136 ATTENDANCES (ALL TYPES)
73,088 EMERGENCY ADMISSIONS

67,711 AMBULANCE ARRIVALS

PLANNED CARE
50,517 DAY CASE PROCEDURES
739,842 OUTPATIENT APPOINTMENTS
23,938 THEATRE OPERATIONS
2,027 A DAY
DELIVERING HIGH QUALITY CARE

- Embed quality and safety systems to respond to quality concerns and reduce harm
- Ensure the highest standards of infection control
- Embed The PRIDE Way, our quality improvement methodology

PROVIDING EXCELLENT QUALITY CARE, OUTCOMES AND SAFETY
Our patients are at the heart of everything that we do, and delivering first-class care is our top priority.

We believe we have had a positive year, with a strong focus on improving the quality of care, embedding and sustaining improvements in this area.

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

We welcomed the CQC back to the Trust at the start of 2018 to undertake further reviews, including one of the ‘Well Led’ domain. At the time of writing this report, we await the CQC’s written report, but we were encouraged by their informal feedback.

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

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

These gatherings, which are for all the clinical divisions, continue to be extremely valuable opportunities for learning and reflection, and it was encouraging to hear positively from the Secretary of State for Health and Social Care, Jeremy Hunt MP about his enthusiasm for them when he visited us.

VITALPAC
The rollout of VitalPac this year has been another huge step forward. This software system allows us to record patient observations on iPod touch devices at the bedside which means we no longer have to write down patient observations.

This new technology is helping our staff and patients by recording information in real time and will therefore be always up-to-date, and it boasts an early warning system to help identify high risk patients, or those who may be deteriorating.

QUALITY AND SAFETY
We are continuing to feel the benefit of the addition of an expert quality and safety team to help our frontline staff to deliver high quality, safe care. We continue to focus on four main objectives:

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

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

This is because often, any near misses which are spotted by staff first, before any patient is harmed, can result in pre-emptive action to mitigate the future risk. More reporting demonstrates a more vibrant safety culture.

We have previously acknowledged that we have not done well enough historically at reporting clinical incidents. Last year we reported a real step forward, with significant increases in the numbers of incidents reported. Naturally, it is not possible to keep increasing numbers indefinitely, so this year has been about consolidating this position, embedding these practices, and improving how we learn from incidents.

At the end of this year, we are now in the top 20% of Trusts nationally. From having been in the bottom 20 in 2015, this marks a huge improvement.

We held three Rapid Process Improvement Workshops (RPW) across the year, using our improvement methodology from The PRIDE Way (see p22/23) to focus on improving how we report, progress and report back on incidents. We look forward to the year ahead as a further opportunity to progress.

PRESSURE ULCERS

A pressure ulcer is damage to the skin and the deeper layer of tissue under the skin. This happens when pressure is applied to the same area of skin for a period of time. Periods of immobility and ill health are significant risk factors. Key to preventing this damage is understanding each patient’s risk and responding appropriately.

In 2017/18 we said we would:

• Reduce hospital acquired pressure ulcers by 5% for the 2017/18 period
• Continue pressure ulcer prevention and management training for nursing staff via clinical training sessions, induction and mandatory programmes; with the aim of training 3,096 nursing staff over a three-year period
• Continue to investigate hospital acquired incidents for grade 2, 3 and 4 pressure ulcers and where required ensure action plans are in place to address issues through the pressure ulcer review panels.

We are very pleased that we actually reduced the number of patients with hospital acquired pressure ulcers by 38.9% from 2016/17 – a total of 140 patients at an incident rate of 0.40%.

We also hit our training aspiration ahead of the original target date of November 2018, which was extremely encouraging.

NATIONAL COLLABORATIVE

The Trust has also been one of 25 trusts across the country taking part in a ‘National Collaborative’ aimed at the reduction of pressure ulcers, led by NHS Improvement.

This work has been a huge success.

Two wards were involved in this project for the six month duration. Ward 1 was aiming to reduce its incidence of avoidable hospital acquired pressure ulcers by 20% and Ward 2 was demonstrating healing of inherited pressure ulcers; with the aim of demonstrating improvement or healing of wounds by 50% from the baseline audit.

Ward 1 had no avoidable pressure ulcers by the end of the project on 31 March 2018 and had achieved 166 days without an avoidable pressure ulcer by the end of the project.

Ward 2 exceeded their target by demonstrating healing of 25% of wounds and 75% of wounds showed improvement; all patients with pressure ulcers and moisture damage on the ward were monitored as part of this project.

In the year ahead we will continue to take forward our learning, and we have appointed a tissue viability nurse for a short period to work with staff on the elderly care wards to improve further.

INFECTION PREVENTION AND CONTROL

We’ve seen improvements this year in our performance in infection prevention and control which are encouraging, but it remains a target area for us and we will ensure continued vigilance, emphasis and messaging to staff.

We made a big improvement this year in our performance against C. difficile infection. We achieved the national stretch target for C. difficile infection with 15 cases this year, against a target of <30. This compares with 29 cases last year, but we missed our target for MRSA infections (five cases against a target of zero).

We will continue to do what we can to improve our hand hygiene and to ensure that staff are fully trained in specialist ‘non-touch’ techniques that protect against the spread of infection.

FALLS

Falls are a serious problem among older people. A major cause of disability and mortality, falls also have a significant psychological impact on confidence and independence.

We are now midway through our three-year Falls Strategy for 2016-2019 with an annual action plan which was introduced across our hospitals.

We have run a comprehensive training programme throughout the year, comprising sessions in our simulation suites and online, with supporting information made available for both staff and patients.

Our target for 2017/18 was to seek a 3% reduction in the number of falls overall per 1,000 bed days, and we were able to achieve this.

We also pay close attention to falls which result in moderate, or more serious, harm. There were a total of 19 incidents in the year, compared with 25 the year before, so we achieved a 25% reduction in the number of falls with harm.
IMPROVING THE PATIENT EXPERIENCE

OUR PATIENT ENVIRONMENTS

We know that the environment in our hospitals can have a significant impact on patients. As across the NHS, we continue to utilise Patient-Led Assessments of the Care Environment (PLACE) inspections to drive action plans for the year ahead. These involve both staff and patients/volunteers.

We have a rolling programme of improvement works to keep our facilities as up-to-date and welcoming as possible. As the year opened, we were ready to open our new, improved facilities in phlebotomy and pre-assessment, both at King George Hospital in April. The moves for both these services represent a significant improvement for patients and staff, with more space, better waiting areas, and purpose-built cubicles.

Further detail on specific projects, including the reconfiguration and improvement of our Emergency Department/Enhanced Urgent Care Centre (EUC/G) at Queen’s, and the work undertaken to install the UK’s first Halcyon radiotherapy machine, is elsewhere in this report.

PATIENT EXPERIENCE

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

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

FRIENDS AND FAMILY TEST

We continue to work with external partner “I Want Great Care” to help us gather and analyse data relating to our Friends and Family Test (FFT) scores. We received more than 135,000 this year – a significant evidence base from which we can further refine and improve in coming years.

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

We use the FFT scores to identify and reward our Team of the Week, motivating our staff to continue encouraging patients to participate, but we also changed the criteria for Team of the Week this year, acknowledging that not every team has the opportunity to earn this feedback. It has been nice to get the chance to recognise the efforts of even more of our colleagues.

Many of the comments and suggestions we have received have already led to changes and improvements to our services.

PATIENT EXPERIENCE COLLABORATIVE

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

A key component of the work relates to how we talk to our patients about their experience. We identified eight wards where we have piloted a patient experience questionnaire which asked patients detailed questions about their care and treatment.

We were the only trust to also include a staff experience element to this work as we recognise the clear link between good staff experience and good patient experience. Putting patients at the heart of everything we do, we also ensured that a Patient Partner was part of our collaborative team – the only trust in the programme to have done this.

#HELLOMYNAMES

We continue to build on the national #HelloMyNameIs campaign to develop our own approach to greeting patients. The initiative, started by Dr Kate Granger before she passed away, is to ensure all patients get a more positive first impression when in hospitals, and so many plan who is looking after them.

We want to encourage our staff to create a great impression by smiling, introducing themselves, explaining their role and either offering to help, or explaining what they are here to do. It’s really simple, but it has a big impact. We were delighted to welcome Kate Granger’s husband, Chris Pointon, to Queen’s Hospital as part of a tour this year, to raise awareness, and we were delighted so many staff took the time to attend his sessions.

ROYAL ASSOCIATION FOR DEAF PEOPLE QUALITY MARK — BECOMING THE FIRST DEAF-AWARE HOSPITAL

We were delighted to become the first NHS trust to achieve the Deaf Aware Quality Mark from the Royal Association for Deaf People for Queen’s Hospital. We have worked really hard on improving communication, information and accessibility for patients who are deaf and hard of hearing, so it was fantastic to get this recognition.

The regular training sessions for staff continue to be really popular and well-attended. For 2018/19 we will be working on getting the same accreditation for King George Hospital.

KING GEORGE AND QUEEN’S HOSPITALS CHARITY

Our charity continues to provide invaluable support, raising funds so that we can make both of our hospitals even better for patients.

The restructured charity team is thriving and over the course of the last year has raised around £580,000, an increase of over 36% on the previous year.

The charity organises several public charity events throughout the year; the most popular and successful of these remains the annual Christmas Ball – tickets from the 2017 Motown-themed event sold out several weeks in advance and raised over £59,000.

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

At the time of writing this report, we have just strengthened the team by bringing in a new team member with event experience, who will be instrumental in 2018/19 in delivering more high quality events.

All the money the charity receives is reinvested in our hospitals, via the Charitable Funds Committee, which meets regularly to discuss applications.

CASE STUDY

CLAIRE’S NEST AND MINIBOOS

The charity has worked closely with the specialist team in Queen’s to find ways to make life even more comfortable for our tiniest patients. Parents of a baby needing to be in an incubator often lose out on those precious cuddles that support the important parent/baby bonding. Charity funds provided soft and comforting fabric nests called Claire’s Nests to help the baby feel secure and cosseted while in their incubator.

Miniboos are little star shaped characters made from soft bamboo rayon that come in packs of two. Parents get to keep one on their person, as well as leaving one alongside the baby, swapping back and forth so they can smell baby, while their smell becomes familiar to the baby too. They can also aid with breastfeeding.
CASE STUDY

REMINISCENCE INTERACTIVE THERAPY ACTIVITIES

With a growing and aging population, caring for our elderly and those with complex cognitive illness is a priority. The charity has raised funds with the help of The League of Friends from King George Hospital to purchase touch screen PCs and iPads for patients in wards at King George Hospital.

These systems have been specifically designed to engage patients who are living with all types of cognitive illness such as dementia, Alzheimer’s, Delirium or Parkinson’s. Becoming engaged and enjoying the day helps our patients to find better eating and sleeping patterns, resulting in a reduction in trips and falls caused by wandering at night.

Patients use them to watch films; listen to music, be entertained with their favourite TV shows from the past as well as taking part in games, competitions and even armchair exercises. Staff say the wards seem more calm and relaxed and they have seen many positive outcomes. The charity is now raising funds to buy the same equipment for patients in Queen’s Hospital very soon.

LEARNING FROM PATIENT FEEDBACK

Despite our best intentions, we don’t always get things right. Last year we took steps to improve our complaints processes to make them more responsive, and this year has seen a positive continuation of the improvement.

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

We believe we are offering a more responsive, comprehensive and thorough complaints process than ever before.

During the year we also successfully launched the Patient Advice and Liaison Service (PALS) Twitter account and Facebook page. We did this to offer another route for our patients to engage with us, recognising that increasing numbers use social media to ask questions or provide feedback or opinions. This has been well received and a helpful addition.

However, our increased accessibility may have something to do with the increased numbers of complaints overall. Although we hoped to achieve an overall reduction, we actually saw the number increase – to a total of 919, compared with 843 last year.

We also introduced a follow up process to all complainants via telephone, which appears to have had a positive impact on reducing the numbers of reactivated complaints.

The focus for the year ahead will be on further thematic analysis to identify any problem areas and also general workshops and training to try and deal with patient concerns before they escalate.

WE BELIEVE WE ARE OFFERING A MORE RESPONSIVE, COMPREHENSIVE AND THOROUGH COMPLAINTS PROCESS THAN EVER BEFORE.

A PATIENT’S STORY — JENNIFER SYKES

My GP said that because of my symptoms I needed to have a colonoscopy. To be honest, I was dreading it because I had had a dreadful experience at Queen’s Hospital about 10 years ago.

This time, the whole experience was amazing. It made me appreciate that we expect the clinical care to be good and, as long as it is, then what matters to the patient is how they are made to feel.

It all started with the wonderful Raj phoning me a few days after I saw my GP and together we arranged an appointment date and time. It was so good not to just be sent an appointment and then have the difficulty of trying to change it. He explained what would happen during the procedure and more than once asked me if I had any questions. He left me feeling so much better.

The medication to prepare for the procedure arrived as Raj had said through the post – how easy! And the instructions were easy to understand. However, I really struggled to take it. It was awful but it worked.
THE PRIDE WAY — EMBEDDING IMPROVEMENTS

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

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

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

We have had a very positive year in 2017/18 as we continue to move towards embedding the principles of The PRIDE Way across our organisation, particularly through the launch of the PRIDE Way for Leaders training, which will gather even more momentum through 2018/19.

We are increasingly moving the ‘theory’ of The PRIDE Way, into ‘action’, with the focus on four key areas (referred to as value streams) where we are making real progress on improving our processes, improving efficiency, standardising work and eliminating waste.

There are four key value streams:
- The first 24 Hours for frail and elderly patients
- Diagnostic processes
- Discharge processes, and
- Managing patient safety incidents.

We chose these value streams because we believe that to improve them, across our hospitals, would have a dramatic positive impact on the quality of care we provide.

One of the main tools we use to make these improvements are comprehensive five-day workshops, called Rapid Process Improvement Workshops (RPIW), involving representatives of all the staff who have any role in the identified process. Critically, every one of these workshops includes one of our patient partners, to provide the patients’ perspective.

The case studies below highlight how we have made real improvements, and we will continue to work to embed these in the teams and the organisation.

For 2018/19, we will be continuing to embed the methodology across the organisation, primarily through our Leaders’ Agreement, and the roll out of a major staff training programme – The PRIDE Way for Leaders.

Case Study

Dealing with Serious Incidents

Two RPIWs took place in December 2017 and March 2018 to improve the process of raising and closing patient safety incidents for our staff. It’s really important that in order to keep encouraging staff to report incidents, the process is as simple and straightforward as possible.

The teams streamlined both the incident form and the closing manager’s form, as well as reducing the number of recipients of the initial incident report and the number of incidents that require manual closure by a closing manager (by creating an automated closure function) as a number of incidents are raised for data collection purposes.

As a result, the teams significantly reduced the time taken to complete an incident form (from over nine minutes to around four minutes). Furthermore, as a result of the changes, 100% of staff felt positive when closing an incident or receiving the closure feedback on an incident that they had raised.

Both of these RPIW outputs are awaiting formal ‘go-live’ dates.

Case Study

Getting Medication to Patients and Dispensing

We held two RPIWs to focus on pharmacy and medication as we recognised that patients were waiting for long periods of time after they had been told they could be discharged from the wards.

Some of the reasons for the ‘wait’ were due to delays in Electronic Discharge Summary (EDS) sign off, screening, dispensing and transportation of the medications to the wards. These RPIWs looked at both processes to eliminate waste to ensure the patient has a better inpatient experience.

As a result of the dispensing workshop (which is currently still being measured) we can say that patients being discharged from all wards are getting their ‘To Take Away’ (TTA) medication dispensed within 40 minutes which is a 50% improvement from before the workshop.

As a result of the medications to patient workshop we can say that patients are now getting their medication within 32 minutes of being dispensed which is a 68% improvement from before the workshop.

Together both RPIWs are ensuring that once an EDS is screened by a pharmacist, it will now take a median of 1 hour 12 minutes for patient TTA medications to be dispensed and delivered to all 40 wards in Queen’s Hospital. This is an improvement of 60% from the baseline which originally took three hours.
Over the last year, our teams have worked hard to improve our services against national and locally-agreed quality and performance measures. You can find out more detail about the quality of our services and the care we provided in our Quality Account, available on our website.

**EXTERNAL ASSESSMENT – CQC**

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

When the CQC visits, it asks five key questions:
- Are we well-led?
- Are we safe?
- Are we responsive?
- Are we effective?
- Are we caring?

The CQC inspected the Trust in February 2018, focusing on:
- Urgent and emergency services
- Maternity
- Surgery
- Medical care (including older people’s care)

There was also an inspection of the Trust against the ‘Well Led’ domain, which took place in March 2018.

While at the year end we were still awaiting the CQC’s final reports, we were encouraged by the informal feedback from the inspection team regarding the quality of care and the commitment of our staff.

When we receive the report, which will identify any Must Do actions, we will ensure that these are prioritised for attention through the remainder of 2018/19.
CONSTITUTIONAL STANDARDS PERFORMANCE

FOUR HOUR TARGET AND ED PERFORMANCE
This has represented a challenge for the trust this year. With a regional and national context of ever-increasing pressure on emergency services, it is unquestionably the case that this has been one of the most difficult areas of our performance.

It was an exceptionally busy winter particularly, with very high attendances throughout and continuing to the end of March. At times we were seeing around 900 attendees a day at our Emergency Departments.

We continued to see very high numbers of patients transferred via ambulance – once more Queen’s Hospital saw more ambulances than almost any other hospital in London.

We also continue to notice an increase in acuity. Patients are sicker, and are staying longer.

Staffing, particularly in our Emergency Departments, also continues to be a significant issue. We are routinely in a position where we have to turn to agency staff to fill rota gaps. We know that this impacts upon our ability to see and treat patients efficiently.

As a result, we have not hit the constitutional standard of treating, admitting, or discharging 95% of patients within four hours this year. We received regular visits from the CQC, NHS England and NHS Improvement, particularly over the busy winter period, and the consistent feedback was that we continue to provide good quality care, which was pleasing.

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

CAPITAL INVESTMENT – ENHANCED URGENT CARE CENTRE (EUCC)
The Department of Health invited applications from trusts to bid for capital funding to invest in key changes to facilitate new ways of working to assess and stream patients.

We prepared a bid which set out the key changes we would seek to make to the layout and configuration of the Emergency Departments at Queen’s and King George hospitals.

We were delighted to complete our EUCC project at Queen’s Hospital on schedule, opening in January 2018.

The project entailed the reconfiguration of much of the wider space in and around the reception and waiting area, and moving the entrance to our Emergency Department. It required the movement of several teams to other areas of the hospital and was no minor undertaking, but we are pleased with the new environment and the improved accessibility to key services to help our patients more quickly.

We now have a new reception, with better private areas for initial assessments; more private consultation rooms – with walls and doors, not just curtains to separate them; and a number of services, such as blood tests and x-rays, are available in one place so patients aren’t sent from department to department, having to find different areas across the hospital.

While there were some challenges in implementing some of the care pathways since the EUCC opened, we have now worked through them to ensure all patients receive the most appropriate treatment effectively.

We are now preparing to undertake improvements at King George which will be completed in 2018/19.

OUTPATIENTS
There were nearly 740,000 outpatient appointments last year. Across both hospitals that’s more than 2,000 a day. We also handle around 6,000 telephone calls to our appointments centre each week.

We have made some positive changes to our Outpatients team which have had impacts for our staff and our patients. We introduced a new senior team structure to improve the management of our Outpatients service, and to ensure that patient experience, quality of care and staff engagement are top priorities.

SERVICE IMPROVEMENTS – TEXT MESSAGING, BOOKINGS AND OUTCOME FORMS
In November 2017 we introduced the Envoy text messaging system to improve our contact with patients and to reduce the numbers of patients not attending appointments. The service is a two-way system that sends a reminder a week before an appointment reminding them of the date, time, site and team.

Another reminder is sent 48 hours before. The patient can confirm, rebook or cancel via text, so this flags the team in the booking centre who can attempt to rebook and fill any gaps.

This has had a positive impact on reducing the numbers of patients who Did Not Attend, along with our appointment of Hybrid Mail – a third party which is ensuring more of our letters reach our patients, guaranteeing they receive them.

We continue to feel the benefit of the booking system brought in last financial year, which helps ensure the right information is populated on the system and the right rooms are booked for clinics, reducing delays and confusion.

We have also made good progress on improving how we complete and distribute outcome forms from our outpatient clinics. These forms detail the necessary follow up actions for patients and any further referrals.

It’s really important that we process them quickly and accurately, and we’ve made good changes to our processes on that front this year to ensure we are also getting accurate information to our Clinical Commissioning Groups (CCGs) about our numbers of patients, thereby ensuring we are giving an accurate picture of our levels of activity.
OUR HOSPITALS HAVE:
52 CRITICAL CARE BEDS
22 THEATRES
911 INPATIENT BEDS
62 MATERNITY BEDS

THANKS TO A HUGE PROGRAMME OF WORK WITH OUR SYSTEM-WIDE PARTNERS, INCLUDING OUR CLINICAL COMMISSIONING GROUPS AND GPs, WE WERE DELIGHTED TO BE ABLE TO REPORT IN JULY 2017 THAT WE HAD RETURNED TO HIT THE RTT NATIONAL STANDARD – AHEAD OF THE AGREED TRAJECTORY.

RECALL TO TREATMENT (RTT)
We announced in 2014 that we had identified several issues with our Recall to Treatment reporting, dating back several years. RTT is part of the NHS Constitution which states that 92% of patients should receive hospital treatment within 18 weeks of having been referred by their GP.

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

Thanks to a huge programme of work with our system-wide partners, including our Clinical Commissioning Groups and GPs, we were delighted to be able to report in July 2017 that we had returned to hit the RTT national standard – ahead of the agreed trajectory.

This was a significant achievement for the whole Trust.

While we have not quite been able to sustain the national standard for all the subsequent months, we are still ensuring that nine in 10 patients are being seen within the 18-week timeline. This is a significant improvement on where we were, and placing us comfortably in the top half of all trusts.

We ensured that nearly every elective (planned) appointment over the winter was fulfilled – we felt it was important to continue to ensure that patients were able to have operations or treatment many had been waiting for.

The comprehensive and robust recovery plan we have implemented has included a number of key workstreams, including:

- Validation of waiting list data
- Outsourcing of patients to independent providers
- Improving our theatre productivity
- Enhancing our resources to treat patients
- Carrying our detailed demand and capacity work
- Implementing processes to manage the demand from GP referrals.

Our clinical harm review of patients continues to show that no serious harm has been found in patients who have been kept waiting too long.

We are confident that the new processes, data, management and scrutiny we have collectively put in place will ensure that we do not see a repeat of where we were, so this is a positive outcome. However, the year ahead will undoubtedly prove challenging as we continue to strike the appropriate balance of activity with our commissioners.
CANCER SERVICES

Our cancer performance is undoubtedly one of the highlights of the year. This year has seen a step-change in our cancer performance across the Trust.

For 2017/18, our objective was to meet all the national standards for cancer pathways (these are detailed in the Performance Analysis section); whether a two-week wait, the 31 day standard, or the 62 day target; which stipulates that 85% of patients should have received treatment within 62 days of urgent referral.

We were delighted that we were able to achieve this objective for the year.

Since July 2017 we have achieved the national 62-day standard – which states that 85% of patients should start cancer treatment within 62 days of being urgently referred by their GP, putting us in the top 25% of acute Trusts nationally. This is the most challenging of all the cancer standards so it is a significant achievement to have met this and all the others during such busy periods in our hospitals.

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

This success has been built on a solid foundation of work delivered last year and this, particularly in the form of implementing a comprehensive and robust recovery trajectory and cancer action plan, developed with support from the CCGs and NHS Improvement (Intensive Support Team).

This action plan includes:

• Improving clinical engagement and communication with our GPs colleagues
• Improving pathway management across all the tumour groups enabling patients to be treated in a timely manner – this includes improvements in the booking processes in addition to reporting turnaround times for histopathology and imaging
• Offering patients an appointment within seven days across all tumour groups so that patients are seen much quicker in their pathway, allowing more time for diagnostics, first treatments and referral to other providers for surgery
• Implementing Straight To Test (STT) across specific tumour groups
• The recruitment of consultants to create more capacity, and coordinators and trackers to improve tracking of patients through to their treatment.

MULTI DIAGNOSTIC CENTRE PILOT CASE STUDY

We have had a positive experience as one of 10 pilot trusts trialling the Multi-Diagnostic Centre approach within the gastroenterology specialty.

This is where patients with suspected cancer are given a priority referral and we make a full suite of appropriate diagnostic tests available on one day, so patients come in, are taken care of by a specialist cancer nurse, and then can undertake any further diagnostic tests, for example a CT scan.

We have had one of the highest detection rates of the trusts in this pilot – around 17% of the patients referred to us are diagnosed with cancer. This highlights both the high prevalence of cancer in our community, and the value of such an approach.

HALCYON AND EDGE RADIOThERAPY MACHINES

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

As the year ended we were in the middle of the installation of a second machine – the Edge – as part of our planned replacement cycle. Most of the funding came from the Department of Health for this project, but we added additional features by funding it ourselves.

We refurbished the rooms too, including redecorating and installing sky panels to help provide the most welcoming and calming environment possible.

SURGICAL ASSESSMENT UNIT

We made some changes to improve our surgical capacity for the benefit of our patients and colleagues.

We found we were experiencing challenges resulting from a lack of surgical assessment space, which means that emergency patients who are waiting for surgical assessment can’t always be seen promptly. This leaves them waiting longer than we’d like, and affects our flow of patients through the Emergency Department.

So, we reconfigured our surgical services to generate additional Surgical Assessment Unit (SAU) space, and introduced a new Surgical Stepdown Unit (SSU) for those patients recovering from surgical procedures who are more acutely unwell and therefore require more specialist care.

We recruited new nurses to help staff the improved facilities. Overall, the new layout and setup is enabling us to offer senior clinical evaluation more quickly and efficiently, reducing patients’ waiting times, and with greater continuity of care.
Becoming an Employer of Choice

- Implement the Leaders’ Agreement to enable our staff to achieve excellence
- Establish new roles and implement our academic and education strategies to develop our staff
- Increase and retain our substantive workforce

Leadership Development – The Leaders’ Agreement
At the centre of the change in culture required to deliver continuous improvement in our organisation is the development of our Leaders’ Agreement.

The Leaders’ Agreement sets out a series of expected behaviours of staff in leadership roles as well as articulating what the organisation will do to support leaders to create this new, dynamic change culture.

We worked to engage over 1,000 staff, patients and visitors to develop the content of our agreement, involving dozens of interactive engagement events, to which managers across the organisation were invited to discuss the Agreement, and give their own views on how we need to shape the leadership of our Trust in the future.

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

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

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

At the end of March our vacancy rate stood at 13.3%. This is still higher than we would like, however we have increased the number of staff we employ.

We are still spending too much money on agency staff however – during the year, our total spend on agency staff was 9% of our entire pay bill. We continue to consider ways that we can reduce this level. One planned development which should make a difference will be introducing weekly pay runs, so that staff on Trust Temps (our bank) can get a similar experience to those working for agencies.

We set a challenging target for sickness absence in April 2017 at 2.8%, and although during certain months during the year we have achieved that figure, our average absence rate was 3.4%.
RECRUITMENT AND RETENTION
Over the past year we recruited 907 new staff members, including a record number of nursing staff. However, during the same period, we lost nearly as many – the majority from clinical posts; nurses, allied health professionals and doctors.

Recruitment takes time and resources, and a constant turnover of staff impacts on the delivery of patient care, staff morale and the ability to build teams.

By the end of the year, we were beginning to see some positive results. At the start of the year, we were losing 26% of staff within their first year. By the end, this was down to 20%. We had also got our staff turnover to under 16%, but it’s still above the NHS average of 10%.

Towards the end of the year we conducted a significant review of all our data, including the staff survey, outcomes from exit interviews, and specific focus groups and discussion groups. These highlighted a number of issues, including:
- Some unhappiness due to lack of flexible working opportunities and consideration for work-life balance.
- Issues around bullying and harassment and the respect they are given whilst at work.
- An absence of support from their immediate line manager.
- Lack of education investment and ‘release time’ to support career development and skills.

TACKLING THE CHALLENGE
To tackle these issues, all Divisions have developed retention and engagement plans, with a specific focus undertaken on nurse retention first.

We will be encouraging managers to support flexible working and flexible retirement; working to support improvements in E-rostering so that our staff can have a better work-life balance.

We have also made good progress with our People Strategy 2018-2020. This will be launched at the beginning of the 2018 financial year and will set out our plan to take forward our workforce as we move towards 2020.

We are continually looking at new ways of working to support our workforce challenges and improve both career development and retention. This year we have supported the Trainee Nurse Associate Programme, with just under 50 going through a training programme shared with North East London Foundation Trust (NELFT). In addition we have supported the introduction of both the Advanced Care Practitioner role (13 posts) and Extended Care Practitioners roles (16 posts) within our Emergency Department. These extended nursing roles will help bridge the gap between our medical and nursing groups.

INTERN MENTORING PROGRAMME
We launched an exciting new scheme, in which our more experienced nurses work to support less experienced nurses, or those new to our Trust, providing them with practical and emotional support and advice, and helping them settle into their career.

We started with one mentor and appointed two more who started in January 2018. Ordinarily we would typically recruit around 150 Band 5 (newly qualified) nurses every year. From this group, we would typically expect one in four, so about 35-40, would leave within their first year. From when we introduced this support in September, to the end of the financial year, just three Band 5 nurses have left our Trust.

NURSING TRANSFER SCHEME
We have introduced this year an internal transfer scheme so that nurses can transfer very easily within the Trust, without going through the full application process, to move between wards and specialty areas. This is not offered universally across the NHS, but we have already found it to be a very positive move to help career development and motivation.

STAFF SURVEY
Nearly 2,900 staff returned a completed questionnaire this year, giving an improved response rate of 47%. This makes us now slightly above the average response rate for acute trusts (44%) which is pleasing given our history – we were in the bottom 20% in 2014.

Our overall engagement score remained in line with the national average – this is an indicator of staff motivation, advocacy and involvement in the organisation.

Our staff remain among the most motivated in the acute sector and have a high level of satisfaction with the quality of work and care they deliver. We are also among the top 20% of acute trusts for staff agreeing their role makes a difference (92% of staff). The areas where staff experience is poorest relate to the practicalities of doing the job but what can be classed as cultural and relationship factors. Therefore focused and continued action is needed to improve against these key findings.
We hope the programme will pave the way to allow young people the opportunity to volunteer in a more formal arrangement which both supports our local community and offers exposure into the life of a hospital and has obvious benefits for their future employment prospects.

We also introduced a way of supporting new volunteers. It’s not always easy to start working with a ward. Volunteer champions are our way to help, by pairing an experienced volunteer with a new one – they work together for the recruit’s first few sessions. It’s proved really successful.

We also designed new Ward Befriender packs – an innovative little set of credit card-sized cards which attach to the volunteer’s lanyard, and which contain useful information on who to contact in an emergency, information about protected mealtimes and other tips and guidance.

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

In particular, we have not seen any improvements in key findings related to equality, diversity and inclusion. We remain in the bottom 20% of trusts for staff believing we provide equal opportunities for career progression and promotion; staff experiencing discrimination, harassment, bullying and abuse at work; and satisfaction with flexible working.

INSPIRE BME PROGRAMME
Our staff survey findings and our Workforce Race Equality Standard (WRES) data both highlight ongoing differences in the experiences and treatment of BME staff in our Trust compared to white staff, particularly with career progression and experience.

So we were delighted as the year drew to a close to announce that 21 BME colleagues were accepted onto the INSPIRE BME talent management and mentoring programme, which will support and help drive the development and progression of our BME colleagues.

OUR VOLUNTEERS
We have taken some big steps forward this year. At the start of the year, we set ourselves the challenge of increasing the numbers of volunteers in our hospitals to 500 – by 31 March we were delighted to have 506 volunteers engaged, delivering in excess of 30,000 hours of volunteering over the year.

This year we introduced the start of our new Students in Volunteering programme. This is a formal agreement with us and local colleges/schools. Havering Sixth Form College were our first cohort of students this year. We have taken on six of their students, for a six month period, during which they received a four-week induction period.

We are very proud of our efforts to create accessible pathways into nursing, midwifery and other professions, and our ground-breaking work with Nursing Associates is a good example.

The Nursing Associate role is designed to bridge the gap between existing health care assistants; who have completed a care certificate; and registered nurses. We have one of the largest cohorts of Nursing Associate trainees in the country and we are really proud of them.

The trainees are currently in the middle of spending two years in an apprentice-style working and learning environment, with one day a week spent at London South Bank University (our local education partner).

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

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

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

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

Staff are encouraged to nominate colleagues for a Star of the Month award, and patients can also get involved – putting forward the name of a particular member of staff who has stood out for them, as well as Team of the Week (see p18).

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

- Work with our partners to deliver the Sustainability and Transformation Plan
- Improve engagement and community development with our partners, patients and public
- Work with our partners to develop services to align with our Clinical Services Strategy

OUR SUPPORT FOR THE INTEGRATED CARE SYSTEM

It is worth noting that the strategic landscape continues to evolve at a fairly rapid rate.

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

We are committed to collaborative working with our provider partners in the Barking and Dagenham, Havering and Redbridge health system.

We have formed a ‘provider alliance’ which includes us, our community and mental health partners: North East London Health Foundation Trust, Barking and Dagenham, Havering and Redbridge GP Federation Chairs and HealthWatch representatives from each of the boroughs and the local authorities. We are all in agreement that we need to focus on pathways in order to improve patient care and to drive efficiencies.

ENGAGING PATIENTS

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

The PPC brings our patient partners and our staff together to help improve the quality and safety of the care we provide.

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

It comprises 11 lay members (including chair/vice chair); clinical staff (including doctors, nurses and a Deputy Chief Nurse); and non-clinical staff.

The council’s work touches on all aspects of the care we provide, services and pathways.

Each of the services below has a dedicated patient partner ‘lead’:

- Anaesthetics
- Care of the Elderly
- Cancer and Clinical Support
- Children and Young People
- Emergency Care
- Learning Disabilities
- Maternity and Women’s Health
- Outpatients
- Specialist Medicine
- Surgery

Our patient partners work closely with our Patient Experience team, ensuring that we are listening and acting appropriately. In addition to this group, we have a wide range of patient partners who are involved in other work in the hospital, at every level. Patient partners are a key part of everything we do and we have recruited many this year to support us in improving our services.

Our Patient Engagement and Experience Assurance Group continues to scrutinise the work that we do. Made up of patients and carers, this group provides us with important insight and contribute to the development of our services, putting patients at the centre of the decisions that we make.
WE WILL CONTINUE TO EVOLVE OUR APPROACH, SO THAT WE ARE PROVIDING MORE OPPORTUNITY FOR PARTNERS TO ACTUALLY SEE AND EXPERIENCE WHAT LIFE IS LIKE IN OUR HOSPITALS AND HOW WE ARE CARING FOR PATIENTS.

Our relationships with the media have improved, and we have built new relationships with key journalists, correspondents and producers. We have taken good opportunities to achieve national exposure for our work and our people, for example our Senior Intern nursing mentors, and a feature with one of our bed and site managers, both on the BBC.

We aim to provide a fast and effective press office, responding to queries and questions promptly. The year has shown its share of both positive and negative coverage – mainly due to the circumstances in the Trust which are described elsewhere, but the reporting has been mainly balanced, accurate and fair, and where less so, we have challenged as we should.

STAKEHOLDER ENGAGEMENT

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

We welcomed Jeremy Andrew Rosindell MP and Simon Stevens, Chief Executive of NHS England.

Amongst others, we have welcomed Jeremy Rosindell MP and Simon Stevens, Chief Executive of NHS England.

We have had regular meetings with our MPs to keep them fully informed, and to ensure openness and transparency.

We will continue to evolve our approach, so that we are providing more opportunity for partners to actually see and experience what life is like in our hospitals and how we are caring for patients.

Our stakeholder e-newsletter continues to be a valuable channel of information.

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

We have routinely facilitated access to our hospitals via structured visits, so that local and national stakeholders, from both a health and policy perspective, can get a better idea of how we operate. We continue to support the Department of Health’s Connect programme – we are very happy to provide the opportunity for civil servants to understand the operational realities of a busy acute hospital to ensure informed policy.

Amongst others, we have welcomed Jeremy Hunt MP; Mike Gapes MP; Wes Streeting MP; Andrew Rosindell MP; and Simon Stevens, Chief Executive of NHS England.

WE WILL CONTINUE TO EVOLVE OUR APPROACH, SO THAT WE ARE PROVIDING MORE OPPORTUNITY FOR PARTNERS TO ACTUALLY SEE AND EXPERIENCE WHAT LIFE IS LIKE IN OUR HOSPITALS AND HOW WE ARE CARING FOR PATIENTS.

of what needs to happen in order to make transition smooth.

Thanks to the efforts of colleagues in pathology, it was particularly gratifying to resolve the technical issues around the access to the Cyberlab testing and results system. This was one of the top problems being reported by GPs, so it was pleasing to make significant progress.

NEW COMMUNICATIONS AND ENGAGEMENT STRATEGY

At the beginning of 2018 we launched our new Communications and Engagement Strategy for the Trust, replacing our previous strategy which was introduced in 2015.

The strategy sets out our aspirations for delivering the very best communication and engagement with all our key audiences – our patients and public; our staff and volunteers; key stakeholders and partners; and the media.

It identifies the specific strategies, tactics and actions that will enable us to drive this forward.

ENGAGING WITH THE PUBLIC

We continue to see much higher traffic to our website since the redesign and relaunch at the beginning of the last financial year. Its accessibility and ‘responsiveness’ – where the content resizes if being looked at on a tablet or mobile – continue to be valuable features.

Social media is an increasingly important channel for us to engage with the public, to share news about us and to try and improve people’s understanding of the work we do, and of how and where to get the right care more broadly. We are particularly active on Twitter and Facebook, and these will be important for future development.

The new strategy identifies the importance
MANAGING OUR FINANCES

- Embed service line reporting and management to improve decision-making and budgetary control
- Make sure we get paid for all the work we do
- Achieve financial balance with the inclusion of transformation funding

This year has undoubtedly been a very challenging one in terms of our financial position.

As the year unfolded, it became apparent that our financial situation was not as we had previously stated. An account of what occurred is set out below, including some commentary which extends beyond the 2017/18 financial year, in the interests of completeness and for contextual purposes.

In summary, for 2017/18 our agreed financial target was to achieve a surplus of £1.7m. Our reported position for the year end was a loss of £49m.

Our overall financial picture was significantly impacted by the failure to secure a significant sum (£12.6m) from the Sustainability and Transformation Fund. This loss resulted from issues with delivering against our cost improvement programme (£16.2m), changes to some accounting policies and judgement (£13.0m) and outstanding expert determination issues with our main commissioner (assessed at £7.2m).

It is unfortunate that we once more needed to go through formal contract resolution and ultimately, with the expert determination to agree with our commissioners about work we have undertaken, and to seek the appropriate level of income. While we know this is reflective of a broader financial challenge locally, it still has a significant impact on our Trust.

HOW THE SITUATION DEVELOPED

In the autumn of 2017 we discovered a serious cash shortfall. The issue had caused us to delay payments to many suppliers, with some knock on operational impacts, but at that time we were not fully aware of the extent of the issue or the underlying causes.

We approached NHSI for the necessary loans to enable us to resolve the situation in the short term and we asked the accountancy firm, Grant Thornton, to carry out a thorough independent investigation.

As these investigations developed, it became evident that there were a number of broad problems across the Trust with our approach, in terms of day-to-day management and culture, escalation, reporting and overall financial governance.

FINANCIAL SPECIAL MEASURES

As a result of the above, and the significant in-year financial deterioration, which meant we were well adrift of our agreed plan, on Friday 9 February, NHS Improvement announced that they were placing us into special measures for finance to ensure we could be provided with additional support and so as to be in a better position to provide oversight and scrutiny.

NHSI required that we bring on board additional consultancy support to help us refine and improve our approach to cost improvement planning and delivery.

We undertook a procurement exercise to appoint a company to provide this support, and we appointed PwC – an accountant and consultancy firm – to work with our teams and to help us bring forward our Financial Improvement Plan.

GRANT THORNTON REPORT KEY FINDINGS

The Grant Thornton report was circulated to all staff, key stakeholders and placed on our website on 18 April 2018, having been reviewed and approved by our Board, and by the co-commissioner of the report, NHS Improvement.

The report makes clear that a number of factors came together to create a broader problem. It identifies that over a prolonged period of time, we developed a flawed approach of not paying our suppliers on time.

Some other factors include: higher demand and delivery of services above the levels agreed with our clinical commissioners; some optimistic assumptions about 2017/18; overspending; weak financial control; and a lack of forward analysis of our cash requirements.

Grant Thornton found that repeated instances of delayed payments to suppliers were being reported by clinical and operational teams. However, the overall cash-flow risk was not high enough on the Board’s agenda and the manner in which the cash problem progressively developed, and ultimately unfolded, represented a significant breakdown in financial governance at our Trust.

There were also points raised about the robustness of our approach to delivering our Quality and Cost Improvement Programme (QCIP). It’s evident that we weren’t focusing enough on cost reduction.

We felt that the report was a fair and thorough reflection of the issues, and that many of the recommendations made by the Grant Thornton team were sensible and necessary – in many areas we had in fact already started making changes through the latter half of the year.

To accompany the report we produced a response document which set out our progress and timelines for progress against all the key recommendations made by Grant Thornton.

We will be making significant changes to the ways that we manage our finances, our financial governance, processes of escalation and oversight, and the way that we report to ensure the appropriate scrutiny.

We were not focusing enough on cost reduction.

We would like to thank our suppliers for their patience over this time and we are pleased that cashflow issues are much more transparent and we are now able to pay suppliers within a much shorter time frame.

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

CAPITAL INVESTMENT

This year, we invested more than £21.4m in capital programmes. This includes a new multi-speciality ICU at QE and major work at Queen’s Hospital improving our Enhanced Urgent Care Centre and our main commissioner (assessed at £7.2m).

Some other factors include: higher demand and delivery of services above the levels agreed with our clinical commissioners; some optimistic assumptions about 2017/18; overspending; weak financial control; and a lack of forward analysis of our cash requirements.

FINANCIAL OUTLOOK

The Annual Plan for 2018/19 was submitted to NHSI at the end of April 2018. The proposed planned income and expenditure deficit, based on current assumptions, for 2018/19 is £34.8m.

There remain a number of material uncertainties in setting this plan, including:

- Agreement of income principles with the expert determinant in the resolution of 17/18 outturn
- Finalisation of the individual cost improvement schemes that total the efficiency ask
- Understanding of the proposed risk sharing agreement with the CCGs for 2018/19
- Understanding of how the 2018/19 nationally agreed pay award will be afforded outside of tariff
- Cash and payment by CCGs during the year is a risk.

To deliver the proposed planned deficit a 7.1% QCIP (£39.0m) is required and needs to be cash releasing. There has been considerable progress on identification of the QCIP that has been commissioned to support the identification and assist delivery of the QCIP over the first quarter of 2018/19.

The Trust has submitted realistic activity growth forecasts, which are higher than the Commissioner’s plans. If our figures are delivered as it’s believed, then this will be unaffordable for the local CCGs.

With no expected capital external funding the Trust’s internal resources available is £4.9m. Of this amount there are already £5.9m approved projects being deferred to start next year which will take priority over the available funding, taking the Trust into a capital cash deficit.

The Trust will need cash support for 2018/19 to the value of £104m. This includes the request for a loan support for £28.1m to repay the existing principle loan due for repayment in December 2018; the Trust request for a revenue deficit loan support for £34.8m, excluding STF; the Trust request for a capital programme loan support for £10.0m, and the Trust request for a working capital loan of £31.1m.

These loans attract an interest payment of up to 6% - a full year cost pressure in excess of £1.1m dependent on timing of the loans.

Risks have been identified and where possible have mitigations to reduce the impact or occurrence of the relevant risk.

The financial challenges are substantial, and therefore action in particular to make efficiency savings and productivity gains is imperative as early as possible to prepare the Trust for the coming years.

2018/19 would see the beginning of a three year plan that returns us to a financially sustainable position and to establish a platform on which to re-finance the balance sheet.
**OUR PERFORMANCE REPORT**

This year has been a difficult year in terms of delivery against the emergency access target. We still have considerably more work to do with our partners to improve the situation so that patients are seen and treated as quickly as we would like.

But the biggest area for attention for 2018/19 will undoubtedly be bringing our finances back under control as a result of the situation which unfolded in 2017/18.

As is explored elsewhere in this report, our loss of control was not good. While I am relieved that no patients came to any harm as a result of our financial difficulties according to our investigation, we will need to spend considerable time and effort now getting back on track.

Finally, we identified here last year that we wanted to reduce the number of healthcare acquired infections we recorded. I’m pleased to report that we showed improvements in numbers of both MRSA and Clostridium difficile (C.diff) – in the case of the latter, we recorded. I’m pleased to report that we showed improvements in numbers of both MRSA and Clostridium difficile (C.diff) – in the case of the latter, we halved the number of cases.

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

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

Matthew Hopkins
Chief Executive

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**OUR PERFORMANCE**

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

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

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

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

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

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

**PERFORMANCE**

**THE STANDARD**

- Emergency access
  - 95% of all patients attending our Emergency Departments to be treated, admitted or discharged within a maximum of four hours
  - Not achieved: 81.8%

- Access to treatment
  - 92% of patients referred to us to have treatment started within 18 weeks
  - Not achieved: 90.8%

- Cancer: urgent referrals
  - 93% of our patients to be seen in two weeks following an urgent referral from their GP
  - Achieved: 96.8%

- Cancer: 31 days
  - 96% of our patients to have a diagnosis and first treatment within 31 days of the decision to treat
  - Achieved: 98.5%

- Cancer: 62 days
  - Target of 85% of patients receiving first treatment from the date of GP referral
  - Achieved: 86.2%

- Infection control: C.diff
  - No more than 30 cases
  - Achieved: 15

- Infection control: MRSA
  - Zero cases of MRSA bacteraemia
  - Not achieved: 6
## PERFORMANCE TRENDS
The below table shows the targets set nationally that we work towards. As well as measuring performance weekly and monthly, we also monitor trends over time.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clostridium difficile cases</td>
<td>20</td>
<td>15</td>
<td>29</td>
<td>36</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of MRSA bloodstream infection cases</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Access to treatment</td>
<td>% of patients waiting a maximum of 31 days from diagnosis to first definitive treatment</td>
<td>96.00%</td>
<td>96.52%</td>
<td>98.67%</td>
<td>96.10%</td>
<td>96.00%</td>
<td>96.10%</td>
</tr>
<tr>
<td>% of patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)</td>
<td>96.00%</td>
<td>100.00%</td>
<td>99.88%</td>
<td>99.70%</td>
<td>99.60%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>% of patients waiting a maximum of 31 days for subsequent treatment (surgery)</td>
<td>94.00%</td>
<td>99.56%</td>
<td>99.15%</td>
<td>96.10%</td>
<td>96.30%</td>
<td>87.80%</td>
<td>100.00%</td>
</tr>
<tr>
<td>% of patients waiting a maximum of 62 days from urgent GP referral to treatment</td>
<td>85.00%</td>
<td>86.21%</td>
<td>74.22%</td>
<td>74.00%</td>
<td>81.20%</td>
<td>84.20%</td>
<td>83.00%</td>
</tr>
<tr>
<td>% of patients waiting a maximum of 62 days from consultant screening service referral to treatment</td>
<td>90.00%</td>
<td>96.78%</td>
<td>95.16%</td>
<td>93.70%</td>
<td>94.00%</td>
<td>96.20%</td>
<td>100.00%</td>
</tr>
<tr>
<td>% of patients waiting a maximum of 62 days from urgent GP referral to date first seen</td>
<td>93.00%</td>
<td>96.79%</td>
<td>95.20%</td>
<td>94.50%</td>
<td>91.30%</td>
<td>90.50%</td>
<td>98.40%</td>
</tr>
<tr>
<td>% of symptomatic bleed patients (cancer not initially suspected) waiting a maximum of 4 weeks from urgent GP referral to date first seen</td>
<td>93.00%</td>
<td>97.89%</td>
<td>93.47%</td>
<td>93.20%</td>
<td>80.10%</td>
<td>80.40%</td>
<td>96.90%</td>
</tr>
<tr>
<td>Access to A&amp;E</td>
<td>19 weeks referral to treatment - total incomplete</td>
<td>92.00%</td>
<td>90.80%</td>
<td>98.20%</td>
<td>Not reported</td>
<td>92.10%</td>
<td></td>
</tr>
<tr>
<td>Access to treatment</td>
<td>% of patients waiting a maximum of 4 hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>95.00%</td>
<td>81.84%</td>
<td>85.65%</td>
<td>87.90%</td>
<td>85.30%</td>
<td>88.60%</td>
</tr>
</tbody>
</table>

Cancelling operations
Number of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital | 0 | 651 | 974 | 524 | 494 | 378 | 400 |

Cancelling operations not performed within 28 days
Number of patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days | 0 | 77 | 42 | 18 | 39 | 14 | 11 |

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

### RISKS
A growing and aging population means that demands on our services will be increasing over the coming years, and we are already seeing the impact of that.
If we do not match our capacity and capability to the increasing number of referrals and emergency attendances then we risk not meeting national performance targets. More importantly, we will not be providing the outstanding care that we aspire to. We are working as a whole health economy to deal with these issues.

There is a risk that financial pressures will impact on performance, although we have Quality and Cost Improvement Programmes in place which are helping to mitigate that risk.

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

While we have seen some improvements in recruitment and retention, we face on-going challenges in attracting and retaining permanent staff, which means that we are still using more bank and agency staff than we would like, which can impact performance.

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

By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supercede this target by reducing our carbon emissions 28% by 2019/20 using 2012/13 as the baseline year. To date, performance is 19.8%.

### POLICIES
We ensure that sustainability is considered in key policy areas, including travel, business cases, procurement (environmental and social aspects), and suppliers’ impact.

In order to fulfil our responsibilities for the role we play, we have a sustainability mission statement within our Sustainable Development Management Plan (SDMP) to “continually sustain, retain and enhance the savings and culture change to meet our sustainability commitments.”

An update to our SDMP is required because it has not been approved by the Board in the last 12 months. However, a review and update is provided through our Annual Performance Reports, to be considered in the Trust’s Annual Financial Reports.

Our organisation evaluates by using the tools such as SDAT and also used other measures such as the environmental and socio-economic opportunities during our procurement process.

We understand the social and economic impact of the trust and our staff through measures such as the number of staff doing mandatory sustainability training, the total number of staff cycling, Carbon and energy savings, and waste reduction and recycling rates. Sustainability and waste management is included in our corporate staff induction.

### ADAPTATION, GREEN SPACE AND BIODIVERSITY
Climate change brings new challenges both in direct effects, but also to patient health.
Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Board approved plans address the potential need to adapt the delivery the organisation’s activities and infrastructure to climate change and adverse weather events.

We achieve this by delivering a health and wellbeing strategy in conjunction with our sustainable travel plan. Initiatives include preserving green spaces, hosting an on-site fruit and veg stalls, and a healthy hike around the site for walking and relaxing spaces.

### PERFORMANCE
Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain why both the organisation and its performance on sustainability has changed over time.

<table>
<thead>
<tr>
<th>Context info</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor Space (m²)</td>
<td>154,022</td>
<td>154,022</td>
<td>154,022</td>
<td>154,022</td>
</tr>
<tr>
<td>Number of Staff</td>
<td>5,557</td>
<td>5,732</td>
<td>5,905</td>
<td>6,039</td>
</tr>
</tbody>
</table>

### ENERGY
We have spent £2,991,090 on energy in 2017/18, which is a 8.7% decrease on energy spend from last year. We managed to retain the UK CRC Tax exemption status by meeting the EU ETS Emissions target helping to achieve approximately £250,000 in tax savings. We generate approximately 16% of our own electricity saving approximately £200,000.

![Carbon Emissions - Energy Use](image)
Performance/key achievements

Despite increasing activity, the Trust has managed to retain and make further savings year-on-year. 100% of our electricity use comes from renewable sources in 2017/18. Up to 16% of our total electrical demand is generated on-site through a Combined Heat and Power plant. This represents savings of 2,452 tonnes CO2e and approximately £200,000 savings a year.

Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public who use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport. Around 5% of travel and transport in England is due to NHS services so we have quantified the impacts on health. In 2017/18 travel and transport related to our services reduced the local population health by 0.0 Quality Adjusted Life Years (QALYs). As an organisation we aim to minimise our impact.

<table>
<thead>
<tr>
<th>Category</th>
<th>Mode</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and visitor own travel</td>
<td>miles</td>
<td>0</td>
<td>673,831</td>
<td>650,049</td>
<td>181</td>
</tr>
<tr>
<td></td>
<td>tCO2e</td>
<td>0</td>
<td>2425.08</td>
<td>209.01</td>
<td>181</td>
</tr>
<tr>
<td>Staff commute</td>
<td>miles</td>
<td>5,537,718</td>
<td>5,556,280</td>
<td>5,674,720</td>
<td>5,801,542</td>
</tr>
<tr>
<td></td>
<td>tCO2e</td>
<td>1,981.23</td>
<td>1,991.25</td>
<td>2,051.95</td>
<td>2,067.20</td>
</tr>
<tr>
<td>Business travel and freight</td>
<td>miles</td>
<td>0</td>
<td>1,150</td>
<td>522</td>
<td>5.34</td>
</tr>
<tr>
<td></td>
<td>tCO2e</td>
<td>0</td>
<td>0.48</td>
<td>0.51</td>
<td>2.01</td>
</tr>
<tr>
<td>Active &amp; public transport</td>
<td>miles</td>
<td>0</td>
<td>20</td>
<td>279</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>tCO2e</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Owned Electric and PHEV mileage</td>
<td>miles</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tCO2e</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Total cost of business travel</td>
<td>£</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Performance/key achievements

- Introduced Go By Bike – a staff pool bike scheme
- Implemented a 125% increase in the cycle parking facility across the Estates
- Up to 2% increase in the number of staff cycling to work since 2014/15
- Successfully conducted Travel Surveys, and revised our Sustainable Travel Plan
- Introduced the FAXI car share scheme to reduce single occupancy car use
- Bus route 5 is now rerouted to Queen’s Hospital following last year’s partnership work with the Transport for London (TfL) and Havering Council.

Waste Breakdown

- 23% less, high cost incineration clinical waste against 2012/13
- 6% increase in recycling rate against 2012/13
- Doubled the offensive waste, a low environmental impact waste rationalisation
- We launched an online “Healthcare Waste Management course” which mandatory for all clinical staff with RCN and CIWM accreditation
- The implementation of Green Machine, a Reverse Vending machine to reward for recycling
- Introducing cardboard waste containers instead of plastic containers in pharmacy for waste drugs

The use of water is the most significant impact on the environment.

Finite resource use – Water

We are now consuming 14% less water in comparison with 2012/13, and noted another successful year in 2017/18, dropping below 190,000m³ for the first time since 2012/13.
MODELLED CARBON FOOTPRINT
Resulting in an estimated total carbon footprint of 73,779 tonnes of carbon dioxide equivalent emissions (tCO2e). Our carbon intensity per pound is 124 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for acute services is 200 grams per pound.

Proportions of Carbon Footprint

Breakdown of 2017/18 emissions (tCO2e)

Climate Change Act Target

Benchmarking

Many of our plans and ambitions are delivered with key partners, such as Sodexo (our facility management partner) the NHS Sustainable Development Unit, local councils (London Boroughs of Havering, Redbridge and Barking and Dagenham), and Transport for London. The collaboration and support offered by all continues to be a very positive story.
This section of the Annual Report focuses on our governance, providing information about the legal status of our Trust, the processes and structures by which we maintain our commitment to good governance.
Our Trust

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

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

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

Our Trust can hold contracts in its own name under these Acts. The statutory functions of the Trust Board are set out in the NHS Act 2006, (Chapter 3 and Schedule 4) and in the Establishment Order as amended by Amendment Order 2009 No 43.

Leadership

The Chair is responsible for the leadership of our Board. He is responsible for ensuring the Board’s effectiveness and setting its agenda. The Chair facilitates the effective contribution and performance of all Board members who collectively are responsible for our long-term success and sustainability. He also ensures that there is sufficient and effective communication with stakeholders to understand their issues and concerns.

The Role of the Trust Board

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

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

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

The Chief Executive is responsible for executing the strategy agreed by the Board and developing the Trust’s objectives through leadership of the executive team. He recommends to the Board any investment or new business opportunities which meet this strategy. He also ensures that the Trust’s risks are adequately addressed and appropriate internal controls are in place.

Appointments

It is the role of NHSI to appoint or re-appoint the Chair and Non-Executive Directors (NEDs). A new Chair, Mr Joe Fielder, was appointed on 1 November 2017. The previous chairman, Dr Maureen Dalziel, left in June 2017.

In the interim period, Ms Jackie Westaway was appointed to the post on 21 August 2017. She replaced Mr Diju Amrohi who left our Trust on 30 June 2017.

At the end of the year, five non-executive directors were considered independent in character and judgement using the criteria for independence listed within the UK Corporate Governance Code.

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

In order to maintain strong leadership during this period the following appointments were made or were in effect:

- Mr Jeff Bulger as Acting Chair, from 1 March 2017, and then Mr Chris Brown from 24 July 2017.

- Mr Stephen Collins as Acting Director of Finance, from 13 March 2017 until 20 December 2017.

- Ms Sarah Tedford, Chief Operating Officer, left the Trust on 1 September 2017, and Mr Jon Scott joined as interim Chief Operating Officer from September 2017 to 20 December 2017, and then Ms Shelagh Smith as Acting Chief Operating Officer from 3 January 2018.

- Ms Anne Robinson as interim Director of People and Organisational Development from 13 December 2017.

- From 26 December 2016 to 12 September 2017, Dr Magda Smith became Acting Medical Director.

As with all staff, new directors receive a full and tailored induction on joining the Board.

The Board ensures that directors, especially NEDs, have access to funded, independent professional advice. This is facilitated through the Trust Secretary. The availability of independent external sources of advice is made clear at the time of appointment. A full-time Trust Secretary has been in place since September 2017.

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

Ms Sandra Malone – People and Culture Committee
Mr Jonathan Steiner – Quality Assurance Committee, Audit Committee
Mr Mehboob Khan – Quality Assurance Committee, Audit Committee, People and Culture Committee
Mr George Wood is the Chair of the Charitable Funds Committee
Ms Sue Levy and Ms Caroline Roberts were not members of any Board Committees in 2017/18.

Ensuring the Board Maintains High Standards of Governance

Our Board recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance and has adopted, where applicable, the NHS Foundation Trust Code of Governance which sets out best practice principles and processes to help NHS Foundation Trust boards of directors to:

- Maintain good quality corporate governance
- Contribute to better organisational performance
- Provide safe, effective services for patients
- The Trust has maintained its significant efforts during 2017/18 to improve its corporate governance framework through:

  - Continuing to drive improvement actions following the strategic governance review in 2015 supported by the Good Governance Institute, embedding a system of governance and risk management meetings at both departmental and divisional levels across core services
  - Continuing the development of the Improvement Portfolio to sustain the improvements already made, and to provide a framework for the way we monitor improvements, and to ensure we keep a dedicated focus on quality of care
  - Implementing clearer leadership and investing resources into improving corporate governance structures and risk management
  - Redefinition of the Board Assurance Framework (BAF) to manage risks and deliver objectives in conjunction with ongoing board development
  - Development of the Trust’s Operating Plan for 2016/17 and 2017/18 with reference to priorities identified by NHSI in the shared planning guidance for NHS Trusts
  - Establishing a Board level task and finish group to implement related recommendations from its commissioned review of the financial governance at the Trust
  - Reviewing the procurement function of the Trust (with the Audit Committee overseeing the implementation of recommendations).

During the year, the Trust experienced significant cash flow challenges and after adjusting its forecast year-end outturn to a significant deficit from a planned small surplus, the Trust was placed into financial special measures.

Committees of the Trust Board

The Trust Board can delegate and make arrangements to exercise any of its functions through a committee, sub-committee or other group, such as a task and finish group. During 2017/18, the Trust further embedded its new management structure and refined its committee structure.

How we Conduct Trust Board Meetings

The Trust has maintained its support of the Principles of Public Life and makes the majority of its decisions at Board meetings held in public. During the year, the Trust held 10 Board meetings.

The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Decision details what types of decisions can be delegated to board committees, management groups and staff.
Membership and attendance at Trust Board and committee meetings is summarised in the table below:

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

### Directors’ attendance at meetings: 2017/18

<table>
<thead>
<tr>
<th></th>
<th>Trust Board</th>
<th>Audit</th>
<th>Finance and Investment (FIC)</th>
<th>Quality Assurance</th>
<th>People and Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Maureen Dalziel</td>
<td>6/6</td>
<td>4/6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joe Fielder</td>
<td>4/4</td>
<td>3/4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dusty Amroliwala</td>
<td>1/1</td>
<td>1/1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Lam</td>
<td>7/10</td>
<td>5/5</td>
<td>6/11</td>
<td>4/4</td>
<td></td>
</tr>
<tr>
<td>Joan Saddler</td>
<td>7/10</td>
<td>6/11</td>
<td>3/4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eric Sorensen</td>
<td>1/10</td>
<td>5/5</td>
<td>11/11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prof Anthony Warrens</td>
<td>6/10</td>
<td></td>
<td>6/11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tom Phillips</td>
<td>6/10</td>
<td>5/5</td>
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<tr>
<td>Jackie Westaway</td>
<td>3/4</td>
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<td>3/5</td>
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<tr>
<td><strong>Executive Directors</strong></td>
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<tr>
<td>Matthew Hopkins</td>
<td>4/4</td>
<td>4/6</td>
<td>5/7</td>
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<tr>
<td>Jeff Buggle</td>
<td>5/5</td>
<td>5/5</td>
<td>2/4</td>
<td>1/1</td>
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<tr>
<td>Kathryn Halford</td>
<td>9/10</td>
<td>7/11</td>
<td>10/11</td>
<td>3/4</td>
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<tr>
<td>Dr Nadeem Moghal</td>
<td>4/4</td>
<td>3/6</td>
<td>4/7</td>
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<tr>
<td>Jason Sez</td>
<td>9/10</td>
<td>7/11</td>
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<tr>
<td>Deborah Tarrant</td>
<td>4/4</td>
<td>4/6</td>
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<tr>
<td>Sarah Tedford</td>
<td>4/5</td>
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<tr>
<td>Anne Robson</td>
<td>4/6</td>
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<tr>
<td>Steve Collins</td>
<td>7/11</td>
<td>3/8</td>
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<tr>
<td>Ian D’Connor</td>
<td>1/1</td>
<td>2/2</td>
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<td>Jon Scott</td>
<td>3/3</td>
<td>4/4</td>
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<tr>
<td>Shelagh Smith</td>
<td>2/2</td>
<td>1/2</td>
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<tr>
<td>Magda Smith</td>
<td>5/5</td>
<td>11/11</td>
<td>2/2</td>
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<tr>
<td>Peter Hunt</td>
<td>2/3</td>
<td>3/4</td>
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</tbody>
</table>

The values shown are the number of attendances against the number of meetings held during the year that the director was eligible to attend. The shaded areas indicate that the director was not a member of that committee.
Mr Joe Fielder
Chairman
Member: FIC, Remuneration Committee
Joe is chairman in common, being also the chairman of the North East London Foundation Trust since April 2016. Prior to his NHS roles, Joe gained a number of years’ experience at Board level within BT, having served on both south east and south east regional boards. He was previously Sales & Marketing Director of BT Fleet Ltd, a wholly owned subsidiary of BT Plc.

Joe has a track record in delivering transformational change programmes for cost improvement and in driving business growth in a variety of senior sales, marketing and operational roles.

Eric Sorensen
Independent Non-Executive Director, Vice Chairman / Senior Independent Director, Chair Finance and Investment Committee
Member: Audit Committee, Remuneration Committee
Eric Sorensen was appointed in July 2014. Following his earlier civil service career, Eric has worked for many years to promote regeneration and development, particularly in east London. He is Chair of a local community regeneration trust in Tower Hamlets, of a grant-giving trust in Newham, and of an Islington primary school.

Eric is an experienced NHS non-executive director having held posts at Homerton Hospital and at South East London Healthcare Trust.

Mark Lam
Independent Non-Executive Director, Chair, People and Culture Committee
Member: Audit Committee, Finance and Investment Committee, Remuneration Committee
Mark Lam was appointed in September 2014. A senior corporate executive, Mark has extensive global experience in telecommunications and information technology. He is an executive and Chief Information Officer at Openreach, a BT Group business, and has previously held management positions at Siemens and The Carphone Warehouse. His experience of global business spans Europe, the USA and Asia, where he has led major contracts and operations.

Joan Saddler OBE
Independent Non-Executive Director
Member: Audit Committee, People and Culture Committee, Remuneration Committee
Joan Saddler OBE was appointed in September 2014 for a four year term of office. Joan spent five years as the National Director of Patient and Public Affairs at the Department of Health and is now responsible for national policy and practice in public and patient engagement at the NHS Confederation. She previously served as the Chair of Waltham Forest Primary Care Trust.

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

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

Matthew Hopkins
Chief Executive
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee
Matthew Hopkins was appointed as Chief Executive in April 2014. Prior to joining our Trust, Matthew was Chief Executive of Epsom and St Helier University Hospitals NHS Trust for three years. He has also worked at a number of other London teaching hospitals including Guy’s and St Thomas’, Imperial, and Barts and The London. Starting his NHS career as a nurse, Matthew trained at Addenbrooke’s Hospital in Cambridge before spending five years as a Macmillan nurse.

Professor Anthony Warrens
Non-Executive Director
Member: Quality Assurance Committee, Remuneration Committee
Anthony joined the Trust in July 2011. A qualified doctor with a clinical practice in renal medicine and based principally at Barts Health NHS Trust, Anthony has a particular interest in transplantation medicine.

He is a former President of the British Transplantation Society.

Since 2010 he has been Dean for Education at Barts and The London School of Medicine and Dentistry, where he has re-organised educational structures within the School and improved basic science teaching.

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

Jackie Westaway
Independent Non-Executive Director
Member: Quality Assurance Committee, Finance and Investment Committee from November 2017 to April 2018, Remuneration Committee
Jackie has experience of delivering commercial success within the tightly regulated environment of the Pharmaceutical Industry. She is highly experienced in change management and UK and global marketing leadership. She has a strong customer focus with a track record of effectively working alongside the NHS.

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

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### Profiles of Our Board

**Dr Nadeem Moghal**  
**Medical Director, Caldicott Guardian**  
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee  

Dr Nadeem Moghal joined the Trust in January 2015. He is responsible for leading and directing our medical workforce, clinical standards, patient safety, and clinical governance. Prior to joining our Trust, Nadeem was the Director of Strategy and Knowledge Management at George Eliot Hospital in North Warwickshire, where he led the implementation of a transformative and unique paediatric service model and worked with the senior leaders and teams to lead the organisation out of special measures.

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

**Kathryn Halford**  
**Chief Nurse**  
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee  

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

**Ian O'Connor**  
**Director of Finance and Investment**  
Member: Finance and Investment Committee, People and Culture Committee, Quality Assurance Committee  

Ian’s experience covers a number of settings including commissioning, acute, mental health, and community services, so is well placed to support our journey into the world of integrated care organisations and more collaborative working.

Ian has won HFMA awards for innovative practice in the development and implementation of cost improvement programmes.

As well as promoting the need for financial rigour he actively promotes the need to look beyond the numbers and apply commercial skills to the delivery of clinical and non-clinical services, working with multidisciplinary teams to deliver real change for the benefit of patients.

**Deborah Tarrant**  
**Director of People and Organisational Development**  
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee  

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

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

Deborah is President of the Healthcare People Management Association.

**Shelagh Smith**  
**Interim Chief Operating Officer**  
Member: Finance and Investment Committee, Quality Assurance Committee, People and Culture Committee  

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

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

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

**Peter Hunt**  
**Director of Communications and Engagement**  
Member: Quality Assurance Committee, People and Culture Committee  

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

**Jason Seez**  
**Director of Strategy and Planning**  
Member: Finance and Investment Committee  

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

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

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

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ADDITIONAL DISCLOSURES

This section includes items of information which we are required to include in our annual report.

ACCOUNTING POLICIES

The Accounting policies for the Trust are shown as Note 1 to the Accounts and include policies on pensions and other retirement benefits. Details of senior employees’ remuneration are set out in the Remuneration Report. The Trust’s external auditors’ remuneration and fees are shown in operating expenses in the Accounts.

EXTERNAL AUDITORS

The external auditors appointed to audit the accounts for the year ended 31 March 2018 were KPMG LLP. KPMG LLP has not carried out any non-audit work for the Trust during the year.

COST ALLOCATION AND CHARGES FOR INFORMATION

We have complied with HM Treasury’s guidance on cost allocations for information required.

BETTER PAYMENT FOR SUPPLIERS

The Trust supported The Better Payment Practice Code that was established in 1998 by business and government leaders, to help improve the payment culture amongst organisations trading in the UK. The Code is supported by public as well as private sector organisations. Collectively they represent about 20% of the UK’s gross domestic product.

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

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

The Better Payment Practice Code was replaced by The Prompt Payment Code in 2009. It applies the following principles to suppliers and agreements and fees are shown in operating expenses in the Accounts.

MODERN SLAVERY ACT 2015

Barking, Havering and Redbridge University Hospitals NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015 and we expect our staff and suppliers to comply with the legislation. We have updated a number of relevant policies and ensured that training about slavery and human trafficking is available to staff through the safeguarding team. Future actions include scoping our procurement flows and developing a clear action plan to ensure Modern Slavery is not taking place in any part of business or any of our supply chains.

POLITICAL AND CHARITABLE DONATIONS

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

EXIT PACKAGES AND SEVERANCE PAYMENTS

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

OFF PAYROLL ENGAGEMENTS

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

INFORMATION GOVERNANCE

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

• Health records management breach – which related to ED cards taken offsite against Trust policy. The patient records were held securely and there was no report of unauthorised access. Duty of Candour applied and patients were informed and invited to raise concerns. The investigation was closed with an improvement plan
• The national cyber-attack - on 12 May 2017, we were one of 48 NHS trusts in England that came under an unprecedented global cyber-attack, which also affected many organisations in 99 countries. The virus spread very quickly through our trust’s computing network and significantly affected access to Trust information and the provision of services. The investigation closed with a national improvement plan
• Adoption data breach – personal information of birth mothers sent to adopter. The birth mother was an overseas patient who was required to pay for maternity services and owed the Trust for this. Eventually the birth mother’s contact details were passed on to the Trust’s debt collection agency, along with a change of address, however this information was incorrect. Further investigation confirmed that it was another NHS Trust had changed the address and was responsible for the breach. The investigation closed with improvement plan
• Staff data loss - A Health and Safety Executive (HSE) Approved third party contractor responsible for managing and storing radiation doses of Trust staff was a victim of a data security attack. Unauthorised access was detected and malware was installed by unknown person(s) on contractor’s UK server. This led to the breach of person identifiable data of 674 Trust staff. Hundreds of other NHS Trusts were also affected. Investigation closed with national improvement plan
• PACS – during the PACS migration project, access to the Trust’s CPW PACS database was lost during, and following, the WannaCry cyber-attack in May 2017. Clinicians were unable to access mismatched records for a period of time however workarounds were in place. Reports remained available but there was potential for some delayed reporting. Investigation closed with improvement plan.

DIRECTORS’ STATEMENT TO THE AUDITOR

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

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 such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and 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

Chief Executive

Date: 24 May 2018

Director of Finance and Investment

Date: 24 May 2018

Barking, Havering and Redbridge University Hospitals NHS Trust
**SCOPE OF RESPONSIBILITY**

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

**THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL**

The system of internal control is designed to manage risks to a reasonable level rather than to eliminate all risks of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Barking, Havering and Redbridge University Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them effectively, efficiently, and economically. The system of internal control has been in place in Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

**CAPACITY TO HANDLE RISKS**

The Trust faced risk management challenges throughout the year, as well as uncovering some weaknesses in its controls, and during the course of that time has worked to improve its related processes. By year end, the Trust had ensured that its risk management system received the appropriate leadership and management. The Trust has ensured that its risk management system received the appropriate leadership and management. We have a Risk Management Policy and Strategy which applies to all our staff. At the strategic level, our board assurance framework (BAF) enables us to assess and evaluate the principal risks to achieving our strategic objectives.

During the year, the BAF was developed with the help of the Good Governance Institute (GGI) and reviewed at a Board development seminar in October 2017, before regularly being presented to the Board and Audit Committee. It provides a current view around the risks to our meeting strategic objectives, and the appropriate controls, assurances, gaps in controls and planned actions. Risks are assigned to executive directors. Risk appetite is determined by the Board in accordance with the Trust Risk Management Strategy and Policy.

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

<table>
<thead>
<tr>
<th>ROLE</th>
<th>RISK RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Designated Accountable Officer and overall accountability for our risk management</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Caldicott Guardian and joint lead on the management of quality and patient safety</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>Joint lead on the management of quality and patient safety</td>
</tr>
<tr>
<td>Director of Finance and Performance</td>
<td>Financial control and investment risks; Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks from 01 August 2016 to 01 November 2017</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Risk relating to the delivery of clinical services</td>
</tr>
<tr>
<td>Director of People and Organisational Development</td>
<td>Workforce and organisational development risks</td>
</tr>
<tr>
<td>Director of Strategy and Development</td>
<td>Risks relating to the development of strategy and estates</td>
</tr>
<tr>
<td>Director of IM&amp;T</td>
<td>From 1 November 2017: Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks</td>
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</table>

Assurance around operational risks is provided to our Board through both the management route, and from additional scrutiny from the committee structure. The Risk and Compliance Group reviews the Trust risk register monthly. From October 2017, the Audit Committee began the inviting of a divisional director and corporate director to attend meetings to present their risk registers and from January 2018, the Trust Executive Committee commenced the quarterly review of the Trust corporate risk register. The chief nurse is the governance and risk lead.

The Risk and Compliance Group reports to the Trust Executive Committee through the Quality Governance Steering Group. The Risk and Compliance Group scrutinises key risk management instruments such as the risk register and the operation of the risk escalation process through the direct engagement of senior operational staff. The risk register is a live instrument that is increasingly connected to other risk and safety systems such as incident reporting, serious incident (5i) investigation and patient feedback.

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

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

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

The Audit Committee scrutinises risk management on behalf of the Trust Board. In 2017/18, the committee met five times, and retains the capacity to meet more often, if necessary, and scrutinises the integrity of the Trust’s risk management processes and the board assurance framework (BAF). The Quality Assurance Committee meets monthly as the high-level committee which scrutinises quality assurance and specific risks on behalf of the board. The Finance and Investment Committee meets monthly to scrutinise, and assure the Board, of matters related to Finance, and the People and Culture Committee meets bi-monthly to oversee, for Board assurance, all workforce and culture related issues in the Trust. The Trust also has a Trust Executive Committee, chaired by the chief executive, which provides a forum and mechanism for executive decisions and management.

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

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

- Executives, directors and managers within the organisation who have responsibility for the development and maintenance of the system of risk management and internal control
- Performance against national and local standards
- The work of Internal Audit (KPMG) through the year
- The results of External Audit’s (KPMG) work on our annual accounts and local tailored performance management reviews
- Patient and staff surveys and feedback, NHS Litigation Authority (now NHS Resolution) and Care Quality Commission assessments, Ombudsman and other sources of external scrutiny and accreditation

**ANNUAL GOVERNANCE STATEMENT 2017/18**

Barking, Havering and Redbridge University Hospitals NHS Trust
THE RISK AND CONTROL FRAMEWORK

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

By the end of the financial year, risk management was embedded in the activities of the organisation in the following ways:

- Corporate and divisional objectives are risk assessed as part of the annual business planning and performance management process.
- Structured processes are used for the completion of local risk assessments to populate the Trust’s risk register.
- The Risk and Compliance Group monitors risk registers.
- There are structured processes in place for incident reporting, the investigation of Serious Incidents (SIs), complaints and litigation cases.
- The Audit Committee reviews divisional and corporate risk register at its meetings, and the Trust Executive Committee reviews the corporate risk register.
- All executive directors regularly review the BAF to ensure that appropriate action is being taken against key risks to the Trust’s strategic objectives and the Board formally reviews the BAF at its meetings in public.

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

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

- A failure to recruit and retain appropriate numbers of permanent, capable staff to deliver the operational plan.
- The failure to deliver the Constitutional Standards and other key operational targets will have detrimental consequences, such as impact on patients, reputational loss and contractual firing.
- Not being able to embed an appropriate high-performing culture throughout the whole Trust.
- Failure to deliver the control total.
- Commissioner inability to fund activity within the payment by results (PBR) contract.
- Failure to identify solutions to the cash flow deficit.

The Trust is one of five trusts in the UK working in ground-breaking partnership with the Virginia Mason Institute to introduce a standardised approach to quality improvement using Lean methodology throughout the organisation. Through this process our staff that deliver the service, improve the service, by using rapid process improvement workshops to address quality defects and reduce waste in our systems and processes.

One of the successful improvements in incident reporting processes which will contribute to even better incident reporting rates, monitored through the integrated quality report.

The Trust achieved the national benchmark for harm free care in all four quarters. The Trust did not achieve the A&E 4-hour wait target during the year, and did not maintain RTT standard performance at all times during the year. It did achieve the cancer standards throughout the year, with the exception of the 62-day cancer standard, which was achieved in quarters 2 and 3. There were 143 SIs reported during the year and 5 never events. These and other year-end key performance indicators are referenced in the performance report section of the annual report and within the quality account. The Trust achieved the targets for safe staffing in all four quarters.

The Trust has received multiple quality based visits and inspections to its Emergency Departments, all of which provided assurance that quality and safety were at a high level. The Trust has also developed its Urgent Treatment Centre (UTC), which is the focus of targeted improvement activity, through a task and finish group.

The Trust implemented a mortality review process during the year as well as developing a strong Mortality Faculty, and establishing a mortality assurance group. The Trust also agreed a learning from deaths policy and reviewed all deaths and escalated any, where there were concerns, to a structured subject review using the Royal College of Physicians approved methodology. The Trust’s measures of mortality (MRSA and SHMI) reduced over the year, and are within ‘expected limits’. Performance around this is regularly scrutinised by the Quality Assurance Committee and presented to the Board. Risks in relation to data security are placed on the risk register.

We have redesigned our data quality strategy to become an information rich organisation. During the year, internal audit reviewed data quality, for RTT and cancer waiting times, which received reasonable assurance. The Trust has in place a comprehensive validation and data quality strategy which has been overseen by our chief operating officer. Reports are presented to our weekly Access Board chaired by our deputy chief operating officer detailing the worsening of patients and waiting times data that have been checked each week. We have audit trails and a robust recording system for all of our actions. Our elective access policy has been reviewed by a third party – the Intensive Support Team from NHS Improvement.

The Trust had a surplus financial plan agreed with NHS Improvement at the start of the year, which included recognised risks. During the year, however, it became apparent that the Trust had some significant cash flow and financial challenges, and after review, it realised a revised deficit forecast. The cash flow pressures had caused us to further delay payment to suppliers. At year-end, the Trust recorded a £49m deficit. In response to this, the Trust commissioned Grant Thornton to conduct a financial analysis and financial governance review. The report had a number of recommendations, which the Trust is working to complete, overseen by the Financial Governance Steering Group, established by, and reporting to, the Finance and Investment Committee. The Trust was placed in special measures for finances by NHSI in February.

The Board reviews and monitors monthly performance reports to meet the requirements of NHS Improvement’s (NHSI) Accountability Framework building those requirements into its annual operational plan, and ensuring that they are addressed as part of our integrated planning process.

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

The CQC visited the Trust between 13 January and 21 February 2018 to carry out unannounced inspections of our emergency and urgent care, medical care (including older people care) and surgery at both Queen’s Hospital and King George Hospital. They returned from 13 to 15 March 2018 to complete a well-led review. The completion report is not expected before June 2018. The Improvement Plan, set from the previous CQC inspection, last year, has largely been completed, and was developed into a trust-owned Improvement Portfolio which has become part of our “business as usual”. This was integrated our quality improvement strategy flowing from our partnership with the Virginia Mason Institute. We have compiled with the relevant guidance on Corporate Governance. The Trust continued to implement its Board development programme throughout the year, using months when we did not hold a Board meeting in public. This has provided opportunities for the Board to reflect on priorities, behaviours and working assumptions around key strategic issues. During the year, it focused on the development of the BAF, how well-led it was, discussed strategic topics such as development of an ACS, and dedicated time to the Trust’s financial challenges, which were uncovered during the year.

With reference to the requirements of our Standing Orders, the director of finance and investment assessed the arrangements for the discharge of statutory functions. No irregularities or gaps in legal compliance have been identified other than those identified within this statement. The Trust, after review, made some changes to the SIF to provide additional discipline to the adherence of budgets throughout the Trust, which were ratified at the May 2018 Board meeting.

Overall responsibility for quality governance rests jointly with the chief nurse and medical director. The medical director is executive lead for clinical standards, patient safety and clinical governance, and is the Trust’s Caldicott Guardian. The chief nurse is our executive lead for improving patient experience. A new patient experience strategy was approved in the first quarter of 2017/18. The Good Governance Institute continued to support the Trust in developing the quality governance arrangements and in particular, reviewing the quality groups that reported to the Quality Governance Steering Group.

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

Our governance framework and system of internal control helps us to manage risk to a reasonable level; it does not eliminate all risk, and it therefore provides reasonable and not absolute assurance of effectiveness. Our system of internal control aims to identify and prioritise risks to compliance with policies, and the achievement of our aims and objectives, and evaluate the impact and likelihood of risks being realised and to manage them efficiently, effectively and economically.
PENSIONS
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employee’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

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

EQUALITY, DIVERSITY, AND HUMAN RIGHTS
Control measures are in place to ensure that the organisation’s obligations under equality, diversity and human rights legislation are complied with. The Trust has established a process to ensure that equality and diversity and human rights is embedded in its policy development process. All new, and reviewed, policies have an equality impact assessment completed, which is considered by the approving group and the Trust’s Policy Ratification Group. Board papers require an assessment of equality and diversity issues.

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

INFORMATION GOVERNANCE
Our Information Governance (IG) Assessment Report for the period 2017/18 was 79%, and was rated as satisfactory. The Trust declared that it has complied with information governance guidelines and the Data Protection Act 1998.

I can confirm that there has been five level two Information Governance incidents reported to the ICO during 2017/18. To date the ICO has taken no action against the Trust.

The Trust has been preparing for GDPR, and the Board reviewed risks to implementation of the requirements by 25 May 2018.

ANNUAL QUALITY ACCOUNT
Our Quality Account is the annual report to the public from providers of NHS healthcare about the quality of services delivered. The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Our 2017/18 Quality Account will:

- Aim to improve organisational accountability to the public and engage our board in the quality improvement agenda for the organisation
- Enable us to review our services, decide and show where we are doing well, but also where improvement is required
- Enable us to demonstrate what improvements we have made against our 2017/18 priorities
- Provide information on the quality of our services to patients and the public
- Demonstrate how we involve and respond to feedback from patients and the public, as well as other stakeholders.

We will also include a review of mortality, as we are expected by NHS England to report on our progress in using learning from deaths to inform our quality improvement plans for the 2017/18 Quality Account. This will build on the work of the Royal College of Physicians in developing a methodology to support our process.

An editorial group led by our Medical Director, Thornton, and established the Financial College of Physicians in developing a methodology to support our process.

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

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

Matthew Hopkins
Date: 24 May 2018
Chief Executive and Accountable Officer
Barking, Havering and Redbridge University Hospitals NHS Trust
Our remuneration policy states that Agenda for Change applies to all directly employed staff except very senior managers and those covered by the Doctors’ and Dentists’ Pay Review Body. A personal performance review process incorporating development plans is in place to enable performance and talent management of our people.

The remuneration package and conditions of service for executive directors is agreed by the Remuneration Committee. The remuneration for executive directors does not include any payments to former senior managers or amounts payable to third parties for the permanent services of a senior manager.

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

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

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

### Single Total Figure Remuneration Table

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Period (See Note 7)</th>
<th>Salary £000</th>
<th>Taxable Pay £000</th>
<th>Performance Related Pay £000</th>
<th>Long term performance related pay £000</th>
<th>Pension related benefits £000</th>
<th>Total Remuneration £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Maureen Gabriel - Chief</td>
<td>01/04/2017 - 29/06/2017</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15-20</td>
</tr>
<tr>
<td>Jon Endler - Chief</td>
<td>01/10/2017 - 31/03/2018</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15-20</td>
</tr>
<tr>
<td>Matthew Hopkins - Chief Executive</td>
<td>01/04/2017 - 29/06/2017</td>
<td>200-265</td>
<td>0</td>
<td>0</td>
<td>42.5 - 42.5</td>
<td>147.5 - 205</td>
<td>265-400</td>
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<tr>
<td>Chris Brown (interim Chief Executive)</td>
<td>01/07/2017 - 01/09/2017</td>
<td>15-20</td>
<td>0</td>
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<td>15-20</td>
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<tr>
<td>Jean Seer - Director of Strategy and Planning</td>
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<tr>
<td>Deborah Tenant - Director of Finance and Investment</td>
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</tr>
<tr>
<td>Nicholas Franks - Chief Operating Officer</td>
<td>01/04/2017 - 24/06/2017</td>
<td>15-20</td>
<td>0</td>
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<td>0</td>
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<td>15-20</td>
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<tr>
<td>Jeff Buggle - Acting Chief Executive</td>
<td>01/04/2017 - 01/09/2017</td>
<td>65-70</td>
<td>7</td>
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<td>0.0 - 2.5</td>
<td>65-70</td>
<td>180-185</td>
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<tr>
<td>Steve Collins - Acting Director of Finance &amp; Investment</td>
<td>01/04/2017 - 22/01/2017</td>
<td>120-125</td>
<td>0</td>
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<td>4.5 - 47.5</td>
<td>170 - 175</td>
<td>280-285</td>
</tr>
<tr>
<td>Amy Al-Abbar - Acting Director of People &amp; Organisational Development</td>
<td>01/04/2017 - 12/06/2017</td>
<td>65-90</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>65-90</td>
<td>185-215</td>
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<tr>
<td>Chris Bown - Interim Chief Executive</td>
<td>01/04/2017 - 30/06/2017</td>
<td>90-115</td>
<td>0</td>
<td>0</td>
<td>37.5 - 90.0</td>
<td>175-180</td>
<td>410-415</td>
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<tr>
<td>Kathryn Halford - Chief Nurse</td>
<td>01/04/2017 - 29/06/2017</td>
<td>150-165</td>
<td>0</td>
<td>0</td>
<td>45.0 - 58.75</td>
<td>205 - 220</td>
<td>620-650</td>
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<tr>
<td>Dr Nickson Moghal - Medical Director</td>
<td>01/04/2017 - 29/06/2017</td>
<td>150-165</td>
<td>0</td>
<td>0</td>
<td>45.0 - 58.75</td>
<td>205 - 220</td>
<td>620-650</td>
</tr>
<tr>
<td>Rachel Ropell - Director of Communications &amp; Marketing</td>
<td>01/04/2017 - 29/06/2017</td>
<td>150-165</td>
<td>0</td>
<td>0</td>
<td>45.0 - 58.75</td>
<td>205 - 220</td>
<td>620-650</td>
</tr>
<tr>
<td>CDCI Centre - Interim Director of Finance &amp; Investment</td>
<td>01/10/2017 - 31/03/2018</td>
<td>85-90</td>
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<td>0</td>
<td>85-90</td>
<td>240-255</td>
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<tr>
<td>Sarah Judd - Acting Chief Operating Officer</td>
<td>01/10/2017 - 31/03/2018</td>
<td>85-90</td>
<td>0</td>
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<td>0</td>
<td>85-90</td>
<td>240-255</td>
</tr>
<tr>
<td>Nigel Stone - Acting Medical Director</td>
<td>01/04/2017 - 05/09/2017</td>
<td>90-110</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>90-110</td>
<td>260-280</td>
</tr>
<tr>
<td>Tom Scott - Interim Chief Operating Officer</td>
<td>01/04/2017 - 05/09/2017</td>
<td>110-115</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>110-115</td>
<td>290-310</td>
</tr>
<tr>
<td>Peter Hargreaves - Director of Communications and Engagement</td>
<td>01/01/2017 - 31/03/2018</td>
<td>40-60</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>40-60</td>
<td>140-160</td>
</tr>
<tr>
<td>Pete Crossman - Non-executive Director</td>
<td>01/01/2017 - 31/03/2018</td>
<td>0-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0-10</td>
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<tr>
<td>dusty Arrebola - Non-executive Director</td>
<td>01/04/2017 - 30/06/2017</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0-5</td>
</tr>
<tr>
<td>Mark San - Non-executive Director</td>
<td>01/04/2017 - 30/06/2017</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0-5</td>
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<tr>
<td>Jackie Whetton - Non-executive Director</td>
<td>01/04/2017 - 30/06/2017</td>
<td>0-5</td>
<td>0</td>
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</tr>
<tr>
<td>Jon Sanders - Non-executive Director</td>
<td>01/04/2017 - 30/06/2017</td>
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<tr>
<td>Tim Philip - Non-executive Director</td>
<td>01/04/2017 - 30/06/2017</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0-5</td>
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<tr>
<td>Medium remuneration of all staff in the Trust (Q)</td>
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<tr>
<td>Highest paid director of the Trust remunerated (4) (5)</td>
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</tr>
</tbody>
</table>

Total of the abovetwo figures 84,863

Notes
(1) Due to a planned period of absence Matthew Hopkins was not present to discharge his duties as Chief Executive from the 1st of April to the 31st of July 2017.
(2) Jeff Buggle was Acting Chief Executive until 21st July 2017 when he left the Trust.
(3) Chris Brown took over the Acting Chief Executive role from Jeff Buggle until Matthew Hopkins (Substantive Postholder) returned from sabbatical absence.
(4) Steve Collins was asked to act into the role of Director of Finance and Investment from the 1st of April 2017 until he left the Trust on the 22nd of December 2017.
(5) Sarah Tedford left the Trust at the end of August 2017 on an agreement to retire.
(6) Anne Robson (Interim) was appointed to cover the role of Director of People and Organisational Development from 1st April - 30th of September 2017 following a period of absence for the substantive Director postholder Deborah Tenant.
(7) Unless the period is stated the Directors were here throughout the full financial year (ie 1st April 2017 - 31st March 2018).
PENSION ENTITLEMENTS OF SENIOR MANAGERS

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real Remuneration in £000</th>
<th>Real Remuneration in £000 at age 60</th>
<th>Total accrued pension at March 2018</th>
<th>Total Remuneration at March 2018</th>
<th>Cash Equivalent Transfer Value at April 2017</th>
<th>Cash Equivalent Transfer Value at March 2018</th>
<th>Real Equivalent CETV: Expenditure Year</th>
<th>Real Equivalent CETV: Expenditure Year at Sustainable Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matthew Hopkins - Chief Executive</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>1.4 - 3.7</td>
<td>1.4 - 3.7</td>
<td>0.0 - 2.5</td>
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<td>Jason Seez - Director of Planning &amp; Governance</td>
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<td>0.0 - 2.5</td>
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<td>Deborah Tarrant - Director of People &amp; Organisational Development</td>
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<tr>
<td>Sarah Tedford - Chief Operating Officer</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
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<tr>
<td>Jeff Buggle - Acting Chief Executive</td>
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<td>Steve Collin - Acting Director of Finance &amp; Investment</td>
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<td>Kathryn Hall - Nurse</td>
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<td>0.0 - 2.5</td>
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<td>Dr Nadeem Moghal - Medical Director</td>
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<td>2.5 - 5.0</td>
<td>2.5 - 5.0</td>
<td>2.5 - 5.0</td>
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<td>Rachel McCallie - Director of Communications</td>
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<tr>
<td>Jon O’Connor - Acting Director of Finance &amp; Investment</td>
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<td>Shafeeq Smith - Chief Operating Officer</td>
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<td>Magdi Smith - Medical Director (Acting)</td>
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<tr>
<td>Jon Scott - Deputy Chief Operating Officer</td>
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<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
</tr>
</tbody>
</table>

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

CASH EQUIVALENT TRANSFER VALUES
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent benefits paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme).

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

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

Matthew Hopkins, Chief Executive

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

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

Band of the highest paid director’s total remuneration (£000)

<table>
<thead>
<tr>
<th>Band of director’s total remuneration (£000)</th>
<th>Median pay (£000)</th>
<th>Median pay multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>200-205</td>
<td>33,058</td>
<td>6.1</td>
</tr>
<tr>
<td>200-205</td>
<td>33,205</td>
<td>6.1</td>
</tr>
</tbody>
</table>

The highest paid director salary was £240,500 (2016/17, £240,500) in the current year after a median salary of £33,058 (2015/16, £33,205), resulting in no change to the median pay multiple.

The band of remuneration of the highest-paid director in the Trust in the financial year 2017/18 was in the band £200k-£205k (2016/17, £200k-£205k). This was 6.1 times the median remuneration of the workforce, which was £33,058 (2016/17, £33,205). Total remuneration includes salary and nonconsolidated performance-related payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff costs have been outlined in detail in note 8 of the accounts. In 2017/18, the Trust spent a total of £605m of which staff costs accounted for £370m (61%).

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

Ethnicity | Headcount
----------|--------
A - White - British | 272
B - White - Irish | 149
C - White - Any other White background | 241
C2 - White Northern Irish | 6
C3 - White Unspecified | 8
CA - White English | 18
CB - White Scottish | 7
CC - White Welsh | 2
CE - White Clyde (non specific) | 2
CF - White Greek | 10
CG - White Greek Cypriot | 4
CH - White Turkish | 2
CI - White Turkish Cypriot | 1
CJ - White Italian | 40
CM - White Traveller | 1
CF - White Polish | 31
CQ - White ex-OSIR | 11
CR - White Kosovan | 2
CS - White Albanian | 3
CU - White Croatian | 3
CV - White Serbian | 1
CW - White Other Ex-Yugoslav | 1
CX - White Mixed | 9
CY - White Other European | 103
D - Mixed - White & Black Caribbean | 35
DD - Mixed - White & Black African | 22
E - Mixed - White & Asian | 23
G - Mixed - Any other mixed background | 46
GA - Mixed - Black & Asian | 2
GB - Mixed - Black & Chinese | 1
GC - Mixed - Black & White | 2
GD - Mixed - Chinese & White | 1
GF - Mixed - Other Unspecified | 16
H - Asian or Asian British - Indian | 497
J - Asian or Asian British - Pakistani | 734
K - Asian or Asian British - Bangladesh | 101
L - Asian or Asian British - Any other Asian background | 247
LA - South London Indian | 8
LB - Asian Punjabi | 24
LC - Asian Kashmiri | 3
LD - Asian East African | 5
LE - Asian Sri Lankan | 18
LF - Asian Tamil | 10
LG - Asian Sinhalese | 5
LI - Asian British | 78
LJ - Asian Caribbean | 8
LK - Asian Unspecified | 10
LM - Black or Black British - Caribbean | 195
LN - Black or Black British - African | 118
LP - Black or Black British - Any other Black background | 22
PA - Black Somal | 10
PB - Black Malaysian | 7
PC - Black Nigerian | 99
PD - Black British | 80
PE - Black Unspecified | 7
Q - Chinese | 53
R - Any Other Ethnic Group | 120
SC - Filipino | 324
SD - Malaysian | 9
SG - Other Specified | 1
U - Not Stated | 72
S - Not Stated | 78
Grand Total | 6585
The number of staff disclosed in the staff report are in absolute terms whereas the figure disclosed in note 10 of the accounts is an average for the year.

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

Our expert staff work across the following disciplines:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Headcount</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin, Clerical &amp; Maintenance</td>
<td>1434</td>
<td>21.8%</td>
</tr>
<tr>
<td>Allied Health Professionals (PAMs)</td>
<td>519</td>
<td>7.9%</td>
</tr>
<tr>
<td>Ancillary &amp; Non-patient-care SWkrs</td>
<td>32</td>
<td>0.5%</td>
</tr>
<tr>
<td>HCAs &amp; Patient-care SWkrs</td>
<td>913</td>
<td>13.9%</td>
</tr>
<tr>
<td>Medical - Career Grades</td>
<td>560</td>
<td>8.5%</td>
</tr>
<tr>
<td>Medical - Training Grades</td>
<td>337</td>
<td>5.1%</td>
</tr>
<tr>
<td>Midwives</td>
<td>333</td>
<td>5.1%</td>
</tr>
<tr>
<td>Other Qualified Nurses</td>
<td>1786</td>
<td>27.1%</td>
</tr>
<tr>
<td>Professional, Technical &amp; Scientific</td>
<td>671</td>
<td>10.2%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>6585</td>
<td></td>
</tr>
</tbody>
</table>

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

The table below gives the gender breakdown within the Trust (as at 31 March 2018).

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Level Director</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Non Executive Director / Chair</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>288</td>
<td>153</td>
</tr>
<tr>
<td>All Other Employees</td>
<td>4810</td>
<td>1323</td>
</tr>
<tr>
<td>Grand Total</td>
<td>5101</td>
<td>1484</td>
</tr>
</tbody>
</table>

The Interim Chief Operating Officer was also appointed to cover the role in response to the departure of the substantive person on secondment to a role in NHSI, prompting the Trust, with agreement from NHSI, to appoint an Interim Chief Executive until the return of the substantive Chief Executive. The Interim Chief Operating Officer role covered the period of 1st April 2017 to 12th September 2017.

Expenditure on consultancy
In 2017/18 the Trust spent £4,700k on consultancy services.

Exit Packages
Details of staff exit packages are included in Note 55 of the Accounts.
INDEPENDENT AUDITOR’S REPORT TO THE BOARD OF DIRECTORS OF BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

OPINION
We have audited the financial statements of Barking, Havering and Redbridge University Hospitals NHS Trust (“the Trust”) for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1. In our opinion the financial statements:

• Give a true and fair view of the state of the Trust’s affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
• Have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

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

MATERIAL UNCERTAINTY RELATED TO GOING CONCERN
We draw attention to note 1.1.2 to the financial statements which indicates that the Trust has submitted a 2018/19 Plan to NHS Improvement which forecasts a £34.8 million deficit. These events and conditions, along with the other matters explained in note 1.1.2, constitute a material uncertainty that may cast significant doubt on the Trust’s ability to continue as a going concern. Our opinion is not modified in respect of this matter.

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

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

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

ANNUAL GOVERNANCE STATEMENT
We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

RENUMERATION AND STAFF REPORT
In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

DIRECTORS’ AND ACCOUNTABLE OFFICER’S RESPONSIBILITIES
As explained more fully in the statement set out on page 71, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust’s ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

As explained more fully in the statement of the Chief Executive’s responsibilities, as the Accountable Officer of the Trust, on page 73 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

REPORT ON THE TRUST’S ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN ITS USE OF RESOURCES

ADVERSE CONCLUSION
As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Barking, Havering and Redbridge University Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

BASIS FOR ADVERSE CONCLUSION
In considering the adequacy of the Trust’s arrangements for securing economy, efficiency and effectiveness in the use of resources and specifically in terms of sustainable resource deployment and informed decision making, we identified the points above relating to the in-year and cumulative deficit. In addition, the Trust has not yet succeeded in addressing the underlying deficit, which has increased in-year. The Trust entered special measures for finance on 9 February 2018 and these remain in place as at 31 March 2018. The Trust also breached its statutory break even duty in year by £49 million.

Barking, Havering and Redbridge University Hospitals NHS Trust
Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 73, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

Statutory reporting matters

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

- We issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- We make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Other matters on which we report by exception: referral to the Secretary of State

We have a duty under Section 30 of the Local Audit and Accountability Act 2014 to refer a matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust is about to make, or has made, a decision involving unlawful expenditure or is about to take, or has taken, unlawful action likely to cause a loss of deficiency.

On 1 April 2018 we wrote to the Secretary of State in accordance with Section 30(1)(a) of the 2014 Act in respect of the Trust’s failure to deliver its break-even duty as set out in paragraph 2(1) of Schedule 5 of the National Health Service Act 2006. The Trust’s financial statements for financial year ended 31 March 2018 identify a cumulative deficit of £408.6m, with £49m of that incurred in the 2017/18 financial year.

The purpose of our audit work and to whom we owe our responsibilities

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

Certificate of completion of the audit

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

Neil Thomas
for and on behalf of KPMG LLP, Statutory Auditor Chartered Accountants
15 Canada Square
London E14 5GL
29 May 2018
SECTION THREE:
FINANCIAL STATEMENTS AND NOTES
Statement of Comprehensive Income

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td></td>
</tr>
<tr>
<td>Operating income from patient care activities</td>
<td>515,754</td>
<td>500,262</td>
</tr>
<tr>
<td>Other operating income</td>
<td>53,853</td>
<td>57,704</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(576,380)</td>
<td>(564,550)</td>
</tr>
<tr>
<td>Operating surplus/(deficit) from continuing operations</td>
<td>(6,773)</td>
<td>(6,584)</td>
</tr>
<tr>
<td>Finance income</td>
<td>287</td>
<td>270</td>
</tr>
<tr>
<td>Net finance costs</td>
<td>(28,539)</td>
<td>(26,398)</td>
</tr>
<tr>
<td>Other gains / (losses)</td>
<td>(10)</td>
<td>37</td>
</tr>
<tr>
<td>Surplus / (deficit) for the year from continuing operations</td>
<td>(35,035)</td>
<td>(32,675)</td>
</tr>
<tr>
<td>Surplus / (deficit) on disposal of discontinued operations</td>
<td>752</td>
<td>-</td>
</tr>
<tr>
<td>Surplus / (deficit) for the year</td>
<td>(34,283)</td>
<td>(32,675)</td>
</tr>
</tbody>
</table>

Other comprehensive income

Will not be reclassified to income and expenditure:

- Impairments | (641) | (524) |

Total comprehensive income / (expense) for the period | (34,244) | (33,199) |

Statement of Financial Position

<table>
<thead>
<tr>
<th>NOTE</th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
<td></td>
</tr>
<tr>
<td>Non-current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>6,436</td>
<td>5,543</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>316,706</td>
<td>296,177</td>
</tr>
<tr>
<td>Investment property</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investments in associates and joint ventures</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other investments / financial assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>4,499</td>
<td>4,530</td>
</tr>
<tr>
<td>Other assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>327,641</td>
<td>306,244</td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>16,895</td>
<td>18,069</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>52,780</td>
<td>47,565</td>
</tr>
<tr>
<td>Other investments / financial assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-current assets held for sale / assets in disposal groups</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>3,249</td>
<td>1,548</td>
</tr>
<tr>
<td>Total current assets</td>
<td>72,948</td>
<td>67,236</td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>60,028</td>
<td>53,501</td>
</tr>
<tr>
<td>Borrowings</td>
<td>36,942</td>
<td>9,247</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>309</td>
<td>566</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>5,251</td>
<td>4,152</td>
</tr>
<tr>
<td>Liabilities in disposal groups</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>102,530</td>
<td>67,465</td>
</tr>
<tr>
<td>Total assets less current liabilities</td>
<td>298,059</td>
<td>306,024</td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Borrowings</td>
<td>327,709</td>
<td>308,286</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>6,482</td>
<td>2,886</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>3,638</td>
<td>3,851</td>
</tr>
<tr>
<td>Total non-current liabilities</td>
<td>338,029</td>
<td>315,023</td>
</tr>
<tr>
<td>Total assets employed</td>
<td>(39,970)</td>
<td>(9,003)</td>
</tr>
<tr>
<td>Financed by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>481,033</td>
<td>477,076</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>1,943</td>
<td>-</td>
</tr>
<tr>
<td>Available for sale investments reserve</td>
<td>1,943</td>
<td>-</td>
</tr>
<tr>
<td>Other reserves</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Merger reserve</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td>488,033</td>
<td>488,033</td>
</tr>
<tr>
<td>Total taxpayers’ equity</td>
<td>(39,970)</td>
<td>(9,003)</td>
</tr>
</tbody>
</table>

The notes on pages 8 to 59 form part of these accounts.

Matthew Hopkins
Chief Executive
Date: 24/05/2018
### Statement of Changes in Equity for the year ended 31 March 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>Public dividend capital £000</th>
<th>Revaluation reserve £000</th>
<th>Available for sale investment reserve £000</th>
<th>Other reserves £000</th>
<th>Merger reserve £000</th>
<th>Income and expenditure reserve £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taxpayers’ equity at 31 March 2017 - brought forward</strong></td>
<td>477,076</td>
<td>1,943</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(488,022)</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) for the year</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(9,003)</td>
</tr>
<tr>
<td>Transfers by absorption: transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments</td>
<td>-</td>
<td>(641)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(641)</td>
</tr>
<tr>
<td>Revaluations</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer to retained earnings on disposal of assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Share of comprehensive income from associates and joint ventures</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fair value gain/(loss) on available-for-sale financial investments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Recycling gain/(loss) on available-for-sale financial investments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Foreign exchange gain/(loss) recognised directly in OCI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other recognised gains and losses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Taxpayers’ equity at 31 March 2018</strong></td>
<td>481,033</td>
<td>1,302</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(522,305)</td>
</tr>
</tbody>
</table>

### Statement of Changes in Equity for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Description</th>
<th>Public dividend capital £000</th>
<th>Revaluation reserve £000</th>
<th>Available for sale investment reserve £000</th>
<th>Other reserves £000</th>
<th>Merger reserve £000</th>
<th>Income and expenditure reserve £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taxpayers’ equity at 31 March 2017 - brought forward</strong></td>
<td>477,076</td>
<td>1,943</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(488,022)</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) for the year</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(9,003)</td>
</tr>
<tr>
<td>Transfers by absorption: transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments</td>
<td>-</td>
<td>(641)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(641)</td>
</tr>
<tr>
<td>Revaluations</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer to retained earnings on disposal of assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Share of comprehensive income from associates and joint ventures</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fair value gain/(loss) on available-for-sale financial investments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Recycling gain/(loss) on available-for-sale financial investments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Foreign exchange gain/(loss) recognised directly in OCI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other recognised gains and losses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Taxpayers’ equity at 31 March 2016 - restated</strong></td>
<td>477,076</td>
<td>2,467</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(455,347)</td>
</tr>
</tbody>
</table>

### Information on reserves

**Public dividend capital**

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

**Revaluation Reserve**

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they receive impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear evidence of impairment.

**Available-for-sale investment reserve**

Available-for-sale investment reserve movements comprise changes in the fair value of available-for-sale financial instruments, other than those instruments that are derecognised, cumulated or losses previously recognised as other comprehensive income and expenditure are reported in income or expenditure.

**Merger reserve**

This reserve reflects balances formed on merger of NHS bodies.

### Statement of Cash Flows

**Cash flows from operating activities**

Net cash generated from / (used in) operating activities (925) 10,374

**Cash flows from investing activities**

Net cash generated from / (used in) investing activities (10,963) (10,976)

**Cash flows from financing activities**

Net cash generated from / (used in) financing activities 15,589 332
1. ACCOUNTING POLICIES AND OTHER INFORMATION

1.1 BASIS OF PREPARATION

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with the related items considered material in relation to accounts.

1.1.1 ACCOUNTING CONVENTION

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

1.1.2 GOING CONCERN

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

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

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

The Trust has submitted a 2018/19 plan to NHS Improvement for an in-year deficit of £34.8m. The Trust's financial priority is to introduce and seek to embed processes for Quality and Cost Improvement, as part of its longer term financial strategy.

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

1.2 SOURCES OF ESTIMATION UNCERTAINTY

The following are the judgements, apart from the future and other major sources of estimation uncertainty that have a significant risk of resulting in material adjustments to the carrying amounts of assets and liabilities within the next financial year:

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

Provisions cover a number of areas and are estimated as follows:

- Pension provision is calculated based on individuals total estimated pension payments with reference to actuarial life expectancy tables and discounted cash flows.
- Legal claim provision values are provided by our service providers based on outstanding cases.
- Redundancy provision is calculated based on payroll information in respect of the commitment agreed as at 31 March 2018.
- The Carbon Reduction Commitment (CRC) scheme provision is calculated based on utility during the previous financial year.
- Accruals are based on the value of invoices relating to the 2017-18 financial year received after 31 March 2018, including those receivable; previous year's invoice values when relating to an ongoing supplier of products or services; and costs directly advised by the supplier.
1.3 INTERESTS IN OTHER ENTITIES
Charitable Funds

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

At the end of the financial year the charity held capital and reserves of £1.97m, a decrease in year of £0.06m.

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies can be consolidated within the entity’s financial statements. Such a consolidation has not been done in these accounts as the 2017-18 income and total funds are viewed below materiality. The Trust determined this by comparing the total charities turnover to the Trust’s and concluded that as it was less than 5% it was immaterial, and consolidation was therefore not necessary.

The Charity continues to publish a separate set of accounts for FY 2017/18 in accordance with the Statement of Recommended Accounting Practice “Accounting and Reporting by Charities”; FR 102.

1.4 INCOME

Income in respect of services provided is recognised when, and in the event that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

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 been subsequently paid e.g. by an insurer. The NHS trust recognises the income when the notification from the Department of Work and Pension’s Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Revenue grants and other contributions to expenditure

Grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The value of the benefit received when the revenue funds from the government’s apprenticeship scheme are recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 EXPENDITURE ON EMPLOYEE BENEFITS

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

Pension costs

NHS Pension Scheme

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

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

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

1.6 EXPENDITURE ON OTHER GOODS AND SERVICES

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

1.7 PROPERTY, PLANT AND EQUIPMENT

1.7.1 RECOGNITION

Property, plant and equipment is capitalised when:

• it is held for use in delivering services or for administrative purposes;

• it is probable that future economic benefits will flow to, or service potential be provided to, the trust;

• it is expected to be used for more than one financial year.

The cost of the item can be measured reliably;

• the item has cost of at least £5,000; or

• Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

1.7.2 MEASUREMENT

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IPS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

• Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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

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

Subsequent expenditure

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the nature of the economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the GAN, impairments that arise from a clear consumption of economic benefits or
1.3 DERECOGNITION

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale is likely to be completed within 12 months of the date of classification as ‘held for sale’;
• the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following rediscussion, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged. Assets are derecognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is derecognised when scrapping or demolition occurs.

1.4 DONATED AND GRANT FUNDED ASSETS

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

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

1.5 PRIVATE FINANCE INITIATIVE (PFI) AND LOCAL IMPROVEMENT FINANCE TRUST (LIFT) TRANSACTIONS

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

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

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Lifecycle replacement

The Trust pays a contribution to the lifecycle replacement costs of building assets requiring replacement through the annual unitary payment. In return, the PFI operator maintains a contractual obligation to maintain the facility to an agreed standard, but is under no direct obligation to spend the lifecycle funds at pre-determined intervals. The Trust receives no financial benefit for any lifecycle savings derived during the duration of the PFI agreement. Conversely, the Trust does not bear the risk of additional lifecycle costs should the facility require additional work. Where appropriate, lifecycle replacement costs are capitalised under Property, Plant and Equipment, to the extent that they are identifiable.

The Managed Equipment Service agreement contained within the PFI agreement includes expected lifecycle replacement of medical equipment at specified times at the expected end of useful life of the assets. Since the Trust does not physically possess these future assets at the same time, assets and liabilities are only recognised to the extent that they relate to the equipment available for use. In addition, future replacement of these assets can be varied by agreement. The lifecycle replacement of these assets effectively results in a series of finance leases in accordance with the individual replacement cycles.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as either a prepaid expense or an income balance, depending on the certainty of the expenditure being incurred. If the fair value is greater than the amount determined in the contract, the difference is treated as a ‘free’ asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

The PFI operator is obliged under the Project Agreement to maintain the building to a required standard known as Estate Condition Condition B. The condition of the building is assessed each year to the extent that it is maintained to that standard, and that assessment informs the lifecycle programme for the following year. The PFI operator is also required to hand back the building in Estate Condition Condition B standard at the end of the term. Although a sum allocated to lifecycle expenditure is within the unitary payment paid by the Trust, the operator’s risk is not limited to the extent that the work required is financed by the unitary payment. The Trust recognises as a result of the Project Agreement there is a possible asset or inflow (contingent asset) whose existence is confirmed by the condition of the building.

Assets contributed by the NHS trust to the operator for use in the lifecycle

The Trust pays a contribution to the lifecycle replacement costs of building assets requiring replacement through the annual unitary payment. In return, the PFI operator maintains a contractual obligation to maintain the facility to an agreed standard, but is under no direct obligation to spend the lifecycle funds at pre-determined intervals. The Trust receives no financial benefit for any lifecycle savings derived during the duration of the PFI agreement. Conversely, the Trust does not bear the risk of additional lifecycle costs should the facility require additional work. Where appropriate, lifecycle replacement costs are capitalised under Property, Plant and Equipment, to the extent that they are identifiable.

The Managed Equipment Service agreement contained within the PFI agreement includes expected lifecycle replacement of medical equipment at specified times at the expected end of useful life of the assets. Since the Trust does not physically possess these future assets at the same time, assets and liabilities are only recognised to the extent that they relate to the equipment available for use. In addition, future replacement of these assets can be varied by agreement. The lifecycle replacement of these assets effectively results in a series of finance leases in accordance with the individual replacement cycles.

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Assets contributed by the NHS trust to the operator for use in the lifecycle

The Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust’s Statement of Financial Position.

1.6 USEFUL ECONOMIC LIVES OF PROPERTY, PLANT AND EQUIPMENT

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

<table>
<thead>
<tr>
<th>Property Category</th>
<th>Min Life Years</th>
<th>Max Life Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Buildings, excluding dwellings</td>
<td>15</td>
<td>70</td>
</tr>
<tr>
<td>Dwellings</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Plant &amp; machinery</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Transport equipment</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Information technology</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Furniture &amp; fittings</td>
<td>7</td>
<td>15</td>
</tr>
</tbody>
</table>

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

1.7 INTANGIBLE ASSETS

1.8.1 RECOGNITION

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the trust intends to complete the asset and sell or use it;
• the trust has the ability to sell or use the asset;
• the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

1.8.2 MEASUREMENT

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

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

1.2 Classifications of Financial Instruments

Financial instruments are classified as follows:

- Financial assets are designated as receivables or other financial assets unless they are designated as held for trading.
- Financial liabilities are designated as non-current liabilities or financial liabilities at fair value through income and expenditure unless they are designated as non-current liabilities.

1.3 Financial Instruments and Financial Liabilities

1.3.1 Recognition

Financial assets and financial liabilities arise in the normal course of business transactions. Financial assets are recognised initially at fair value, net of transaction costs incurred, and subsequently measured at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts approximately estimated future cash payments through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

1.4 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.

1.4.1 The Trust as lessee

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

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

The annual rental is split between the repayment of the liability and finance costs so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

Leases of land and buildings

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

1.4.2 The Trust as Lessor

Finance leases

Amounts due from leases under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant
Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Interest on direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

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

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 33.2 but is not recognised in the trust’s accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual report and accounts.

1.16 CONTINGENCIES
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

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

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

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

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

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

1.20 FOREIGN EXCHANGE
The functional and presentation currency of the trust is sterling.

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

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.21 THIRD PARTY ASSETS
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 27.2 to the accounts.

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

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

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

1.24 TRANSFERS OF FUNCTIONS (ITO / FROM OTHER NHS BODIES / LOCAL GOVERNMENT BODIES
There was no transfer of functions between the Trust and other organisations in 2017-18.

1.25 EARLY ADOPTION OF STANDARDS, AMENDMENTS AND INTERPRETATIONS
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.26 STANDARDS, AMENDMENTS AND INTERPRETATIONS IN ISSUE BUT NOT YET EFFECTIVE OR ADOPTED
The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury ReMi interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.
• IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
• IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
• IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

#### 3.1 Income from Patient Care Activities (by Nature)

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective income</td>
<td>64,492</td>
<td>66,156</td>
</tr>
<tr>
<td>Non-elective income</td>
<td>181,396</td>
<td>154,034</td>
</tr>
<tr>
<td>First outpatient income</td>
<td>39,362</td>
<td>30,242</td>
</tr>
<tr>
<td>Follow up outpatient income</td>
<td>34,302</td>
<td>33,693</td>
</tr>
<tr>
<td>A &amp; E income</td>
<td>37,026</td>
<td>32,968</td>
</tr>
<tr>
<td>High cost drugs income from commissioners (excluding pass-through costs)</td>
<td>36,357</td>
<td>37,674</td>
</tr>
<tr>
<td>Other NHS clinical income</td>
<td>118,986</td>
<td>118,171</td>
</tr>
<tr>
<td>Private patient income</td>
<td>2,646</td>
<td>2,876</td>
</tr>
<tr>
<td>Other clinical income</td>
<td>1,176</td>
<td>24,562</td>
</tr>
<tr>
<td>Total income from activities</td>
<td>515,754</td>
<td>500,262</td>
</tr>
</tbody>
</table>

#### 3.2 Income from Patient Care Activities (by Source)

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from patient care activities received from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS England</td>
<td>89,712</td>
<td>95,686</td>
</tr>
<tr>
<td>Clinical commissioning groups</td>
<td>415,693</td>
<td>390,718</td>
</tr>
<tr>
<td>Department of Health and Social Care</td>
<td>20</td>
<td>68</td>
</tr>
<tr>
<td>Other NHS providers</td>
<td>436</td>
<td>2,647</td>
</tr>
<tr>
<td>NHS other</td>
<td>70</td>
<td>739</td>
</tr>
<tr>
<td>Local authorities</td>
<td>4,260</td>
<td>4,832</td>
</tr>
<tr>
<td>Non-NHS: private patients</td>
<td>182</td>
<td>159</td>
</tr>
<tr>
<td>Non-NHS: overseas patients (chargeable to patient)</td>
<td>2,463</td>
<td>2,717</td>
</tr>
<tr>
<td>NHS injury scheme</td>
<td>2,777</td>
<td>3,044</td>
</tr>
<tr>
<td>Non-NHS: other</td>
<td>141</td>
<td>132</td>
</tr>
<tr>
<td>Total income from activities</td>
<td>515,754</td>
<td>500,262</td>
</tr>
</tbody>
</table>

Of which:
- Related to continuing operations: 515,754, 500,262
- Related to discontinued operations: - , -

### 3.3 Overseas Visitors (Relating to Patients Charged Directly by the Provider)

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income recognised this year</td>
<td>2,463</td>
<td>2,717</td>
</tr>
<tr>
<td>Cash payments received in-year</td>
<td>419</td>
<td>469</td>
</tr>
<tr>
<td>Amounts added to provision for impairment of receivables</td>
<td>4,624</td>
<td>1,618</td>
</tr>
<tr>
<td>Amounts written off in-year</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### 4 Other Operating Income

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and development</td>
<td>1,879</td>
<td>1,339</td>
</tr>
<tr>
<td>Education and training</td>
<td>15,758</td>
<td>15,981</td>
</tr>
<tr>
<td>Receipt of capital grants and donations</td>
<td>59</td>
<td>62</td>
</tr>
<tr>
<td>Charitable and other contributions to expenditure</td>
<td>715</td>
<td>311</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>43</td>
<td>125</td>
</tr>
<tr>
<td>Support from the Department of Health and Social Care for mergers</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sustainability and transformation fund income</td>
<td>6,109</td>
<td>20,997</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>2,690</td>
<td>3,146</td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Income in respect of staff costs where accounted on gross basis</td>
<td>1,679</td>
<td>1,799</td>
</tr>
<tr>
<td>Other income</td>
<td>27,088</td>
<td>13,944</td>
</tr>
<tr>
<td>Total other operating income</td>
<td>56,020</td>
<td>57,704</td>
</tr>
</tbody>
</table>

Of which:
- Related to continuing operations: 53,853, 57,704
- Related to discontinued operations: 2,167, -

Within other income are balances, which relates to PFI support money £16,000k, estimates for Incomplete Spells £6,800k as well as an estimate for HCA severance payment £1,000k.

### 5 Fees and Charges

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>3,366</td>
<td>5,282</td>
</tr>
<tr>
<td>Full cost</td>
<td>(2,525)</td>
<td>(2,597)</td>
</tr>
<tr>
<td>Surplus / (deficit)</td>
<td>842</td>
<td>2,685</td>
</tr>
</tbody>
</table>

This relates to income from HCA, private company that provided medical services from the Trust’s premises as well as car parking income.
6.1 OPERATING EXPENSES

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

- Purchase of healthcare from NHS and DHSC bodies 3,122 1,731
- Purchase of healthcare from non-NHS and non-DHSC bodies 4,859 5,442
- Staff and executive directors costs 369,799 350,449
- Remuneration of non-executive directors 27 109
- Supplies and services - clinical (excluding drugs costs) 36,961 29,400
- Supplies and services - general 11,430 13,113
- Drug costs (drugs inventory consumed and purchase of non-inventory drugs) 48,484 45,579
- Consultancy costs 4,700 2,676
- Establishment 4,785 4,013
- Premises 17,676 16,356
- Transport (including patient travel) 4,377 4,442
- Depreciation on property, plant and equipment 11,948 12,613
- Amortisation on intangible assets 2,105 2,070
- Net impairments (14,751) 21,749
- Increase/(decrease) in provision for impairment of receivables 8,598 228
- Increase/(decrease) in other provisions 4,653 -
- Change in provisions discount rate 139 -
- Audit fees payable to the external auditor 71 130
- Audit services- statutory audit 11 27
- Internal audit costs 135 140
- Clinical negligence 30,705 27,995
- Legal fees 1,415 1,100
- Insurance 17 37
- Research and development - -
- Education and training 238 263
- Rentals under operating leases 195 195
- Early retirements - -
- Refurbishment - -
- Changes to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PR /LUST) on IFRS basis 22,750 23,049
- Changes to operating expenditure for off-SoFP IFRIC 12 schemes - -
- Car parking & security - -
- Hospitality 71 86
- L opción, ex gratia & special payments - -
- Closing up consortium arrangements - -
- Other services, eg external payroll - -
- Other 1,516 1,432
- Total 577,795 564,550

Of which:
- Cost capitalised as part of assets 514 150
- Related to continuing operations 576,380 564,550
- Related to discontinued operations 1,415 -

Statutory audit fee and Other auditor remuneration payable to the external auditor excluding VAT are £59k and £9k respectively.

6.2 OTHER AUDITOR REMUNERATION

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

- Audit of accounts of any associate of the trust - 4
- Audit-related assurance services 11 23
- Taxation compliance services - -
- All taxation advisory services not falling within item 3 above - -
- Internal audit services - -
- All assurance services not falling within items 1 to 5 - -
- Corporate finance transaction services not falling within items 1 to 6 above - -
- Other non-audit services not falling within items 2 to 7 above - -
- Total 11 27

The above remuneration are inclusive of VAT.

6.3 LIMITATION ON AUDITOR’S LIABILITY

The limitation on auditor’s liability for external audit work is £2m (2016/17: £0m).

7 IMPAIRMENT OF ASSETS

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

- Net impairments charged to operating surplus / deficit resulting from:
  - Loss or damage from normal operations - -
  - Over specification of assets - -
  - Abandonment of assets in course of construction - -
  - Unforeseen obsolescence 681 680
  - Loss as a result of catastrophe - -
  - Changes in market price (15,432) 21,069
  - Other - -
  - Total net impairments charged to operating surplus / deficit (14,751) 21,749
  - Impairments charged to the revaluation reserve 641 524
  - Total net impairments (14,110) 22,273

These are mainly related to the Valuation of the Trust’s Land and Buildings with changes related to market value movements.

8 EMPLOYEE BENEFITS

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

- Salaries and wages 275,778 267,494
- Social security costs 28,521 28,744
- Apprenticeship levy 1,342 -
- Employer’s contributions to NHS pensions 30,248 29,338
- Pension cost - other 22 -
- Other post employment benefits - -
- Other employment benefits - -
- Termination benefits - 21
- Temporary staff (excluding agency) 34,373 34,360
- Total gross staff costs 370,253 351,956
- Recoveries in respect of seconded staff - -
- Total staff costs 370,253 351,956

Of which:
- Costs capitalised as part of assets 514 1,507
8.1 RETIREMENTS DUE TO ILL-HEALTH

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £755k (£136k in 2016/17).

9 PENSION COSTS

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

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”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment of the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

In addition to the NHS Pension Scheme the trust offers the National Employment Savings Scheme (NEST), an additional defined contribution workplace pension scheme.

10 OPERATING LEASES

Trust as a lessor

This note discloses income generated in operating lease agreements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessor.

1) A 60 year land lease at King George Hospital, Redbridge, granted in 2006 to operate an Independent Sector Treatment Centre.
2) A 10 year space lease at Queen’s Hospital, granted in 2009 for a private healthcare provider to provide oncology medical services. This finished in January 2018.
3) The Trust leases ward space at King George Hospital to an NHS Foundation Trust.
4) The Trust leases space at both hospitals to Barts Health NHS Trust for renal services.
5) The Trust leases space at King George Hospital for GP services.
6) The Trust leases two staff accommodation blocks at King George Hospital to a Housing Association which manages tenancy occupation to NHS employees, keyworkers or other public sector workers.

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11 FINANCE INCOME

Finance income represents interest received on assets and investments in the period.

<table>
<thead>
<tr>
<th>Year</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>199</td>
<td>195</td>
</tr>
<tr>
<td>Contingent rents</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>195</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not later than one year</td>
<td>476</td>
<td>146</td>
</tr>
<tr>
<td>later than one year and not later than five years</td>
<td>1,142</td>
<td>135</td>
</tr>
<tr>
<td>Total</td>
<td>1,618</td>
<td>281</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease receipts</td>
<td>2,571</td>
<td>2,987</td>
</tr>
<tr>
<td>Contingent rent</td>
<td>119</td>
<td>159</td>
</tr>
<tr>
<td>Total</td>
<td>2,690</td>
<td>3,146</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
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<td>195</td>
</tr>
<tr>
<td>Contingent rents</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>195</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
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<td>281</td>
</tr>
</tbody>
</table>
12.1 FINANCE EXPENDITURE

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

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Interest expense:
- Loans from the Department of Health and Social Care: £1,480, £1,511
- Other loans: - -
- Overdrafts: - -
- Finance leases: - -
- Interest on late payment of commercial debt: £123, £2
- Main finance costs on PFI and LIFT schemes obligations: £18,981, £17,942
- Contingent finance costs on PFI and LIFT scheme obligations: £7,913, £6,949
- Total interest expense: £28,507, £26,404
- Unwinding of discount on provisions: £32, (£6)
- Other finance costs: - -
- Total finance costs: £28,539, £26,398

12.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998 / PUBLIC CONTRACT REGULATIONS 2015

2017/18 | 2016/17 | £000 | £000
---|---|---|---
Total liability accruing in year under this legislation as a result of late payments: - -
Amounts included within interest payable arising from claims made under this legislation: £123, £2
Compensation paid to cover debt recovery costs under this legislation: - -

13 OTHER GAINS / (LOSES)

2017/18 | 2016/17 | £000 | £000
---|---|---|---
Gains on disposal of assets: - 37
Losses on disposal of assets: (10) -
Total gains / (losses) on disposal of assets: (10) 37
Gains / (losses) on foreign exchange: - -
Fair value gains / (losses) on investment properties: - -
Fair value gains / (losses) on financial assets / investments: - -
Fair value gains / (losses) on financial liabilities: - -
Recycling gains / (losses) on disposal of available-for-sale financial investments: - -
Total other gains / (losses): (10) 37

14 DISCONTINUED OPERATIONS

2017/18 | 2016/17 | £000 | £000
---|---|---|---
Operating income of discontinued operations: 2,167 -
Operating expenses of discontinued operations: (1,413) -
Gain on disposal of discontinued operations: - -
Loss on disposal of discontinued operations: - -
Corporation tax expense attributable to discontinued operations: - -
Total: 752 -

A commercial agreement allowing a private healthcare provider to provide services from Queen’s Hospital was terminated by mutual consent in January 2018, two years ahead of the expected ten year term.

15.1 INTANGIBLE ASSETS - 2017/18

<table>
<thead>
<tr>
<th>Licences &amp; Trademarks</th>
<th>Internally Generated Information Technology</th>
<th>Development Expenditure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000s</td>
<td>£000s</td>
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</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Valuation / gross cost at 1 April 2017 - brought forward: 263</td>
<td>11,470</td>
<td>979</td>
<td>12,712</td>
</tr>
<tr>
<td>Transfers for acquisition: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Additions: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reversal of impairments: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revaluations: -</td>
<td>2,996</td>
<td>-</td>
<td>2,996</td>
</tr>
<tr>
<td>Reclassifications: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers to / from assets held for sale: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disposals / derecognition: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gross cost at 31 March 2018: 263</td>
<td>14,466</td>
<td>979</td>
<td>15,708</td>
</tr>
<tr>
<td>Amortisation at 1 April 2017 - brought forward: 263</td>
<td>6,823</td>
<td>283</td>
<td>7,169</td>
</tr>
<tr>
<td>Transfers by absorption: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provided during the year: -</td>
<td>2,103</td>
<td>-</td>
<td>2,103</td>
</tr>
<tr>
<td>Impairments: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reversals of impairments: -</td>
<td>-</td>
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<td>-</td>
</tr>
<tr>
<td>Revaluations: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reclassifications: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers to / from assets held for sale: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disposals / derecognition: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Amortisation at 31 March 2018: 263</td>
<td>8,726</td>
<td>283</td>
<td>9,272</td>
</tr>
<tr>
<td>Net book value at 31 March 2018: 263</td>
<td>5,740</td>
<td>696</td>
<td>6,436</td>
</tr>
<tr>
<td>Net book value at 1 April 2017: 263</td>
<td>4,847</td>
<td>696</td>
<td>5,543</td>
</tr>
</tbody>
</table>

15.2 INTANGIBLE ASSETS - 2016/17

<table>
<thead>
<tr>
<th>Licences &amp; Trademarks</th>
<th>Internally Generated Information Technology</th>
<th>Development Expenditure</th>
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</thead>
<tbody>
<tr>
<td>£000s</td>
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</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Valuation / gross cost at 1 April 2016 - as previously stated: 263</td>
<td>14,080</td>
<td>979</td>
<td>15,322</td>
</tr>
<tr>
<td>Transfers for acquisition: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Additions: -</td>
<td>596</td>
<td>-</td>
<td>596</td>
</tr>
<tr>
<td>Impairments: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
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</tr>
<tr>
<td>Revaluations: -</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reclassifications: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers to / from assets held for sale: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disposals / derecognition: (3,206)</td>
<td>-</td>
<td>-</td>
<td>(3,206)</td>
</tr>
<tr>
<td>Valuation / gross cost at 31 March 2017: 263</td>
<td>11,470</td>
<td>979</td>
<td>12,712</td>
</tr>
<tr>
<td>Amortisation at 1 April 2016 - as previously stated: 263</td>
<td>8,102</td>
<td>-</td>
<td>8,102</td>
</tr>
<tr>
<td>Transfers by absorption: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provided during the year: -</td>
<td>1,727</td>
<td>283</td>
<td>2,010</td>
</tr>
<tr>
<td>Impairments: -</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
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<td>-</td>
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<td>696</td>
<td>5,543</td>
</tr>
</tbody>
</table>
### 16.1 Property, Plant and Equipment - 2017/18

<table>
<thead>
<tr>
<th></th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction &amp; Payments on account</th>
<th>Plant &amp; machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
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</tr>
</tbody>
</table>

**Valuation/gross cost at 1 April 2017 - brought forward**

31,470 213,915 9,782 10,129 77,668 - 22,447 4,293 369,705

- Transfers by absorption
- Additions
- Impairments
- Reversals of impairments
- Additions to assets held for sale
- Disposals/degrections
- **Valuation/gross cost at 31 March 2018**

32,320 232,439 9,782 6,434 36,386 - 24,019 6,443 316,706

- Transfers by absorption
- Provided during the year
- Impairments
- Reversals of impairments
- Revaluations
- Transfers to/from assets held for sale
- Disposals/degrections
- Accumulated depreciation at 31 March 2018

3,320 9,772 - 2,240 181 11,948

- Accumulated depreciation at 1 April 2016

- NBV total at 31 March 2018

32,320 228,063 10 6,434 36,386 - 24,019 6,443 316,706

**Prior period adjustments**

- **Valuation/gross cost at 1 April 2016 - as previously stated**

30,620 236,939 9,782 4,060 101,326 57 32,996 4,975 420,755

- Prior period adjustments
- Transfers by absorption
- Additions
- Impairments
- Reversals of impairments
- Additions to assets held for sale
- Disposals/degrections
- **Valuation/gross cost at 31 March 2017**

31,470 210,596 10 10,129 31,774 - 10,173 2,019 296,171

- Accumulated depreciation at 1 April 2016 - as previously stated

3,320 9,772 - 2,240 181 11,948

- Accumulated depreciation at 31 March 2017

3,320 9,772 - 2,240 181 11,948

- NBV total at 31 March 2017

31,470 210,596 10 10,129 31,774 - 10,173 2,019 296,171

### 16.2 Property, Plant and Equipment - 2016/17

<table>
<thead>
<tr>
<th></th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction &amp; Payments on account</th>
<th>Plant &amp; machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
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<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

**Valuation/gross cost at 1 April 2016 - as previously stated**

30,620 236,939 9,782 4,060 101,326 57 32,996 4,975 420,755

- Prior period adjustments
- Transfers by absorption
- Additions
- Impairments
- Reversals of impairments
- Additions to assets held for sale
- Disposals/degrections
- **Valuation/gross cost at 31 March 2017**

31,470 210,596 10 10,129 31,774 - 10,173 2,019 296,171

- Accumulated depreciation at 1 April 2016 - as previously stated

3,320 9,772 - 2,240 181 11,948

- Accumulated depreciation at 31 March 2017

3,320 9,772 - 2,240 181 11,948

- NBV total at 31 March 2017

31,470 210,596 10 10,129 31,774 - 10,173 2,019 296,171

### 16.3 Property, Plant and Equipment Financing - 2017/18

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction &amp; Payments on account</th>
<th>Plant &amp; machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
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<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

**Net book value at 31 March 2018**

- Owned - government granted
- Owned - donated
- Finance leased
- On-SoFP PFI contracts and other service concession arrangements
- PFI residual interests
- On-SOFP PFI residual interests
- NBV total at 31 March 2018

32,320 228,063 10 6,434 36,386 - 24,019 6,443 316,706

**Net book value at 31 March 2017**

- Owned - government granted
- Owned - donated
- Finance leased
- On-SoFP PFI contracts and other service concession arrangements
- PFI residual interests
- On-SOFP PFI residual interests
- NBV total at 31 March 2017

31,470 210,596 10 10,129 31,774 - 10,173 2,019 296,171

### 16.4 Property, Plant and Equipment Financing - 2016/17

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction &amp; Payments on account</th>
<th>Plant &amp; machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

**Net book value at 31 March 2017**

- Owned - government granted
- Owned - donated
- Finance leased
- On-SoFP PFI contracts and other service concession arrangements
- PFI residual interests
- On-SOFP PFI residual interests
- NBV total at 31 March 2017

31,470 210,596 10 10,129 31,774 - 10,173 2,019 296,171

### 17 Donations of Property, Plant and Equipment

The following are the details of Assets received through donations through the Trust's Charities.

There are no restrictions imposed in the use of these assets:

- **£’000s**

  - Documentation System USB 300 & accessories: 15
  - Softare Intensive care chair & cushions: 7
  - Bladder Scan & Mobile cart: 7
  - 22" Touchscreen Pcs & 10" tablets: 32
  - Cube Birthing Couch: 7
18 REVALUATIONS OF PROPERTY, PLANT AND EQUIPMENT

Professional revaluations of Land and Buildings are normally undertaken at least once in every five year period (last undertaken in 2017) and are normally revalued annually by professional valuers, using indices. In view of property price changes in the London region, Land and Buildings were revalued as at 1st April 2017 by Cushman & Wakefield (professional valuers and RICS accredited).

The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal & Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- land and non-specialised buildings – market value for existing use; and
- specialised buildings – depreciated replacement cost (DRC).

The property valuations are carried out primarily on the basis of DRC for specialised operational property (e.g. NHS patient treatment facilities) and Existing Use Value (EUV) for non-specialised operational property. The value of land for existing use purposes is assessed at EUV. For non-operational land including surplus land, the valuations are carried out at Market Value.

The Department of Health has adopted the Modern Equivalent Asset (MEA) approach for its DRC valuations rather than the previous identical replacement method. The MEA approach used to value the property will normally be based on the cost of a modern equivalent asset that has the same service potential as the existing asset and then adjusted to take account of obsolescence.

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

Gains arising from indexation and revaluation are taken to the revaluation reserve, except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there.

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

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

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

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

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

In 2017-18, in line with Trust policy of valuation based on modern equivalent assets, and reflecting representations from the NHS Improvement, the Trust’s sites were valued by applying the MEA on an alternate site basis. This approach is consistent with HM Treasury and the Royal Institute of Chartered Surveyors (RICS) guidance, and does not represent a change in accounting policy.

19.1 INVESTMENT PROPERTY

<table>
<thead>
<tr>
<th>Category</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings (non dwelling)</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Furniture and Fixtures</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Information Technology</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Plant and Machinery</td>
<td>15</td>
<td>70</td>
</tr>
</tbody>
</table>

19.2 INVESTMENT PROPERTY INCOME AND EXPENSES

<table>
<thead>
<tr>
<th>Category</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct operating expense arising from investment property which generated rental income in the period</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Direct operating expense arising from investment property which did not generate rental income in the period</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total investment property expenses</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investment property income</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

20 INVESTMENTS IN ASSOCIATES AND JOINT VENTURES

<table>
<thead>
<tr>
<th>Category</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrying value at 31 March</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
21 OTHER INVESTMENTS / FINANCIAL ASSETS (NON-CURRENT) 2017/18 2016/17 £000 £000

Carrying value at 1 April - brought forward - -
Prior period adjustments - -
Carrying value at 1 April - restated - -
Transfers by absorption - -
Acquisitions in year - -
Movement in fair value - -
Net impairment - -
Reversal of impairment - -
Transfers to / from assets held for sale and assets in disposal groups - -
Amortisation at the effective interest rate (assets held at amortised cost only where applicable) - -
Current portion of loans receivable transferred to current financial assets - -
Disposals - -
Carrying value at 31 March - -

21.1 OTHER INVESTMENTS / FINANCIAL ASSETS (CURRENT) 31 March 31 March 2017/18 2016/17 £000 £000

Loans receivable within 12 months transferred from non-current financial assets - -
NLF deposits (where not considered to be cash equivalents) - -
Other current financial assets - -
Total current investments / financial assets - -

22 DISCLOSURE OF INTERESTS IN OTHER ENTITIES
The Trust operates a Charity whose details are below.

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

23 INVENTORIES 31 March 31 March 2018 2017 £000 £000

Drugs 3,192 3,843
Work in progress - -
Consumables 13,588 14,116
Energy 115 110
Other - -
Total inventories 16,895 18,069

of which:
Held at fair value less costs to sell - -

Inventories recognised in expenses for the year were £76,328k (2016/17: £70,740k).
Write-down of inventories recognised as expenses for the year were £6k (2016/17: £0k).

24.1 TRADE RECEIVABLES AND OTHER RECEIVABLES 31 March 31 March 2018 2017 £000 £000

Current
Trade receivables 52,168 40,840
Capital receivables (including accrued capital related income) - -
Accrued income - -
Provision for impaired receivables (104,405) (3,223)
Deposits and advances - -
Prepayments (non-PFI) 6,974 4,441
PFI prepayments - capital contributions 868 -
PFI lifecycle prepayments - 1,986
Interest receivable - -
Finance lease receivables - -
PDC dividend receivable - -
VAT receivable 1,189 1,284
Corporation and other taxes receivable - -
Other receivables 1,986 1,961
Total current trade and other receivables 52,780 47,565

Non-current
Trade receivables - -
Capital receivables (including accrued capital related income) - -
Accrued income - -
Provision for impaired receivables - -
Deposits and advances - -
Prepayments (non-PFI) 16 -
PFI prepayments - capital contributions - -
PFI lifecycle prepayments 684 139
Interest receivable - -
Finance lease receivables - -
VAT receivable - -
Corporation and other taxes receivable - -
Other receivables 3,799 4,391
Total non-current trade and other receivables 4,499 4,530

Of which receivables from NHS and DHSC group bodies:
Current 39,858 28,851
Non-current - -

24.2 PROVISION FOR IMPAIRMENT OF RECEIVABLES 2017/18 2016/17 £000 £000

At 1 April as previously stated 3,223 2,995
Prior period adjustments - -
At 1 April - restated 3,223 2,995
Transfers by absorption - -
Increase in provision 8,508 163
Amounts utilised (1,326) -
Unused amounts reversed - 65
At 31 March - -

The Trust used the rate of collection of debts and applied a provision equal to the rate of non collection, particularly for overseas debt at 80%.
24.3 Provision for impairment of receivables

### Ageing of impaired financial assets

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trade and other financial assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>0-30 days</td>
<td>312</td>
<td>-</td>
</tr>
<tr>
<td>30-60 days</td>
<td>93</td>
<td>-</td>
</tr>
<tr>
<td>60-90 days</td>
<td>119</td>
<td>-</td>
</tr>
<tr>
<td>90-180 days</td>
<td>500</td>
<td>-</td>
</tr>
<tr>
<td>Over 180 days</td>
<td>9,198</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10,405</td>
<td>-</td>
</tr>
</tbody>
</table>

### Ageing of non-impaired financial assets past their due date

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trade and other financial assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>0-30 days</td>
<td>16,628</td>
<td>26,586</td>
</tr>
<tr>
<td>30-60 days</td>
<td>10,818</td>
<td>-</td>
</tr>
<tr>
<td>60-90 days</td>
<td>998</td>
<td>-</td>
</tr>
<tr>
<td>90-180 days</td>
<td>867</td>
<td>-</td>
</tr>
<tr>
<td>Over 180 days</td>
<td>4,977</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>34,288</td>
<td>-</td>
</tr>
</tbody>
</table>

A significant proportion of the impaired balances relate to overseas debt which are not credit worthy as difficult to collect and needs the use of an external debt collection agency to locate debtors and collect, and sometimes a court action.

25 Other assets

### Current

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>EU emissions trading scheme allowance</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Short term WH finance lease asset</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total other current assets</strong></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Non-current

- Net defined benefit pension scheme asset
- Other assets
- **Total other non-current assets**

26 Non-current assets held for sale and assets in disposal groups

### NBV of non-current assets for sale and assets in disposal groups at 1 April

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>NBV of non-current assets for sale and assets in disposal groups at 1 April</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NBV of non-current assets for sale and assets in disposal groups at 1 April - restated</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by absorption</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assets classified as available for sale in the year</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>Assets sold in year</td>
<td>300</td>
<td>-</td>
</tr>
<tr>
<td>Impairment of assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reversal of impairment of assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assets no longer classified as held for sale, for reasons other than disposal by sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>NBV of non-current assets for sale and assets in disposal groups at 31 March</strong></td>
<td>24</td>
<td>54</td>
</tr>
</tbody>
</table>

26.1 Liabilities in disposal groups

### Categorised as:

- Provisions
- Trade and other payables
- Other
- **Total**

27.1 Cash and Cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

### 31 March 2018 31 March 2017

- Non-current assets held for sale and assets in disposal groups
- Third party assets held by the trust

27.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.
### 28.1 TRADE AND OTHER PAYABLES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade payables</td>
<td>36,963</td>
<td>33,112</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital payables</td>
<td>3,091</td>
<td>3,331</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accruals</td>
<td>7,303</td>
<td>5,698</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipts in advance (including payments on account)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social security costs</td>
<td>4,006</td>
<td>3,738</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAT payables</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other taxes payable</td>
<td>3,694</td>
<td>3,453</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI dividend payable</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accrued interest on loans</td>
<td>634</td>
<td>193</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other payables</td>
<td>4,337</td>
<td>3,976</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total current trade and other payables</strong></td>
<td><strong>60,028</strong></td>
<td><strong>53,501</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade payables</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital payables</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accruals</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipts in advance (including payments on account)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAT payables</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other taxes payable</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other payables</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total non-current trade and other payables</strong></td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Of which payables from NHS and DHSC group bodies:**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade payables</td>
<td>10,982</td>
<td>8,283</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 28.2 EARLY RETIREMENTS IN NHS PAYABLES ABOVE

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To buy out the liability for early retirements over 5 years</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of cases involved</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outstanding pension contributions</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td></td>
<td>4,122</td>
</tr>
</tbody>
</table>

### 29 OTHER FINANCIAL LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derivatives held at fair value through income and expenditure</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 30 OTHER LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred income</td>
<td>5,251</td>
<td>4,152</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred grants</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI deferred income / credits</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lease incentives</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total other current liabilities</strong></td>
<td><strong>5,251</strong></td>
<td><strong>4,152</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred income</td>
<td>3,638</td>
<td>3,851</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred grants</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI deferred income / credits</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lease incentives</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net pension scheme liability</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total other non-current liabilities</strong></td>
<td><strong>3,638</strong></td>
<td><strong>3,851</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 31 BORROWINGS

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank overdrafts</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drawdown in committed facility</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans from the Department of Health and Social Care</td>
<td>29,072</td>
<td>976</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other loans</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI lifecycle replacement received in advance</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)</td>
<td>7,870</td>
<td>8,271</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total current borrowings</strong></td>
<td><strong>36,942</strong></td>
<td><strong>35,424</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans from the Department of Health and Social Care</td>
<td>88,363</td>
<td>71,248</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other loans</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI lifecycle replacement received in advance</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obligations under PFI, LIFT or other service concession contracts</td>
<td>239,346</td>
<td>237,038</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total non-current borrowings</strong></td>
<td><strong>327,709</strong></td>
<td><strong>308,286</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
32. FINANCIAL INSTRUMENTS

Trust as a lessor
Future lease receipts due under finance lease agreements where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessor:

<table>
<thead>
<tr>
<th>31 March</th>
<th>31 March</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>2017</td>
</tr>
</tbody>
</table>

Gross lease receivables
of which those receivable:
- not later than one year;
- later than one year and not later than five years;
- later than five years;
- Unearned interest income;
- Allowance for uncollectible lease payments:

Net lease receivables
of which those receivable:
- not later than one year;
- later than one year and not later than five years;
- later than five years;

Trust as a lessee
Obligations under finance leases where Barking, Havering and Redbridge University Hospitals NHS Trust is the lessee:

<table>
<thead>
<tr>
<th>31 March</th>
<th>31 March</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>2017</td>
</tr>
</tbody>
</table>

Gross lease liabilities
of which liabilities are due:
- not later than one year;
- later than one year and not later than five years;
- later than five years;
Finance charges allocated to future periods:

Net lease liabilities
of which payable:
- not later than one year;
- later than one year and not later than five years;
- later than five years;

Total of future minimum sublease payments to be received at the reporting date:

Contingent rents recognised as an expense in the period:

At 31 March 2018, £438,925k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barking, Havering and Redbridge University Hospitals NHS Trust (31 March 2017: £360,540k).

33.2 CLINICAL NEGLIGENCE LIABILITIES
At 31 March 2018, £438,925k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barking, Havering and Redbridge University Hospitals NHS Trust (31 March 2017: £360,540k).

34. CONTINGENT ASSETS AND LIABILITIES

Value of contingent liabilities
NHS Resolution legal claims:
Employment tribunal and other employee related litigation:
Redundancy:
Other:
Gross value of contingent liabilities:
Amounts recoverable against liabilities:
Net value of contingent liabilities:
Net value of contingent assets:

35. CONTRACTUAL CAPITAL COMMITMENTS

<table>
<thead>
<tr>
<th>31 March</th>
<th>31 March</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>2017</td>
</tr>
</tbody>
</table>

Property, plant and equipment:
Intangible assets:
Total:

36. OTHER FINANCIAL COMMITMENTS
The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

37. DEFINED BENEFIT PENSION SCHEMES
Not Applicable
37.1 CHANGES IN THE DEFINED BENEFIT OBLIGATION AND FAIR VALUE OF PLAN ASSETS DURING THE YEAR

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present value of the defined benefit obligation at 1 April</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Present value of the defined benefit obligation at 1 April - restated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by absorption</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Current service cost</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest cost</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Curtailment by plan participants</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Remeasurement of the net defined benefit (liability)/asset:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Actuarial gain/(losses)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Past service costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total net (charge) / gain recognised in SOCI</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

37.2 RECONCILIATION OF THE PRESENT VALUE OF THE DEFINED BENEFIT OBLIGATION AND THE PRESENT VALUE OF THE PLAN ASSETS TO THE ASSETS AND LIABILITIES RECOGNISED IN THE BALANCE SHEET

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present value of the defined benefit obligation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Plan assets at fair value</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fair value of plan assets at 1 April - restated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by normal absorption</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Remeasurement of the net defined benefit (liability)/asset:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Actuarial gain/(losses)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Changes in the effect of limiting a net defined benefit asset to the asset ceiling</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contributions by the plan participants</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Business combinations</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Settlements</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Plan assets at fair value at 31 March</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Plan surplus/(deficit) at 31 March</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

37.3 AMOUNTS RECOGNISED IN THE SOCI

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current service cost</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest expense / income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Past service cost</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Losses on curtailment and settlement</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total net (charge) / gain recognised in SOCI</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

38.1 IMPUTED FINANCE LEASE OBLIGATIONS

Barking, Havering and Redbridge University Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total on-SoFP PFI, LIFT and other service concession arrangement commitments</td>
<td>4,205,688</td>
<td>4,277,216</td>
</tr>
<tr>
<td>Of which liabilities are due:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>60,952</td>
<td>58,592</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>243,808</td>
<td>234,388</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>3,900,928</td>
<td>3,984,256</td>
</tr>
</tbody>
</table>

38.2 TOTAL ON-SOFP PFI, LIFT AND OTHER SERVICE CONCESSION ARRANGEMENT COMMITMENTS

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total future payments committed in respect of the PFI, LIFT or other service concession arrangements</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Of which liabilities are due:</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- not later than one year;</td>
<td>60,952</td>
<td>58,592</td>
</tr>
<tr>
<td>- later than one year and not later than five years;</td>
<td>243,808</td>
<td>234,388</td>
</tr>
<tr>
<td>- later than five years.</td>
<td>3,900,928</td>
<td>3,984,256</td>
</tr>
</tbody>
</table>
38.3 ANALYSIS OF AMOUNTS PAYABLE TO SERVICE CONCESSION OPERATOR

This note provides an analysis of the trust’s payments in 2017/18:

<table>
<thead>
<tr>
<th>Description</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unitary payment payable to service concession operator</td>
<td>£60,952</td>
<td>£58,592</td>
</tr>
</tbody>
</table>

Consisting of:

- Interest charge | £18,981 | £17,942 |
- Repayment of finance lease liability | £8,373 | £8,462 |
- Service element and other charges to operating expenditure | £22,828 | £22,945 |
- Capital lease maintenance | £1,638 | £2,294 |
- Revenue lease maintenance | - | - |
- Contingent rent | £7,913 | £6,449 |
- Addition to lifecycle prepayment | £122 | £104 |

Total amount paid to service concession operator: £61,074 | £58,696 |

39 OFF-SOFP PFI, LIFT AND OTHER SERVICE CONCESSION ARRANGEMENTS

Barking, Havering and Redbridge University Hospitals NHS Trust incurred the following charges in respect of off-statement of Financial Position PFI and LIFT obligations:

<table>
<thead>
<tr>
<th>Description</th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other receivables excluding non-current</td>
<td>£47,203</td>
<td>£41,725</td>
</tr>
<tr>
<td>Net loans and receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Commitments in respect of off-SOFP PFI, LIFT or other service concession arrangements:</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
- Not later than one year | - | - |
- Later than one year and not later than five years | - | - |
- Later than five years | - | - |
| Total | - | - |

40 FINANCIAL INSTRUMENTS

40.1 FINANCIAL RISK MANAGEMENT

Financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

40.2 CARRYING VALUES OF FINANCIAL ASSETS

**Loans and receivables**

<table>
<thead>
<tr>
<th>Description</th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other receivables excluding non-current</td>
<td>£47,203</td>
<td>£41,725</td>
</tr>
<tr>
<td>Net loans and receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Commitments in respect of off-SOFP PFI, LIFT or other service concession arrangements:</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
- Not later than one year | - | - |
- Later than one year and not later than five years | - | - |
- Later than five years | - | - |
| Total | - | - |

**Assets as per SoP as at 31 March 2017**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loans and receivables</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables excluding non-current</td>
<td>£47,203</td>
<td>-</td>
<td>-</td>
<td>£47,203</td>
</tr>
<tr>
<td>Net loans and receivables</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Commitments in respect of off-SOFP PFI, LIFT or other service concession arrangements:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
- Not later than one year | - | - | - | - |
- Later than one year and not later than five years | - | - | - | - |
- Later than five years | - | - | - | - |
| Total | - | - | - | - |

Currency risk

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

Interest rate risk

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

Credit risk

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

Liquidity risk

The Trust’s operating costs are incurred under contracts with commissioners of healthcare (CCGs/ NHS England), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.
### 40.3 CARRYING VALUE OF FINANCIAL LIABILITIES

<table>
<thead>
<tr>
<th>Liabilities as per SoFP as at 31 March 2018</th>
<th>Total book value</th>
<th>Total book value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borrowings excluding finance lease and PFI liabilities</td>
<td>£117,435</td>
<td>£117,435</td>
</tr>
<tr>
<td>Obligations under finance leases</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Obligations under PFI, LIFT and other service concession contracts</td>
<td>£247,216</td>
<td>£247,216</td>
</tr>
<tr>
<td>Trade and other payables excluding non financial liabilities</td>
<td>£58,548</td>
<td>£58,548</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31 March 2018</strong></td>
<td><strong>£424,200</strong></td>
<td><strong>£424,200</strong></td>
</tr>
</tbody>
</table>

### 40.4 FAIR VALUES OF FINANCIAL ASSETS AND LIABILITIES

### 40.5 MATURITY OF FINANCIAL LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>In one year or less</td>
<td>£101,643</td>
<td>£70,749</td>
</tr>
<tr>
<td>In more than one year but not more than two years</td>
<td>£85,968</td>
<td>£29,302</td>
</tr>
<tr>
<td>In more than two years but not more than five years</td>
<td>£50,829</td>
<td>£47,668</td>
</tr>
<tr>
<td>In more than five years</td>
<td>£204,960</td>
<td>£222,694</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£424,200</strong></td>
<td><strong>£371,033</strong></td>
</tr>
</tbody>
</table>

### 41 LOSSES AND SPECIAL PAYMENTS

<table>
<thead>
<tr>
<th></th>
<th>Total number of cases</th>
<th>Total value of cases</th>
<th>Total number of cases</th>
<th>Total value of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Losses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash losses</td>
<td>67</td>
<td>£61,000</td>
<td>10</td>
<td>£9,000</td>
</tr>
<tr>
<td>Fruitless payments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bad debts and claims abandoned</td>
<td>-</td>
<td>-</td>
<td>100</td>
<td>£135,000</td>
</tr>
<tr>
<td>Stores losses and damage to property</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total losses</strong></td>
<td>67</td>
<td>£70,000</td>
<td>10</td>
<td>£144,000</td>
</tr>
<tr>
<td><strong>Special payments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation under court order or legally binding arbitration award</td>
<td>9</td>
<td>£17,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Extra-contractual payments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ex-gratia payments</td>
<td>16</td>
<td>£6,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Special severance payments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Extra-statutory and extra-regulatory payments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total special payments</strong></td>
<td>25</td>
<td>£23,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total losses and special payments</strong></td>
<td><strong>92</strong></td>
<td><strong>£93,000</strong></td>
<td><strong>26</strong></td>
<td><strong>£144,000</strong></td>
</tr>
</tbody>
</table>

### 42 GIFTS

The value of any gifts received did not exceed £300,000

<table>
<thead>
<tr>
<th></th>
<th>Total number of cases</th>
<th>Total value of cases</th>
<th>Total number of cases</th>
<th>Total value of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total gifts</strong></td>
<td>4</td>
<td>£1,000</td>
<td>7</td>
<td>£1,000</td>
</tr>
</tbody>
</table>
43 RELATED PARTIES
Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Payments to Related Party £’000s</th>
<th>Receipts from Related Party £’000s</th>
<th>Amounts owed to Related Party £’000s</th>
<th>Amounts due from Related Party £’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Collins - Acting Director of Finance (Trisett Ltd)</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chris Bown - Interim Chief Executive (Trisett and Capita Executive Recruitment)</td>
<td>-</td>
<td>-</td>
<td>71</td>
</tr>
<tr>
<td>Anne Robson - Interim Director of People &amp; Organisation Development (Wise Move Consulting Ltd)</td>
<td>64</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Anne Robson - Interim Director of People &amp; Organisation Development (interim Ltd)</td>
<td>21</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Amounts Due Related from Party £’000s</th>
<th>Amounts Due Related to Party £’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Collins - Acting Director of Finance (Trisett Ltd)</td>
<td>3</td>
</tr>
<tr>
<td>Chris Bown - Interim Chief Executive (Trisett and Capita Executive Recruitment)</td>
<td>71</td>
</tr>
<tr>
<td>Anne Robson - Interim Director of People &amp; Organisation Development (Wise Move Consulting Ltd)</td>
<td>64</td>
</tr>
<tr>
<td>Anne Robson - Interim Director of People &amp; Organisation Development (interim Ltd)</td>
<td>21</td>
</tr>
</tbody>
</table>

The Department of Health is regarded as a related party. During the year Barking, Havering & Redbridge University Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are:

- Barking and Dagenham CCG, Havering CCG and Redbridge CCG*
- Barking and Brentwood CCG
- Barts Health NHS Trust
- Health Education England
- Homerton University Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- NHS Blood and Transplant (NHSBT)
- NHS England
- NHS Property Services Limited
- North East London NHS Foundation Trust
- North Middlesex University Hospitals NHS Trust
- St George’s University Hospitals NHS Foundation Trust
- University College London NHS Foundation Trust (UCL)

*Barking and Dagenham CCG, Havering CCG and Redbridge CCG commission services jointly for the Trust. Therefore we have disclosed the aggregate position of our transactions with the three CCGs.

44 TRANSFERS BY ABSORPTION
There has been no transfers by absorption in the year where the trust has been either the receiving or divesting party.

45 PRIOR PERIOD ADJUSTMENTS
There has been no prior period adjustments in the current year.

46 EVENTS AFTER THE REPORTING DATE
There are no reportable events after the end of the reporting period, up to date of submitting these accounts.

47 FINAL PERIOD OF OPERATION AS A TRUST OF NHS HEALTHCARE
Not applicable.

48 BETTER PAYMENT PRACTICE CODE

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2017/18</th>
<th>2016/17</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid in the year</td>
<td>80,645</td>
<td>254,207</td>
<td>84,933</td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid within target</td>
<td>12,611</td>
<td>139,991</td>
<td>21,599</td>
</tr>
<tr>
<td>Percentage of non-NHS trade invoices paid within target</td>
<td>15.64%</td>
<td>55.07%</td>
<td>25.43%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>3,637</td>
<td>11,232</td>
<td>1,809</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>3,399</td>
<td>1,480</td>
<td>639</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>93.2%</td>
<td>13.18%</td>
<td>35.42%</td>
</tr>
</tbody>
</table>
| The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

49 EXTERNAL FINANCING

The trust is given an external financing limit against which it is not permitted to overspend:

<table>
<thead>
<tr>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cash flow financing</td>
<td>39,093</td>
</tr>
<tr>
<td>Finance leases taken out in year</td>
<td></td>
</tr>
<tr>
<td>Other capital receipts</td>
<td></td>
</tr>
<tr>
<td>External financing requirement</td>
<td>39,093</td>
</tr>
<tr>
<td>External financing limit (EFL)</td>
<td>39,646</td>
</tr>
<tr>
<td>Under / (over) spend against EFL</td>
<td>553</td>
</tr>
</tbody>
</table>

Barking, Havering and Redbridge University Hospitals NHS Trust
50  CAPITAL RESOURCE LIMIT

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross capital expenditure</td>
<td>21,414</td>
<td>17,628</td>
</tr>
<tr>
<td>Less: Disposals</td>
<td>75</td>
<td>108</td>
</tr>
<tr>
<td>Less: Donated and granted capital additions</td>
<td>561</td>
<td>760</td>
</tr>
<tr>
<td>Plus: Loss on disposal of donated/granted assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Change against Capital Resource limit</td>
<td>21,280</td>
<td>17,458</td>
</tr>
<tr>
<td>Capital Resource Limit</td>
<td>22,199</td>
<td>18,320</td>
</tr>
<tr>
<td>Under / (over) spend against CRL</td>
<td>639</td>
<td>562</td>
</tr>
</tbody>
</table>

51  BREAKEVEN DUTY FINANCIAL PERFORMANCE

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Adjusted financial performance surplus / (deficit) (control total basis)</td>
<td>(48,977)</td>
</tr>
<tr>
<td>Remove impairments scoring to Departmental Expenditure Limit</td>
<td>-</td>
</tr>
<tr>
<td>Add back income for impact of 2016/17 post-accounts STF reallocation</td>
<td>-</td>
</tr>
<tr>
<td>Add back non-cash element of On-staff pension scheme charges</td>
<td>-</td>
</tr>
<tr>
<td>IRC 12 breakeven adjustment</td>
<td>-</td>
</tr>
<tr>
<td>Breakeven duty financial performance surplus / (deficit)</td>
<td>(48,977)</td>
</tr>
</tbody>
</table>

52  BREAKEVEN DUTY ROLLING ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Breakeven duty in-year financial performance</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
<td>11,281,780</td>
</tr>
<tr>
<td>% change from previous year</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
<td>7.84%</td>
</tr>
</tbody>
</table>

53  STAFF COSTS

<table>
<thead>
<tr>
<th></th>
<th>Permanent £’000s</th>
<th>Other £’000s</th>
<th>Total £’000s</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>245,711</td>
<td>30,400</td>
<td>276,111</td>
<td>275,706</td>
<td>258,414</td>
</tr>
<tr>
<td>Social security costs</td>
<td>27,516</td>
<td>1,500</td>
<td>29,016</td>
<td>28,521</td>
<td>26,744</td>
</tr>
<tr>
<td>Apprenticeship levy</td>
<td>1,342</td>
<td>-</td>
<td>1,342</td>
<td>1,342</td>
<td>1,342</td>
</tr>
<tr>
<td>Employer's contributions to NHS pensions</td>
<td>20,492</td>
<td>766</td>
<td>21,258</td>
<td>30,246</td>
<td>29,358</td>
</tr>
<tr>
<td>Pension cost – other</td>
<td>-</td>
<td>271</td>
<td>271</td>
<td>271</td>
<td>271</td>
</tr>
<tr>
<td>Other post employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Temporary staff</td>
<td>-</td>
<td>33,323</td>
<td>33,323</td>
<td>34,362</td>
<td>34,362</td>
</tr>
<tr>
<td>Total gross staff costs</td>
<td>304,002</td>
<td>66,161</td>
<td>370,163</td>
<td>358,876</td>
<td>358,876</td>
</tr>
<tr>
<td>Recoveries in respect of seconded staff</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total staff costs</td>
<td>304,002</td>
<td>66,161</td>
<td>370,163</td>
<td>358,876</td>
<td>358,876</td>
</tr>
<tr>
<td>% of operating income</td>
<td>-28.2%</td>
<td>-29.6%</td>
<td>-30.8%</td>
<td>-31.3%</td>
<td>-31.3%</td>
</tr>
</tbody>
</table>

54  STAFF SICKNESS ABSENCE AND ILL-HEALTH RETIREMENTS

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1,064</td>
<td>1,064</td>
</tr>
<tr>
<td>% of total staff</td>
<td>0.36%</td>
<td>0.36%</td>
</tr>
</tbody>
</table>

55  STAFF SICKNESS ABSENCE AND ILL-HEALTH RETIREMENTS

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1,064</td>
<td>1,064</td>
</tr>
<tr>
<td>% of total staff</td>
<td>0.36%</td>
<td>0.36%</td>
</tr>
<tr>
<td>Number of employees (WTE) engaged on capital projects</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

56  STAFF SICKNESS ABSENCE AND ILL-HEALTH RETIREMENTS

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total working Days Lost**</td>
<td>46,114</td>
<td>49,075</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>5,694</td>
<td>5,771</td>
</tr>
<tr>
<td>Average working Days Lost per member of staff</td>
<td>7.84</td>
<td>8.49</td>
</tr>
</tbody>
</table>

*Based on the 2017 calendar year, the DH consider these figures to be a reasonable proxy for financial year equivalents.
### Reporting of Compensation Schemes - Exit Packages 2017/18

<table>
<thead>
<tr>
<th>Exit package cost band (including any special payment element)</th>
<th>Number of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Total number of exit packages</th>
</tr>
</thead>
<tbody>
<tr>
<td>£10,000 - £25,000</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>£50,001 - £100,000</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>£100,001 - £150,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£150,001 - £200,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>&gt;£200,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total number of exit packages by type</strong></td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total resource cost (£)</strong></td>
<td>£20,000</td>
<td>£150,000</td>
<td>£170,000</td>
</tr>
</tbody>
</table>

### Reporting of Compensation Schemes - Exit Packages 2016/17

<table>
<thead>
<tr>
<th>Exit package cost band (including any special payment element)</th>
<th>Number of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Total number of exit packages</th>
</tr>
</thead>
<tbody>
<tr>
<td>£10,000 - £25,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£50,001 - £100,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£100,001 - £150,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>£150,001 - £200,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>&gt;£200,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total number of exit packages by type</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total resource cost (£)</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Exit Packages: Other (Non-Compulsory) Departure Payments

<table>
<thead>
<tr>
<th>Payments agreed</th>
<th>2017/18</th>
<th>Total value of agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary redundancies including early retirement contractual costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mutually agreed resignations (MARS) contractual costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Early retirements in the efficiency of the service contractual costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Exit payments following Employment Tribunals or court orders</td>
<td>3</td>
<td>135</td>
</tr>
<tr>
<td>Non-contractual payments requiring HMT approval</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payments agreed</th>
<th>2016/17</th>
<th>Total value of agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
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Goodmayes
Ilford IG3 8YB

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