Barking, Havering and Redbridge University Hospitals NHS Trust

ANNUAL REPORT AND ACCOUNTS 2015-16

PRIDE

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WELCOME

Dr Maureen Dalziel
Chair

A MESSAGE FROM OUR CHAIR

Welcome to our annual report for 2015/16, a year dedicated to sustaining and improving performance for our patients, set against the financial challenges of the NHS and increasing numbers of patients with complex needs.

Whilst we remain in special measures, we are making good progress and, thanks to the dedication of our staff, many reviews show we are improving care in our hospitals.

I am delighted the latest national survey shows our people are amongst the most motivated in the country. Despite the challenges, they are determined to raise standards for our patients and are supported by our patient partners, the volunteers who work with us to improve the experience of people using our services – their support is invaluable.

We have brought patient experience to the fore by appointing mystery shoppers and incorporating their findings into our improvement programmes. Working closely with our patient partners we will continue to drive forward the improvements that reflect and fulfil our patients' needs.

To support this, as part of transforming our services, we are working in partnership with the Virginia Mason Institute in Seattle and will adopt its methodology so our systems and processes become better than ever.
Our drive to improve the health of our local population and our staff has led to us being awarded the Healthy Workplace Charter. No Smoking Day was marked at both of our smoke-free hospital sites and following the success of our fresh fruit stall introduced at Queen's Hospital, we will introduce this at King George Hospital too. We will continue to work with local partners to improve healthcare across our communities.

The King George and Queen's Hospitals Charity has funded many projects this year and these will make a real difference to our patients, visitors and staff, including the refurbishment of outpatient areas and overnight facilities for families in our critical care departments. I am delighted that former Trust Chairman, George Wood, has taken over the reins as Chair of the charity.
I would like to personally thank the Board, the leadership and the staff for their commitment and hard work and I look forward to the year ahead.

SECTION ONE:

PERFORMANCE REPORT

Barking, Havering and Redbridge University Hospitals NHS Trust

OVERVIEW

A MESSAGE FROM OUR CHIEF EXECUTIVE

Matthew Hopkins
Chief Executive

I would like to thank all of our staff, volunteers and partners for their support and dedication this year. It is my second year as Chief Executive of the Trust, and I continue to be impressed by the commitment we share to provide outstanding care.

I am delighted that the Care Quality Commission (CQC) recognised the improvements we have made across our hospitals. Our improvement plan, Delivering our Potential, addresses the 35 'must do' actions the CQC set out. We have made great strides towards implementing these improvements and our patients have started to see the benefits. We publish a monthly progress report to share our achievements which you can read on our website and I look forward to welcoming the CQC back this year to see the changes that have been made, and our plans for the future.

We have met all our financial targets whilst continuing to invest in front-line services to improve patient care, and vital infrastructure like Trust-wide IT systems.

Our focus for next year will be to build on the solid foundations which have been laid, and to make further progress in the areas we know we need to improve in. We will be providing thousands of additional operations, tests and appointments so that people who have been waiting too long can receive treatment as quickly as possible. We will also be continuing our work in our Emergency Departments to ensure that people can be seen quickly and safely.

Many of these major programmes of improvement require changes both within our hospitals and across our local health economy and I would like to thank our health and social care partners who have worked alongside us this year. We share a single aim – to provide the best care to our community – and I look forward to the work which will take place in the coming year as we move towards that goal.

DELIVERING OUR OBJECTIVES

OUR 2015–16 OBJECTIVES

All of our staff and volunteers led the delivery of our corporate objectives for 2015-16 working closely with our local partners and patient representatives.

DELIVERING HIGH QUALITY CARE

- Improving emergency performance and care pathway
- Improving access performance
- Establishing a quality improvement programme, continuing to deliver our Improvement Plan

RUNNING OUR HOSPITALS EFFICIENTLY

- People – developing operational leadership and management
- Process – establishing robust administration systems
- Infrastructure – ensuring our buildings and equipment are fit for purpose

BECOMING AN EMPLOYER OF CHOICE

- Increasing our substantive workforce
- Ensuring good people stay
- Implementing our employee engagement strategy

MANAGING OUR FINANCES

- Developing robust budget management
- Improving the quality of clinical record keeping and clinical coding
- Implementing our Quality and Cost Improvement Programme

WORKING IN PARTNERSHIP

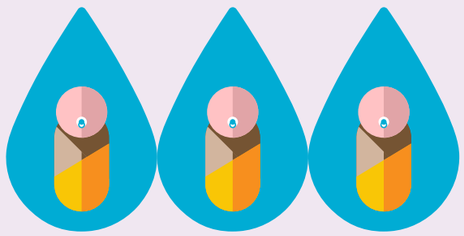
- Updating our clinical services strategy
- Developing services in line with strategy
- Improving stakeholder engagement

OUR HOSPITALS ARE HOME TO...

MATERNITY

8,300 BABIES A YEAR

OUR BIRTH CENTRE– 40% WATER BIRTHS



96% POSITIVE RECOMMENDATIONS

PAEDIATRICS

11,200 OUTPATIENTS EACH YEAR

6,500 PAEDIATRIC INPATIENTS A YEAR

BUSY NEONATAL UNIT LEVEL 2

274,000 ATTENDANCES A YEAR

EMERGENCY

180 AMBULANCES A DAY

55,500 EMERGENCY ADMISSIONS

26,000 INPATIENT OPERATIONS

PLANNED CARE

48,000 DAY CASE PROCEDURES

663,000 OUTPATIENT APPOINTMENTS

OUR YEAR IN PICTURES

APRIL

Our Health and Wellbeing department received the NHS Sport and Physical Activity Gold Award, recognising our commitment to providing varied and innovative activities for our staff.

MAY

The state-of-the-art Elm Breast Care Centre opened its doors at King George Hospital, creating a centre of excellence for breast care services.

JUNE

Almost 3,000 public signatures, collected by local group Havering Loves the NHS, were presented to our Chief Executive to thank staff for the life-saving work they do.

JULY

We were named as one of just five trusts in the country to benefit from a partnership with internationally renowned hospital the Virginia Mason Institute in Seattle.

AUGUST

A service which allows patients needing intravenous antibiotics to stay in their own homes rather than a hospital ward proved a hit.

SEPTEMBER

A knight in shining armour came to thank his own hero – consultant neurosurgeon Ian Low who had been treating him for several years.

OCTOBER

Around 100 delegates travelled from across the country to hear about the improvements we had made in waiting times in our emergency departments.

NOVEMBER

Our HIV service was named Clinic of the Year by sexual health charity NAZ.

DECEMBER

Amy Marren, who swam at the London Paralympic Games in 2012, delivered presents for children in hospital over the festive period.

JANUARY

The Pashley family paid a return visit to Queen's Hospital to thank our staff for saving the life of 16-year-old Matt after he collapsed on the football pitch.

FEBRUARY

A new scheme to make lunchtimes more social and enjoyable was launched – with Mealtime Assistants to support patients who need a little extra help.

MARCH

A national review showed that we were one of just 37 per cent of trusts to offer face-to-face palliative care seven days a week.

DELIVERING HIGH QUALITY CARE

PROVIDING EXCELLENT QUALITY CARE, OUTCOMES AND SAFETY

Our patients are at the heart of everything that we do, and delivering first-class care is our main priority. This year, working with our partners, our focus has been on delivering our refreshed Improvement Plan: Delivering our Potential, and ensuring we have the right processes in place to keep our patients safe. When the Care Quality Commission published its report in July this year, inspectors reported they had seen our staff delivering "compassionate and kind" care.

IMPROVING QUALITY AND SAFETY

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

This year we introduced a new expert quality and safety team to help our frontline staff to deliver high quality, safe care.

REPORTING AND LEARNING

Reporting events or actions that pose a risk or actual harm to our patients is critical to improving levels of safety.

We had not done well enough at reporting clinical incidents, but a major push over the last 12 months has seen us improve our position and bring us in line with other trusts.

When issues are reported, it is vital that we investigate quickly and then feed our findings back to staff so that we can learn and improve. At the start of the year we had a backlog of Serious Incidents that needed to be examined. That has now been reduced down to zero.

POLICE POUND THE HOSPITAL BEAT

We have teamed up with the Metropolitan Police to introduce a dedicated police officer at Queen's Hospital.

With more than 12,000 people at the hospital everyday, the site can be as busy as a small town.

PCSO Shirley Hibbs is now a permanent fixture, keeping our staff, patients and visitors safe and working alongside our own security team. Since she has been with us there has been a fall in crime such as thefts on site.

BREAST CARE SERVICES

A state-of-the-art breast care centre opened at King George Hospital this year.

We invested £0.5million in the centre, with patients involved at every stage – including picking the furnishings and artwork to create an airy and welcoming environment.

The unit has four consulting rooms, three ultrasound rooms, two mammography areas and counselling facilities, treating patients who have been referred by their GP for special assessment. With breast surgery already taking place at King George, we now have a centre of excellence for breast care under one roof.

END OF LIFE CARE

This year's national End of Life Care Review showed that we are providing one of the best services in the country to people nearing the end of their life.

We were above the national average in all five of the key clinical indicators and are one of just 37% of hospitals offering face-to-face palliative care to patients every day of the week.

We have made a raft of improvements to our end of life care and achieved Gold Standard Framework accreditation.

FALLS

There was a particular focus on preventing our elderly patients from falling this year, with a series of events to raise awareness of the issue.

Falls are a common problem among older people – approximately 1 in 3 over 65s will fall in a year, rising to 1 in 2 of those aged over 80. We carried out an audit which showed that a quarter of the over 75s in our Emergency Departments had come to hospital because they had had a fall – the single biggest reason for ED attendances in this age group.

A conference was held for frontline staff, with fantastic feedback from the 80 delegates who found the practical elements particularly helpful. This was followed by a strategic meeting for senior leaders across our health economy to agree a joined-up approach to the issue.

A Falls Awareness campaign was also held across both of our hospitals, promoting the message that patient safety is everyone's responsibility. The number of patients falling on our wards has dropped this year, and we are continuing to work with partners including Age UK to drive further improvements.

MATERNITY

Our maternity services continue to go from strength to strength, with more than 96 per cent of women who use them saying they would recommend them to family and friends.

This year more than 17 per cent of the babies born in our hospitals arrived in the midwife-led Queen's Birth Centre, which has one of the highest water birth rates in the country.

We are now working towards achieving Baby Friendly accreditation - a proven way of increasing breastfeeding rates and ensuring that our staff can give mothers all the support, information and encouragement they need.

INFECTION PREVENTION AND CONTROL

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

We have not achieved the targets we set ourselves last year, so there will be a specific focus on infection prevention and control this year.

We are reviewing and improving our decontamination processes, rolling out training programmes, and supporting Infection Control Champions throughout our hospitals.

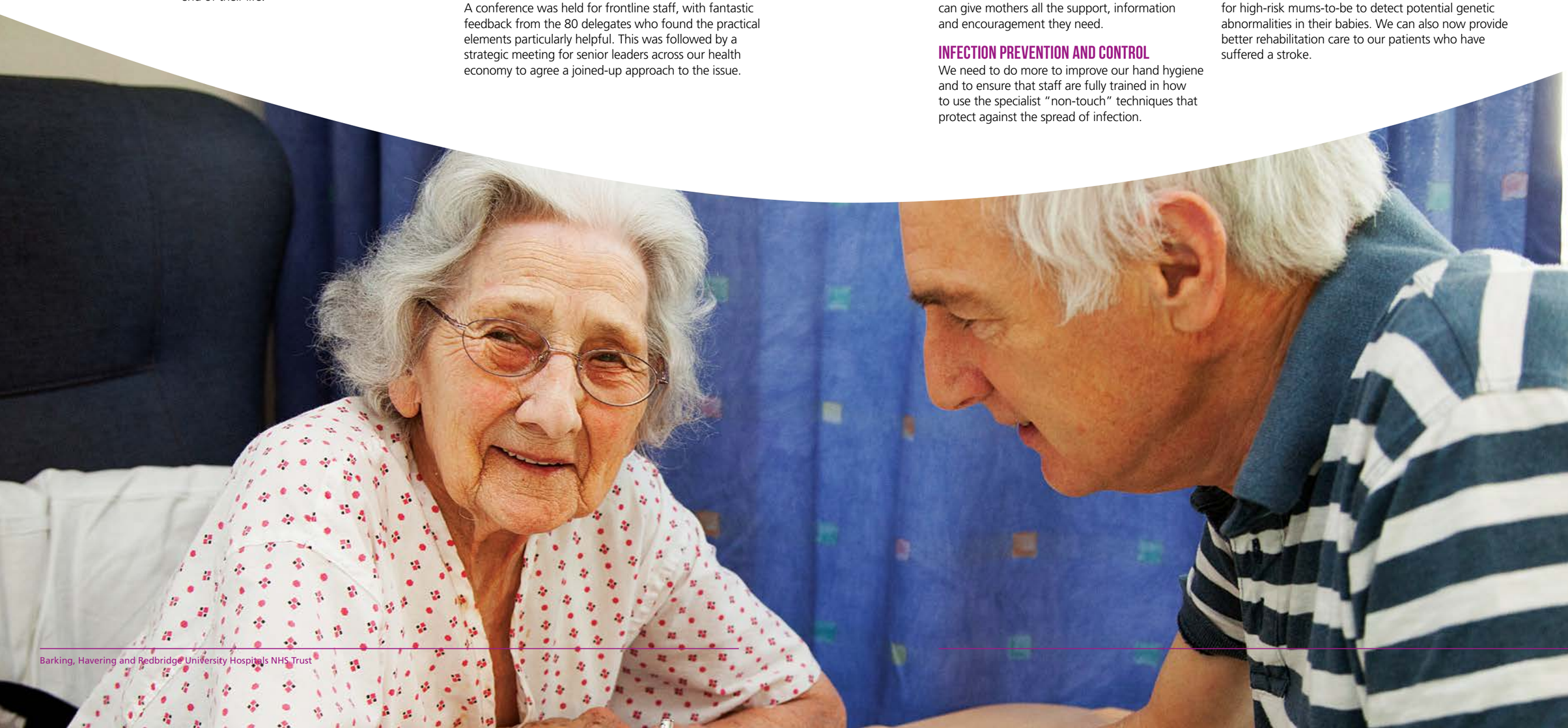
RESEARCH AND INNOVATION

Our research work, and the opportunities that provides to patients, has continued to thrive over the last year.

We now have more than 200 active studies running, and have widened our reach to include research in our sexual health, emergency medicine, and ear, nose and throat departments.

Our research works means we can offer additional services to patients.

For example, we are now providing genetic testing for high-risk mums-to-be to detect potential genetic abnormalities in their babies. We can also now provide better rehabilitation care to our patients who have suffered a stroke.



IMPROVING OUR PATIENT ENVIRONMENTS

The environment in our hospitals can have a significant impact on patients.

We have a rolling programme of improvement works to keep our facilities as up-to-date and welcoming as possible.

In certain areas, such as our Care of the Elderly wards, we have carried out bespoke work to make them 'dementia friendly', using clear signage and colours to support patients who may be distressed or confused.

We have also transformed our outpatient department at King George Hospital, using bright colours and comfy chairs, as well as providing toys to keep our young visitors entertained.

Our charity continues to support this work. One of the projects it funded this year was to redesign and redecorate the overnight areas used by the families of our most critically ill patients. Two areas are available for overnight stays including bedrooms, bathrooms and a sitting area as well as a shared kitchen. The makeover included new furniture, bedding and kitchen utensils.

PATIENT EXPERIENCE

The opinions of our patients are vital as we strive to make improvements that will make a real difference to their experience while they are in our hospitals. Patient feedback is collected in many ways, including through the Friends and Family Test, our Mystery Shopper scheme and via comment cards. Many of the comments and suggestions that have been made this year have directly led to changes in the way we provide our services. These include:

- We have introduced protected mealtimes, stopping all tests and visits on the wards so patients can have their meals without interruption, and freeing up time so that nursing staff can support those who need a little extra help.
- Patients told us that it can be difficult to identify who is in charge of clinical areas, so the nurse or midwife in charge now wears a red armband so that patients and relatives can recognise them immediately.
- Restaurant-style buzzers have been introduced in our outpatient areas so that patients can go for a wander around the hospital, or pop to get some refreshments, knowing that they will be "buzzed" when it is time for their appointment. It also means that patients with learning disabilities, who may find it a little stressful or uncomfortable to stay in the main waiting room, can find somewhere quiet to sit, away from that area.
- Activity books called Monkey Visits the Emergency Department are now available for children in our EDs. This gives them information about what will happen, and helps them to understand why things like blood tests are important. It's also packed with games and puzzles to keep them busy.

Special events and national celebrations are marked on our wards so that patients don't miss out by being in hospital.

Every patient in our hospitals on Christmas Day receives a present, along with a full Christmas dinner.

We joined in the VE Day celebrations this year, with wards decorated with Union Flag napkins and bunting, and patients served afternoon tea.

And children didn't miss out on Pancake Day, with youngsters given ice cream and fruit to create their own pancake treats.

"THERE WAS A NURSE CALLED MARIA WHO WAS WORRIED ABOUT ME - SHE SHOWED ME COMPASSION AND KINDNESS."

A PATIENT'S STORY

STEWART PEARCE

I collapsed in my front room and was found by my brother who brought me in to the Emergency Department at Queen's Hospital. The first thing I remember was a doctor slapping my face trying to rouse me – I think he was trying to find out if my face was alive! I was told I had had a stroke.

I was soon moved to Sahara ward but, having never had a stay in hospital before, I found the experience to be a big shock. Unable to move properly, my senses not functioning properly, I struggled to remember who I had seen. I wasn't able to mobilise and needed assistance going to the toilet. I wet the bed which completely freaked me out, but I found the staff's reassurance and understanding very comforting.

They always explained what was happening and they would constantly soothe me by saying things like "don't be afraid" or "it's okay". Whilst I couldn't talk, I could listen. There was a nurse called Maria who was worried about me - she showed me compassion and kindness. That personable and patient-centred care meant that I felt more relaxed. Maria thought I was having trouble breathing and it appeared that I had a chest infection as well - I was gasping for air. Maria took the initiative and went to get the doctor, who immediately moved me to the Intensive Care Unit where I consequently spent two months.

Whilst in ICU a male nurse would talk to me about nonsensical things but I later realised that talking would help me to focus. I felt the staff fully engaged with me and I felt completely cared for - they spent a lot of time telling me who they were and what they were going to do to help me. I found this very comforting, knowing who they were and having them talk to me. They were wonderful. I made a good recovery and was moved back to Sahara ward.

I don't think there was anything the hospital could have done better. I have never been in a situation where I have been seriously ill. All I can say is that staff should engage with patients - cleaners, porters, doctors, nurses, it doesn't matter. As a patient we are there all the time, so having someone talk to you and engage with you means so much. People telling me who they were, giving me a pat on the head – it breaks down communication barriers and allows us to joke about things that would otherwise be embarrassing.

I am immensely grateful to BHRUT for its professional and caring staff and I am now an advocate for the Trust. I am quite sure if it wasn't for Queen's, I wouldn't be here today. The speed at which I was brought here and the staff on Sahara ward recognised that I didn't just have a stroke but I had another problem too, which meant I deteriorated very quickly. The action people took saved my life. The medicine helped but George, Sharon and Maria saved my life.

"I WAS ESPECIALLY PLEASED WITH THE PASTORAL CARE MY FATHER GOT. THE SENSITIVE, CARING SIDE TO THE WORK HELPED MY SISTER AND ME GET THROUGH A REALLY TOUGH WEEK. "

A FAMILY'S STORY

REV. PHILIP WRIGHT

My father was diagnosed with Prostate Cancer in 2006, which was managed at Queen's Hospital. In November 2014 he was told the cancer had spread and the next stage was chemo. Sadly my mother then passed away, and this meant the treatment was delayed as my father didn't want to be ill for her funeral.

Once treatment started, the first round of chemo was fairly simple with no side effects. The second was a different story. He just wasn't right. I used the document the hospital gave us regarding the side effects, and the question "Do you feel out of sorts?" highlighted exactly how he felt. I rang the number given and was advised to call an ambulance. On arrival in A&E he had blood taken before being seen by two doctors, who were both very clear in their communication with me.

Once in the oncology day unit, he was given a variety of tests before being transferred to Mandarin B.

Over the following week, the doctors were amazing. After a slight improvement, dad developed internal bleeding but was too poorly to have an internal investigation.

At this point my father did something he has never done before. He asked me to pray with him; a very special moment for me. He said very clearly that he didn't want any more treatment, that he wanted to go and be with mum. He was moved to a side ward and we were told it was a case of letting the body slowly stop. My father was made comfortable and given the best care I have seen.

Although it took a week for him to pass away, there were moments of beauty in the trauma. He would occasionally wake up and say something funny, and the moment just before he died was special. He held his hand up for me to hold and he then pointed to the door as if to say you can go now. I told him I loved him and left, he died 20 minutes later.

I was especially pleased with the pastoral care my father got. The sensitive, caring side to the work helped my sister and me get through a really tough week. The palliative care team were excellent, giving him the best care but also explaining what was happening.

Of course the outcome was sad and devastating for us as a family, but with the care of so many wonderful doctors, my father and our family had a positive experience.

"BEING A PART OF THESE IMPROVEMENTS THAT HELP MAKE OUR PATIENTS AND THEIR RELATIVES MORE COMFORTABLE HAS BEEN REALLY ENJOYABLE."

A MATRON'S STORY

MATRON BEV THOMAS

Working on the Intensive Treatment Unit (ITU), you see a lot of patients and get to know their families who spend time talking to and looking after their loved ones. We have always asked visitors to keep a log in a notebook that we provide, recording the time and date they visited, so when their friend or relative is better, we can show them just how many people came to see them and wished them well. My nursing colleagues and I thought it would be nice for the patients to have something more professionally produced so spoke to our charity, King George and Queen's Hospitals Charity, who kindly agreed to fund this initiative as a pilot exercise in Neuro ITU.

The diaries were for the relatives to maintain whilst their loved one was unconscious, so that the patient had a record of what happened to them during this period. Many patients have since reported that they greatly valued this, so they could appreciate some of their experience in ITU. Having been an ITU patient myself, some seven years ago, I would have loved to have been able to read about that lost period of my life.

The other big improvement for our patients' relatives is in general Critical Care at Queen's Hospital. There was a restructure in the department and, as a result, two new overnight rooms were provided for patients' relatives to stay in during their visits. They were functional but not very inviting so, thanks to funding from our charity, we were able to redecorate and furnish the rooms tastefully, making them as homely and welcoming as possible. Refurbishment work then took place at King George Hospital to make sure that families at both sites could be comfortable and supported during a difficult time.

Being a part of these improvements that help make our patients and their relatives more comfortable has been really enjoyable. I'm so grateful to the families who have donated over the years as well as to the hospital charity for its funding, and mostly to my colleagues who have worked with me to make this all possible.

RUNNING OUR HOSPITALS EFFICIENTLY

Over the last year, our staff have worked hard to improve our services against national and locally-agreed quality and performance measures. You can find out more about the quality of our services and the care we provided in our Quality Account, available on our website.

EXTERNAL ASSESSMENT

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.

We were put into special measures in December 2013. The CQC then revisited us to see what improvements had been made, publishing its report in July 2015. We had been previously rated as 'inadequate', but inspectors recognised that changes had been made and updated the rating to 'requires improvement'. We remain in special measures and are awaiting a revisit by the CQC.

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 2015 CQC report confirmed that improvements had been made and highlighted many areas of "outstanding practice". These included:

- Radiotherapy was one of the top five units in the country
- The genitourinary (GUM) clinic had an excellent service
- Outcomes for patients receiving oesophago-gastric cancer services were good
- There were good outcomes for stroke patients
- Play specialists had developed a way of distracting children waiting for MRI scans which involved joining other children and families on a 'train journey' from the outpatient clinic through the hospital corridors
- The development of the Elders' Receiving Unit had improved care for frail, elderly patients
- There was a dedicated team to support patients living with dementia
- The nurse-led oral chemotherapy service was the first in the country
- The end of life care service was patient focussed.

We have worked with our partners to update our improvement plan, Delivering our potential, which sets out how we continue to develop and improve services for patients. Each month we publish our progress report on our website, explaining where we have improved, what we have put in place, and what more needs to be done to ensure our patients receive the quality care they deserve every day.

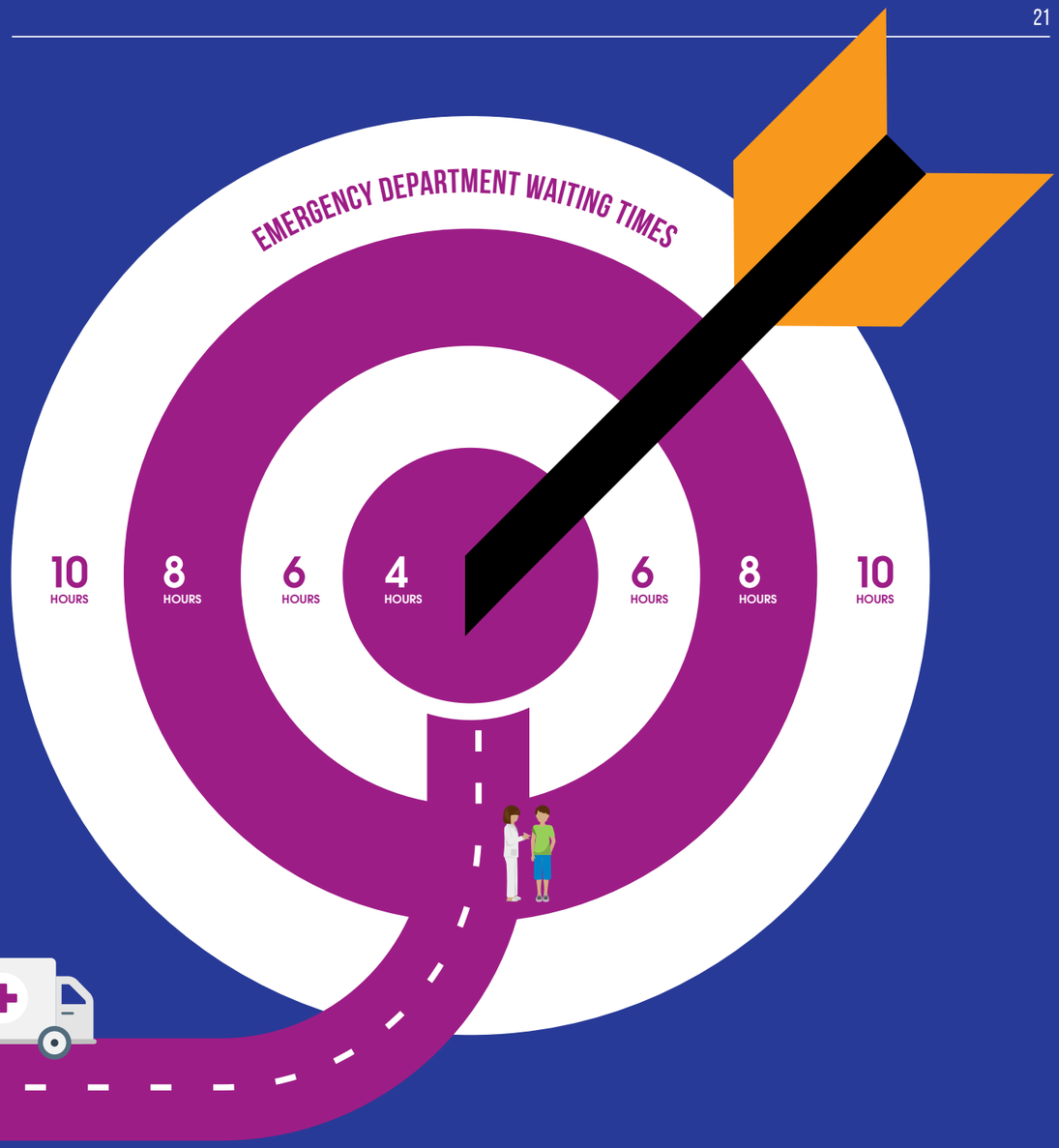
OUR EMERGENCY DEPARTMENTS

There has been a relentless focus on improving waiting times in our Emergency Departments this year.

In July we celebrated hitting the national target of treating, admitting or discharging 95 per cent of patients within four hours for the first time in four years. This was an enormous achievement and the result of radical improvements in the flow of patients through our hospitals and out into the community, and the dedication of the teams involved.

As well as improving performance, more importantly it has also made a difference to the experience of our patients.

The work which had taken place included expanding Medical Assessment Units, opening an Elders' Receiving Unit, and focusing on ambulatory care – treating people as an outpatient rather than admitting them to a hospital bed unnecessarily. We have also increased the number of patients who are discharged home before noon each day.



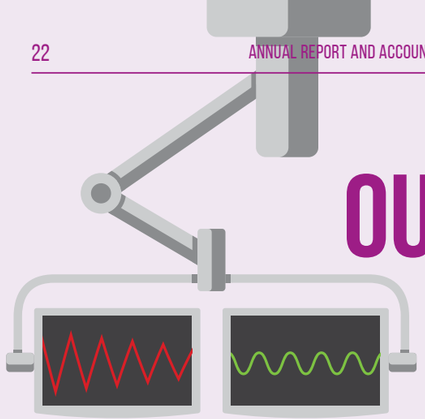
We were approached by other hospitals keen to find out how we had managed to boost performance, so decided to host a conference. Around 100 delegates from across the country came to our Ready, Steady, Flow event, listening to presentations and taking part in workshops about the changes that had been made.

Attendances at our EDs have significantly risen in recent months, and that has had a huge impact on our performance. In the last quarter of the year we saw attendances up 20% on 2015 - that's 4,000 extra people a month coming through the doors of our EDs.

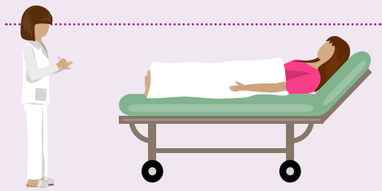
The number of people who were admitted to a hospital bed has decreased as we are able to treat more people in their own homes.

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

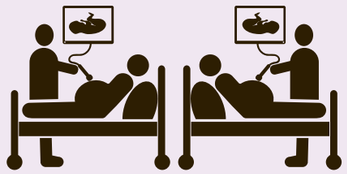
OUR HOSPITALS HAVE:



22 THEATRES



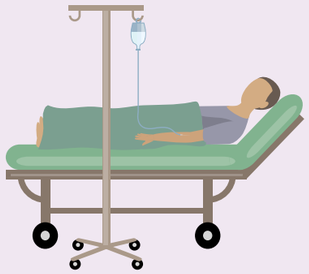
909 INPATIENT BEDS



62 MATERNITY BEDS

INCOME OF **£505M**

44 CRITICAL CARE BEDS



REFERRAL TO TREATMENT TIMES (RTT)

We announced in 2014 that we had identified several issues with our Referral to Treatment reporting, dating back several years.

RTT is national guidance which states that patients should receive hospital treatment within 18 weeks of having been referred by their GP.

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

We have significantly reduced the number of patients who have been waiting, but still have a long way to go.

We have already held many more outpatient clinics so that we could begin to see and treat the people who had been waiting too long, and have put together a recovery and improvement plan, supported by our local Clinical Commissioning Groups, System Resilience Group and overseen by NHS Improvement.

The key focus of our work is to treat those who have been waiting too long as quickly as possible, to assure ourselves that they have not come to any harm as a result of that wait, and to ensure that we put sustainable systems in place so this situation does not arise again.

To make sure that we have the capacity to meet the demand on our services, we will be providing more appointments, carrying out more operations and employing more specialist staff. We will also be carrying out more investigations – MRIs, CT scans, ultrasounds and endoscopies.

Throughout this project we have been supported by our partners, and are working with our Clinical Commissioning Groups to look at how we could move care into more appropriate settings and manage GP referrals.

OUTPATIENTS

Around 2,750 people visit our outpatient departments every day – more than 660,000 a year. We also handle around 6,000 telephone calls to our appointments centre each week.

We know that waiting for an appointment can be frustrating, so we have improved our outpatient areas. Our staff have been given new uniforms to make them easily identifiable, and we have introduced pagers so people can pop out for a walk or a coffee while they are waiting, knowing they will be called when the doctor is ready to see them. At King George we have refurbished every outpatient area, with comfy chairs, television screens and toys for children.

HAVING A DEDICATED, ENGAGED AND MOTIVATED WORKFORCE IS CRUCIAL TO DELIVER IMPROVEMENTS AND TO PROVIDE GREAT CARE TO EVERY PATIENT, EVERY DAY

BECOMING AN EMPLOYER OF CHOICE

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 substantially increased the number of permanent staff we have working in our hospitals to ensure that our patients receive the highest and most consistent levels of care possible.

Recruiting and retaining high quality staff is a key priority in our people strategy. One of our biggest challenges continues to be the recruitment of permanent staff, particularly in specialist areas such as our Emergency Departments. At the end of March our vacancy rate stood at 10.9% - still higher than we would like but down from 13.2% the previous year.

Our management of recruitment has greatly improved and our 'time to hire' staff is now among the best in the country.

These achievements, along with a focus on using internal temporary staffing from our Trust Temps department, means we are less reliant on agency staffing. We know that using our own staff offers better consistency of care and better value for money than using expensive agency staff. In April 2015 we spent 10.25% of our entire staff pay bill on agency cover. That is now down to 6.45%.

OUR STAFF ARE AMONGST THE MOST MOTIVATED IN THE COUNTRY

Attendance at work has improved through better support and management of sickness absence. The target set for sickness absence in April 2015 was 4%, and we have achieved and bettered that throughout the year. This is partly due to a range of health and wellbeing initiatives to promote the importance of a healthy workplace and enable staff to keep fit and well for themselves and our patients.

Schemes include a staff physiotherapy service, cycle to work scheme, healthy eating, walk to work week, teaming up with a personal trainer and introducing a Healthy Hike. Coupled with offering a range of employee benefits, these have supported our work to engage and retain staff.

CULTURE

Our organisational development (OD) strategy was approved by the Board this year, setting out our four strategic priorities: Culture, Leadership, People and Organisational Design. Our PRIDE values of passion, responsibility, innovation, drive and empowerment, are integral to each of these priorities, as is our commitment to equality, diversity and inclusion.

This year's staff survey results showed a significant improvement across many of the key findings and we were reported to have among the most motivated staff in the country. Our overall engagement score improved and is now in line with the national average – this is a key indicator of the quality and safety of care we deliver and of our financial performance. Having engaged and motivated staff is hugely important as we strive to become an employer of choice, attracting and retaining the very best people to work with us, developing and supporting them to flourish and deliver excellent performance whatever their role and whoever they are.

OUR VOLUNTEERS

We are so grateful for the help of our 233 volunteers, who between them have given more than 28,000 hours of support to our patients and staff over the last year. Volunteers complement the work or our staff, and contribute to the smooth and patient-focused running of our services. Our volunteers are an integral part of the team, and their contribution is recognised at our annual PRIDE awards with long service awards and a dedicated Volunteer of the Year prize.

EDUCATION, TRAINING, LEARNING AND DEVELOPMENT

This year we provided education and training for more than 350 postgraduate trainees across a range of medical and surgical specialities and, during the academic year, gave placements to 528 students from four medical schools.

We have a Simulation Centre which has gone from strength to strength this year. It has been used for a wide range of training including a dedicated Intensive Care Nurse programme, a scheme for paediatric and anaesthetic doctors and nurses, and a recovery nurse programme to review lessons learnt from incidents in theatres.

It has been so successful that we were nominated in the Innovative Simulation Training category at the Post Graduate Medical Education awards.

This year we have been encouraging people to consider careers in the NHS. Our Access to Work team provided 64 work experience placements to local students, along with 19 new apprenticeships. We also held an Introduction to the NHS day for the Prince's Trust and Health Education England, with 15 young adults coming along to experience a day in the Health Service.

STATUTORY AND MANDATORY TRAINING

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

We need to continue our focus on ensuring that all of our staff are fully compliant with their training. We now provide more learning programmes that ever before electronically, making it far easier for people to complete their training.

This year we were awarded a certificate of achievement for being the trust with the highest improvement in core skills compliance using e-learning.

CELEBRATING OUR PEOPLE

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

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

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

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

GUARDIAN SERVICE

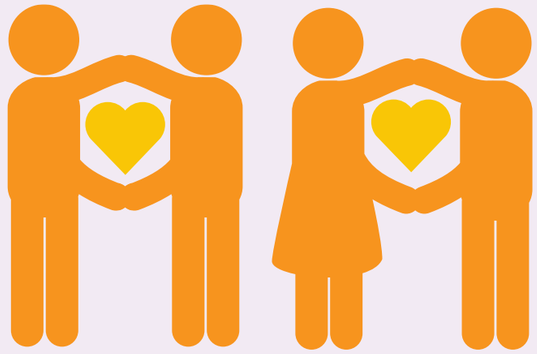
Our innovative Guardian Service, helping our staff to speak up about patient safety concerns, celebrated its second birthday this year.

The service was set up in response to the Francis Report to ensure patients are always put first and we encourage an open and honest culture. The first of its kind in the country, it is led by National Patient Champion Ashley Brooks who has now provided support to more than 200 members of staff.

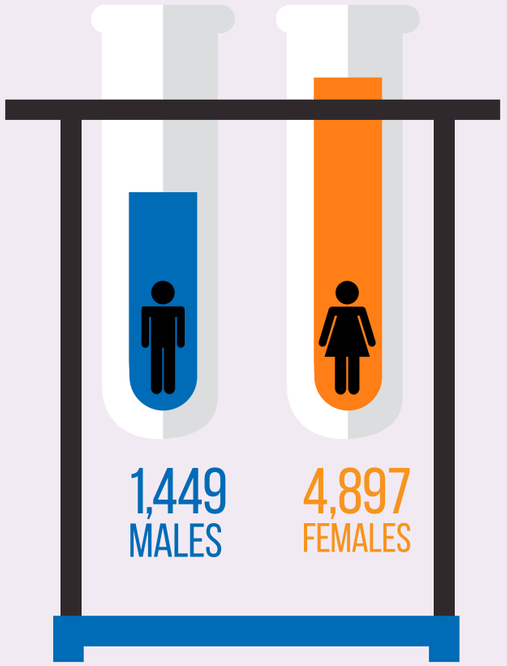
OUR HOSPITALS HAVE

EMPLOYED OVER 111 ADDITIONAL STAFF OVER THE LAST 12 MONTHS

OVER 230 VOLUNTEERS, WHO BETWEEN THEM HAVE GIVEN MORE THAN 28,000 HOURS OF SUPPORT



6,346 STAFF 80% IN DIRECT CLINICAL CARE ROLES



WORKING IN PARTNERSHIP

We are passionate about involving our patients and the public in our work to ensure that they have a say in how we deliver our care. We have continued to build links with our local population with a series of listening events. There has been a particular focus on engaging with young people, and we linked up with Redbridge College to get feedback from hundreds of students. Their views on the care we provide help us to understand what is important to the younger generation and are invaluable as we design and improve services.

We are keen to involve patients in every aspect of hospital life to help us learn and improve, and have introduced patient stories at our Board meetings so that our leaders can hear first-hand about how people feel about the care we provide.

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

We have also strengthened links with our partners and stakeholders. We have created a Local Representatives' Panel, giving updates to members including Healthwatch members and local councillors, and hold regular meetings with key partners like our MPs.

We asked our stakeholders to take part in a second annual survey, and the results show that they feel engaged with us, and are positive about the improvements we are making for our patients.

VIRGINIA MASON INSTITUTE

We have been chosen as one of just five trusts in the country to benefit from the influence of internationally acclaimed healthcare experts.

The USA's 'Hospital of the Decade' – the Virginia Mason Institute – is mentoring us as part of a ground-breaking five-year improvement programme. It will bring its tried and tested techniques to our hospitals to help us to deliver improvements in healthcare for local people.

Clinicians and leaders from Virginia Mason are teaching us the principles and systems that have made it so successful that it has won awards for excellent and safe care.

VANGUARD PROJECT

The way that people access urgent and emergency care in this area is set to change after we were named as a key player in a national vanguard project.

We have linked up with our CCGs, GP Federations, community and mental health provider and councils to put together an ambitious plan for the public to find and get help when they need it.

The project – one of eight across the country – will focus on providing a simple, streamlined system to make is easy for people to get excellent urgent care when they need it. At the moment there are numerous options when people need care and advice, including A&Es, walk-in centres, urgent care centres, GPs, GP access hubs and pharmacies.

The care organisations in Barking, Havering and Redbridge are working on plans to give people three choices for accessing care, supported by a clever digital system that will recognise them and tailor the help they get as soon as they make contact. People will go online for support and information to help them 'self-care' with confidence, and to book urgent appointments if they need them. They will phone for more in depth advice or reassurance from a clinician. Or, if it is a real emergency, they will come to hospital. The three options are: Click, Call or Come in.

The healthcare system put forward the bid to develop the vanguard project after clear feedback from clinicians and patients asking for a simple, consistent system. Now all of the organisations involved are working together to develop the project and implement the changes that we need.

BECOMING AN ACCOUNTABLE CARE ORGANISATION

We have achieved a great deal over the past few years to improve care for our patients, working closely with our partners. However, the current system is not financially viable for the future and won't enable us to deliver the quality improvements that we want to see for our communities.

Following a request from Chancellor George Osborne, who wants to see greater integration of health and social care, we are drawing up a business case with our Clinical Commissioning Groups, local authorities and North East London NHS Foundation Trust to develop an Accountable Care Organisation (ACO) which would be responsible for managing urgent and emergency care, other elements of hospital care, primary and community health services, social care and preventative services across our boroughs.

If we formed an ACO, a large part of the budget currently controlled by NHS England and Health Education England would be devolved to the ACO. This would give us the local flexibility to spend it in a way that would enable us to provide the best care possible for our communities and help to bridge the funding gap.

A business case is being developed and will be ready this summer, setting out how the model might work and what we would need to make it happen.

PERFORMANCE ANALYSIS

OUR PERFORMANCE REPORT

We have made excellent progress with the delivery of our improvement plan: Delivering our Potential this year.

The Care Quality Commission report gave us a helpful benchmark against which we can measure our performance and improvements in 2015/16. Monthly reports setting out the detail of our performance against our plans are available on our website at www.bhrhospitals.nhs.uk, along with further information in our Quality Account.
I am particularly pleased that we have managed to recruit more permanent staff, and that we have met our in-year financial targets.

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

We also made excellent progress against the emergency access target, hitting the 95% standard in July for the first time in four years. Sustaining that performance has been more of a challenge, and we still have considerably more work to do with our partners to improve the situation so that patients are seen and treated as quickly as we would like. We have seen an enormous rise in demand in our emergency departments, and will be looking at ways of encouraging people to access services more appropriately for their needs.

I am disappointed that we are not treating all of our cancer patients within 62 days of a referral from their GP. With the number of GP referrals increasing we are working with our primary care colleagues to look closely at all of our cancer pathways to see where they can be streamlined for our patients. We are introducing one-stop clinics, so that patients can have their diagnostic tests before, or at the same time as, their first outpatient appointment to speed up the process. A trajectory for improvement has been agreed with the Clinical Commissioning Groups and NHS Improvement, and we are meeting those revised targets.

As agreed with NHS Improvement, we are not currently reporting our Referral to Treatment performance as we can't be assured of the quality of the data. We know that people have been waiting longer than 18 weeks for treatment, and that is not acceptable. We are working to deliver our recovery and improvement plan and have made significant progress in clearing the backlog of patients who have been waiting too long. We are working as a health economy to improve the situation, and to ensure we have the capacity to meet the demand on our services.

Considerable work is also underway to reduce the number of healthcare acquired infections we have recorded. Our performance worsened this year, and we are taking action to rectify that by re-training staff and raising awareness across the organisation.

Matthew Hopkins
Chief Executive

OUR PERFORMANCE

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

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

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

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

We have the following assurance measures for our performance reports:

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

We have key targets for data quality for major datasets across all the facets of data quality, and benchmark our performance where data exists nationally.

Data is uploaded monthly onto Unify, where it is accessible to NHS England and NHS Improvement.

PERFORMANCE	THE STANDARD	OUR RESULTS
Emergency access	95% of all patients attending our Emergency Departments to be treated, admitted or discharged within a maximum of four hours	Not achieved: 87.9%
Maternity	% of our mothers-to-be given one-to-one care in active labour	Achieved: 100%
Cancer: urgent referrals	93% of our patients to be seen in two weeks following an urgent referral from their GP	Achieved: 94.5%
Cancer: 31 days	96% of our patients to have a diagnosis and first treatment within 31 days of the decision to treat	Achieved: 96.1%
Cancer: 62 days	Target of 85% of patients receiving first treatment from the date of GP referral	Not achieved: 74%
Infection control: C diff	No more than 30 cases	Not achieved: 36
Infection control: MRSA	Zero cases of MRSA bacteraemia	Not achieved: 5

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

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 the issue, drawing up a business case to develop an Accountable Care Organisation. Financial pressures could also impact on performance, although we have Quality and Cost Improvement Programmes in place which are mitigating that risk.

We have received assurance from NHS Improvement that it expects us to continue as a going concern and that it will make sufficient financing available to the organisation in line with our operational plans. While we have seen real improvement in recruitment, on-going challenges in attracting permanent staff means that we are still using more bank and agency staff that we would like, and this can impact performance. The situation is improving and being monitored closely.

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.

National Targets and minimum standards	Targets	Target 2015/16	2015/16	2014/15	2013/14	2012/13
Infection Control	Number of Clostridium difficile cases	30	36	33	24	65
	Number of MRSA blood stream infection cases	0	5	6	2	9
Access to Cancer services diagnosis to first definitive treatment	% of cancer patients waiting a maximum of 31 days from	96%	96.1%	98.0%	96.1%	99.4%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98%	99.7%	99.6%	100.0%	100.0%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	96.1%	98.3%	87.8%	100.0%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	94%	98.7%	98.7%	95.3%	93.2%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment	85%	74.0%	81.2%	84.2%	83.0%
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	85%	93.7%	94.0%	96.2%	100.0%
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to date first seen	93%	94.5%	91.3%	90.5%	98.4%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	93.2%	80.1%	80.4%	96.9%
Access to treatment	% of patients waiting under 18 weeks	92%				
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	87.9%	85.3%	88.6%	88.4%
Cancelled operations	Number of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	0	524	494	378	400
Cancelled operations not performed within 28 days	Number of patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days	0	38	39	14	11

- As explained earlier in the report, it has been agreed that we will not report our Referral to Treatment performance until we are assured of the quality of the data.

MANAGING OUR FINANCES

This year we met all of our in-year financial targets despite increased financial pressure across the NHS. These included declaring a year end deficit of £33.7m - £4.3m less than our original plan for the year. To achieve this, we saved more than £21m through our Quality and Cost Improvement Programme (QCIP). As an NHS trust we do have a duty to break even and our cumulative deficit over the years now stands at £348.8m. 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.

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

- As well as expanding our overall permanent workforce, we have improved our use of temporary staff by using our own temporary or part-time workers. We also only use approved agencies to supply staff, and have seen benefits from the price limits set by the Department of Health for agency cover.
- We have been part of the first cohort of trusts working together to deliver better value for money outlined by Lord Carter of Coles in areas including procurement, staffing, estates and medicines. This has helped to identify long term benefits and contribute to more than 30% of our QCIP savings.
- The Quality and Cost Improvement Programme has also led to better use of our estates and facilities, better contracting for IT services, and more automation of our stock management and printing services.

CAPITAL INVESTMENT

This year, we invested more than £11m in capital projects, focusing on delivering our improvement plans, our IT strategy, maintaining and expanding our medical equipment and improving our estate and procurement. This is where the money was spent:

Medical Equipment	£3.1m
Service Improvements	£1.7m
IT Hardware	£2.2m
IT Software	£1.1m
Estates	£1.8m
Procurement	£1.2m

FINANCIAL OUTLOOK

Our long term plan is to break even and achieve financial sustainability, and we will continue to work towards that. This will be supported by work across the local health economy as part of the Accountable Care Organisation, further implementation of Lord Carter's proposals, our on-going commitment to service improvements and delivery of future Quality and Cost Improvement schemes.

SUSTAINABILITY

The UK Government has committed to take action on climate change. The Climate Change Act set a target to cut carbon emissions by at least 80% by 2050, with a minimum reduction of 26% by 2020 across the UK.

This ambition is supported by the Department of Health and, in response to this, the NHS Sustainable Development Unit published the NHS Carbon Reduction Strategy 2020. To implement this, each NHS organisation should have a plan and a target of reducing its carbon footprint.

We have a Sustainable Development Management Plan, a Carbon Management Plan and a Sustainable Travel Plan to meet these objectives. We are taking a range of measures to implement carbon reductions across our services and support our environment. This year we have has enormous success, and been recognised with three high profile awards.

- Public Sector Sustainability Award 2015 – Winner, Most Sustainable Public Sector Organisation
- Green Apple Awards 2015 – Winner, Environment Best Practice
- Green Essex Awards 20015 – Winner, Greenest Large Business

SECTION TWO:

OUR ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT, 2015/16

DIRECTORS' REPORT

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

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

LEADERSHIP

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

THE ROLE OF THE TRUST BOARD

The Trust Board has key functions for which it is held accountable by NHSI. Within the context of the broad, overall strategy for the NHS, the Trust Board sets the strategic direction of the organisation and functions as a corporate decision-making body. The Trust Board considers the key strategic issues facing the Trust in carrying out its statutory duties. The Trust Board is required to comply with legislation, meet the standards in the NHS Constitution and those set by the quality and safety regulator, the Care Quality Commission, ensure progress towards delivering against the NHS Outcomes Framework and exercise the functions of the Trust effectively, efficiently and economically, operating as a going concern. In doing so, the Trust Board must ensure high standards of corporate governance and personal behaviour are maintained across the whole organisation.

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

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

APPOINTMENTS

It is the role of NHSI to appoint or re-appoint the Chairman and Non-Executive Directors (NEDs). No new NEDs were appointed during 2015/16. At the end of the year, five NEDs were considered independent in character and judgement using the criteria for independence listed within the UK Corporate Governance Code. The Chairman in post during 2015/16 was considered to be independent.

There was only one new Executive Director appointed during the year, the Chief Nurse, Kathryn Halford, who was appointed in January 2016.

PROVIDING SUPPORT TO DIRECTORS

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

In addition to the Board Directors, the Board has appointed four NED Advisors who provide additional support and capacity to the Board by chairing Consultant Interview Panels, HR Hearings and Appeals. They are paid the same as the NEDs and during 2016/16 they have been invited to attend Trust Board meetings and Sub-Committee meetings as follows:

Sandra Malone – People and Culture Committee

Jonathan Steinert – Quality Assurance Committee, Audit Committee

Mehboob Khan - Quality Assurance Committee, Audit Committee, People and Culture Committee
Prof Simon Jones was also appointed as a NED advisor at the same time but due to work commitments has agreed to be engaged on specific projects as required for which he will receive a pro-rata payment.

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 in preparation for Foundation Trust status; we therefore intend to adopt the NHS Foundation Trust Code of Governance, issued by Monitor, with the objective of establishing and implementing best practice.

The Trust has made significant efforts during 2015/16 to improve its corporate governance framework through:

- A strategic governance review supported by the Good Governance Institute
- Improving engagement with external stakeholders (Local Authorities, CCGs, patients, Community Groups and staff)
- A serious incidents (SIs) recovery plan aimed at clearing the SI backlog and embedding a clear SI management process
- Implementing clearer leadership of the clinical governance corporate function and defined links with the divisional structure to embed processes
- Review of strategic objectives and risks and development of a Board Assurance Framework (BAF) to manage risks and deliver objectives in conjunction with board development work
- Development of the Trust's Operating Plan for 2015/16 with reference to priorities identified in the newly published TDA Accountability Framework The Trust's corporate governance framework was re-visited following the CQC's Clinical Summit which took place in July 2015.

During the year there has been a continued focus on stabilising the Trust and its performance delivery. Looking forward to 2016/17, we will re-double our efforts to deliver and sustain the best quality of service to our patients which is our primary objective.

COMMITTEES OF THE TRUST BOARD

The Trust Board can delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. During 2015/16 the Trust re-embedded its new management structure and further revised 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 has held 11 monthly meetings in public.

The Scheme of Reservation and Decision details what types of decisions are to be taken by the Board and which decisions are to be delegated to management and the Committees of the Board.

ATTENDANCE

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

Table 1 – Directors' attendance at meetings: 2015/16

	Trust Board	Audit	Finance and Investment	Remuneration	Quality Assurance	People and Culture
BOARD MEMBERS IN POST AT 31 MARCH 2016 (ATTENDANCE AS AT 31/3/16)						
Non-Executive Directors						
Dr Maureen Dalziel	11/11		9/11	1/1		
Dusty Amroliwala	8/11			1/1	8/8	
Mark Lam	10/11	3/4	11/11	1/1		5/5
Joan Saddler	7/11			0/1	4/8	2/5
Eric Sorensen	11/11	4/4	10/11	0/1		
Prof Anthony Warrens	9/11			1/1	2/8	
Rob Whiteman	10/11	3/4		0/1		
Executive Directors						
Matthew Hopkins	11/11		8/11		6/8	3/5
Jeff Buggle	11/11		10/11		2/8	3/5
Wendy Matthews	7/8		4/8		4/5	3/3
Dr Nadeem Moghal	11/11		1/11		8/8	3/5
Steve Russell	11/11		5/11		3/8	
Jason Seez	11/11		4/11		5/8	
Deborah Tarrant	8/11		5/11		4/8	5/5
Sarah Tedford	8/11		8/11		7/8	2/5
Kathryn Halford	3/3		2/3		2/3	1/2

The values shown are the number of attendances against the number of meetings held during the year that the director was eligible to attend. Where there is no entry, this means the director was not a member of that committee.

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

The Board has a well-established Audit Committee comprising independent NEDs. The Audit Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by a Board Assurance Framework. During 2015/16, the Board undertook a comprehensive review of its Board Assurance Framework, working closely with the Good Governance Institute.

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

Key activities for 2015/16 included:

- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this was consistent with the audit needs of the Trust as identified in the Board Assurance Framework
- Consideration of the major findings of internal audit work, the appropriateness of management responses, and the timeliness of completion of agreed actions
- Review of all external audit reports, including the annual report To Those Charged with Governance and the annual audit letter
- Review of the Trust's Annual Report and Financial Statements including the Annual Governance Statement and changes in, and compliance with, accounting policies and practices
- Review of the Trust's Quality Account before approval by the Trust Board
- Review of all work related to security, fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect
- Review of policies around raising concerns following the Francis Review.

The Audit Committee also received regular or specific reports on:

- Losses and compensation payments
- Waiver of tendering process and competitive quotations
- Write off of debts
- Governance manual (Standing Orders)
- Compliance with UK Code of Governance
- Any allegation of suspected fraud notified to the Trust
- Payments and Tariff Assurance Framework. The Audit Committee routinely meets with auditors without officers present as part of established good practice.

During the year, the Committee reviewed the work of other committees of the Trust Board, including the Quality Assurance Committee, to ensure relevant assurance on the Trust's overall system of governance.

PROFILES OF OUR BOARD

Dr Maureen Dalziel MD MBChB FFPH FRSA
Chairman
Maureen Dalziel was appointed chair in February 2014, with a term of office until 31 March 2017. A qualified doctor and public health expert, Maureen has held a number of CEO and senior medical roles in regulatory, provider, research and commissioning organisations in the NHS.

In her leadership roles Maureen has re-configured and modernised healthcare delivery, developed and implemented health policy and health quality systems and created innovative strategic partnerships in the UK and across Europe to reduce health inequalities, promote health improvement and raise awareness of healthcare risks.

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

Eric Sorensen
Non-Executive Director/Vice Chairman (Senior Independent Director)
Eric was appointed in September 2014 for a two year term of office. Following his earlier civil service career, Eric Sorensen has worked for many years to promote regeneration and development, particularly in East London. He was Chief Executive for a number of Government and local authority organisations with regeneration aims. He is now Chair of a local community regeneration trust in Tower Hamlets, and of a grant-giving trust in Newham. He is also Chair of an Islington primary school.

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

Air Commodore Dusty Amroliwala OBE
Non-Executive Director, Chair of Quality and Safety
Dusty Amroliwala joined the Trust in September 2014 with a two-year term of office. His career has spanned many different sectors. From 27 years in the Royal Air Force, where he finished his career as the HMG's Director of Defence Diplomacy, to senior Director roles in the Home Office and Cabinet Office. Now the Deputy Vice-Chancellor at the University of East London, he is responsible for delivering the key services across this modern University with some 18,000 students (both in London and overseas).

Mark Lam
Non-Executive Director
Mark Lam was appointed in September 2014 with a term of office until September 2017. 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. Originally from Singapore, Mark is settled in the UK. He holds a degree in literature from Oxford University.

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

Professor Anthony Warrens
Non-Executive Director
Anthony joined the Trust in July 2011. His term of office runs until June 2017. He is Dean for Education and Professor of Renal and Transplantation Medicine at Barts and the London School of Medicine and Dentistry, Queen Mary University of London. He is also a Consultant Physician at Barts Health NHS Trust and is a member of the Human Tissue Authority.

Rob Whiteman
Non-Executive Director
Rob Whiteman is Chief Executive of CIPFA and joined the Trust in July 2014 with a two year term of office.

An accountant by profession, he previously held chief executive positions at London Borough of Barking and Dagenham, the Improvement and Development Agency and the UK Border Agency, an organisation with 25,000 staff and a £1.8bn budget. He is a well-known commentator and writer on public service reform and modernisation across the public sector.

Matthew Hopkins
Chief Executive
Matthew Hopkins joined the Trust in April 2014. Previously, Matthew was the Chief Executive at Epsom and St Helier University Hospitals NHS Trust for three and half years. Under his leadership the Trust performed consistently well in the routine inspections from the Care Quality Commission and performed strongly against the emergency access and referral to treatment targets. Through promoting effective multidisciplinary team working, he also led an improvement in their financial footing, reducing a significant financial deficit of over £38 million to a breakeven position.

In an NHS career spanning 30 years, he has held board level positions at London teaching hospitals including Imperial College Healthcare NHS Trust, and Barts and the London. Matthew started his career as a nurse, and trained at Addenbrooke's Hospital in Cambridge before spending five years as a Macmillan palliative care nurse specialist. Matthew has published articles and authored a chapter in a palliative care textbook, as well as being included in The Evening Standard's 1000 most influential Londoners list.

Steve Russell
Deputy Chief Executive
Steve Russell was appointed in June 2014 as Deputy Chief Executive. Steve is a graduate of the NHS management training scheme and has worked in a range of operational and strategic roles in NHS hospitals for 16 years, starting his career in Northumbria Healthcare NHS Foundation Trust. In 2011 Steve became Chief Operating Officer for South London Healthcare NHS Trust and in 2013 became Programme Director for the London Delivery and Development Team at the NHS Trust Development Authority where he has focused on A&E services across the capital. He was appointed initially in February 2014 as Improvement Director accountable to the NHS TDA overseeing improvements at BHRUT following the Trust being placed in Special Measures. Steve Russell is the Trust's Senior Information Risk Owner.

Jeff Buggle
Director of Finance and Investment
Jeff joined the Trust in December 2014 as the Director of Finance and Investment. He previously worked as the Director of Finance and Performance at East Kent University Hospitals Foundation Trust, and has previous experience as a Director of Finance at two teaching hospitals, as well as nationally as Director of Finance for the NHS in Wales. He is a member of the Chartered Association of Certified Accountants and has an MBA from Henley Management College.

PROFILES OF OUR BOARD

Dr Nadeem Moghal
Medical Director
Dr Nadeem Moghal joined the Trust in January 2015. He is responsible for leading and directing the medical workforce, clinical standards, patient safety, and clinical governance, and is our Caldicott Guardian.

He was previously Associate Medical Director and Director of Strategy and Knowledge Management at George Eliot Hospital in North Warwickshire. There he led the implementation of a transformative and unique paediatric service model and worked with the senior leaders and teams to lead the Trust out of regulatory special measures, with the Care Quality Commission describing the organisation as 'Good'. He has authored and co-authored several peer-reviewed papers in medicine and social science and was co-editor of The Oxford Handbook of Renal Transplant. Whilst leading the regional paediatric nephrology service in Newcastle he completed an MBA which led to a Fellowship at the NHS Institute for Innovation and Improvement.

Practicing leadership and improvement science led him to influence thinking and build teams to lead change in a wide range of services and organisations as well as teach leadership at Newcastle University Business School. He was privileged to learn from the faculty at The Kennedy School of Government at Harvard University. He has a limited clinical practice as a consultant paediatric nephrologist and has worked across Scotland, several regions in England and Germany.

Kathryn Halford
Chief Nurse from 1 January 2016
Kathryn is a Registered General Nurse and Registered Sick Children's Nurse, having gained a wide variety of clinical experience across specialist, secondary and community care. She moved into NHS management in 1994. The management experience she gained at Gloucester Hospital enabled her to move to Great Ormond Street Hospital in London where she was an Associate Director of Nursing with specific responsibility for quality and education.

Kathryn was then seconded to the Department of Health for a year leading on an independent review into Children's Palliative Care before taking up a post with Skills for Health leading on workforce redesign nationally. Kathryn joined Walsall Healthcare in 2010 where she supported the quality and patient experience agenda.

Kathryn was the Executive lead for the Nursing, Midwifery and Therapist Workforce as well as carrying Executive accountability for Safeguarding, Dementia and End of Life Care at the Trust. She was also responsible for Improving the Patient Experience, the Professional Development Unit and Volunteering.

Wendy Matthews
Interim Chief Nurse from 23 March to 31 December 2015
Wendy is a qualified nurse, midwife and supervisor of midwives, and has over a decade's experience in leading Women's and Children's services.

She joined the Trust as Director of Midwifery in 2012. Before that she was Head of Midwifery and then Associate Director of Women's and Children's Services at Princess Alexandra Hospital in Harlow, Essex.

She has been instrumental in turning around a challenged maternity service, transforming a service criticised as failing by the Care Quality Commission into a service given a good rating, in just one year. During this time, she also led a reconfiguration of the service's community boundaries, working with commissioners and neighbouring providers, opened a co-located midwifery birth centre and reconfigured inpatient maternity services onto one hospital site, closing King George Hospital for inpatient maternity care and deliveries.

She is passionate about excellent patient care and is a Council Member of the London Clinical Senate, as well as the London Maternity Clinical Strategic Network. Wendy strongly believes in being visible and in touch with patients and continues to work clinically.

Jason Seez
Director of Planning and Governance
Jason joined from Medway NHS Foundation Trust where he was Executive Director of Strategy, Human Resources, Estates and Facilities, Communications and Re-development. Prior to this he worked for Barts Health NHS Trust. With a strong background in both strategic development and operational service planning and performance, Jason has delivered significant improvements in hospital and community services in London teaching hospitals and Home Counties district general hospitals.

Deborah Tarrant
Director of People and Organisational Development
Deborah was previously the Director of Workforce and Corporate Affairs at The Royal Marsden NHS Foundation Trust. She has worked at several acute Trusts and has been a director for 11 years of her 19 years in the NHS. Prior to this Deborah worked in Museums and Galleries and the private sector. Deborah is a member of the Chartered Institute of Personnel and Development.

Deborah is committed to improving healthcare through well led and managed organisations which engage and develop people. Deborah is President of the Healthcare People Management Association which has a strong branch network covering the whole of the UK. The HPMA is the professional voice of Human Resources in healthcare and aims to develop and support HR and OD leaders and practitioners to improve the people management contribution in healthcare and ultimately improve patient care. Deborah led the business strategy for London HPMA Academy to provide an extended development programme in London.

Sarah Tedford
Chief Operating Officer
Sarah joined us after three years as Deputy Chief Executive at Kingston Hospital NHS Foundation Trust. Her career in the NHS started in 1985 as a student nurse and she held a variety of nursing posts both in England and Scotland. She then moved into management and undertook a Masters in Health Policy and Organisation and held a number of management and senior operational roles.

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

DECLARATIONS OF INTERESTS

Our Standing Orders require all Board members to declare any outside interests which are relevant and material to their position.

A register of all such declarations is maintained and updated on an on-going basis and confirmed at the end of each financial year by the Trust Secretary.

The register below was detailed in the Board papers of 5 April 2016 and updates can be accessed upon request from the Trust Secretary.

DECLARATION OF INTERESTS

BOARD MEMBERS AS AT 31 MARCH 2016

NON-EXECUTIVE DIRECTORS

Dr Maureen Dalziel	Chairman	Associate Zenon Consulting 1 Apr 2013 – Sept 2013 Director MD Health Consultancy Ltd (2004) Ian Dalziel Company Secretary, MD Health Consultancy Ltd (2004) Board Member, Intensive Care National Audit Research Centre (ICNARC) (1994) Board member British Pregnancy Advisory Service (BPAS) (2007 – April 2013
Dusty Amroliwala	Non-Executive Director	MD of Synagee Ltd Partner is senior DG in HMG (Home Office) Trustee of Combat Stress (Armed Services Mental Health Charity) Chair of Trustees, London Design and Engineering University Training College Lay member of the Judicial Conduct and Investigations Office (Ministry of Justice)
Mark Lam	Non-Executive Director	Chief Information Officer, Openreach, a BT Group business Company Director & Company Secretary, Insomnia Consulting Ltd
Joan Saddler	Non-Executive Director	Director DDC ltd Trustee ADRA Charity Ambassador - Mary Seacole Statue Appeal Associate Director – NHS Confederation Co-Chair of the NHS Equality and Diversity Council
Eric Sorensen	Non-Executive Director	Chairman Ocean Regeneration Trust, Tower Hamlets Chairman Royal Docks Trust Board member Old Oak Development Corporation
Prof Anthony Warrens	Non-Executive Director	Chair of Council London School of Jewish Studies Governor and Co-Chair Immanuel College, Bushey, Herts Member: Human Tissue Authority Consultant Private Practice at Wellington, BMI Hendon, London Bridge, Princess Grace and the Physician's Clinic BMI London independent hospitals Private medico-legal Practice Professor and Dean for Education, Barts and London Schools of Medicine and Dentistry, Queen Mary, University of London Honorary Consultant and (paid) Clinical Director, Education Academy
Rob Whiteman	Non-Executive Director	Director, CIPFA Business Ltd Chair, Barking and Dagenham College

EXECUTIVE DIRECTORS

Matthew Hopkins	Chief Executive	Spouse works for South East Commissioning Support Unit
Jeff Buggle	Director of Finance and Investment	Partner is a solicitor at the Department of Health advising the Secretary of State for Health (leading on primary care legislation) Sister in law is Deputy Chair of Havering Healthwatch
Wendy Matthews	Director of Midwifery and Interim Director of Nursing	Member of the London Clinical Senate Council 2 sessions / month Family Planning Nurse, Princess Alexandra Hospital NHS Trust, Harlow Essex
Nadeem Moghal	Medical Director	Director at MMC Ltd. Undertakes private medico and medico-legal work
Steve Russell	Deputy Chief Executive	Partner is Executive Director of Delivery and Improvement at St George's NHS Trust.
Jason Seez	Director of Planning and Governance	Partner employed by NHS Improvement
Deborah Tarrant	Director of People and Organisational Development	Director Tarrant People Solutions Ltd Partner is Senior Partner at Capsticks Solicitors LLP President London Healthcare People Management Association
Sarah Tedford	Chief Operating Officer	No interests to declare
Kathryn Halford	Chief Nurse	No interests to declare

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 2016 were KPMG LLP. KPMG LLP have not carried out any non-audit work for the Trust during the year.

COST ALLOCATION AND CHARGES FOR INFORMATION

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

BETTER PAYMENT FOR SUPPLIERS

The Trust supported The Better Payment Practice Code that was established in 1998 by business and government together, to help improve the payment culture amongst organisations trading in the UK. The Code is supported by public as well as private sector organisations. Collectively they represent about 20% of the UK's gross domestic product. This simple code sets out the following obligations of a business to its suppliers:

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

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

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

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

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 Section 3: 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.

STATEMENT OF DIRECTORS' RESPONSIBILITIES

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury

- make judgements and estimates which are reasonable and prudent

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State.

They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Steve Russell, Deputy Chief Executive
For and on behalf of the Chief Executive
Date: 1 June 2016

Jeff Buggle, Director of Finance and Investment
Date: 1 June 2016

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

The Chief Executive of the NHS Trust Development Authority (NHS Improvement) has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Chief Executive of the NHS Trust Development Authority (NHSI). These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance

- value for money is achieved from the resources available to the Trust

- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them

- effective and sound financial management systems are in place

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Steve Russell, Deputy Chief Executive
For and on behalf of the Chief Executive

ANNUAL GOVERNANCE STATEMENT

1. SCOPE OF RESPONSIBILITY

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

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

2. OUR GOVERNANCE FRAMEWORK

Our governance framework and system of internal control helps us to manage risk to a reasonable level; it does not eliminate all risk, and it therefore provides reasonable and not absolute assurance of effectiveness. The system of internal control was in place for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Our system of internal control aims to:

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

OUR BOARD AND COMMITTEE STRUCTURE

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

Our Board, which met on 11 occasions in public during the year, regularly reviews performance against national standards and regulatory requirements. A summary of performance is included in our Annual Report. The Trust Board reviews and monitors monthly performance reports to meet the requirements of the Trust Development Authority's (now NHS Improvement) Accountability Framework building those requirements into its annual operational plan, and ensuring that they are addressed as part of our integrated planning process.

The challenges we face in meeting these standards and other statutory and regulatory requirements, together with issues identified in the Care Quality Commission (CQC) inspection report published in July 2015, resulted in our Trust remaining in special measures by the then Trust Development Authority. Significant and sustained actions have been taken over the past year to improve the Trust's governance and the quality and safety of services provided. Last year we reported that we have a board and leadership team with the capacity and capability to address the long-standing challenges that impact on the quality of care we provide for our patients. This year we can report sustained progress in implementing change. For example, the Board agreed in September 2015 a new risk management policy and strategy and these have been implemented throughout the Trust. We have a complete executive team too, with no executive directors' positions being held by interims.

We have complied with the relevant aspects of the Corporate Governance in Central Government departments: Code of Good Practice 2011. Of particular note during the year, we undertook an independent board and governance review (May 2015) which was conducted by the Good Governance Institute (GGI) and funded by the then Trust Development Authority. We have been systematically delivering the recommendations from this review as part of improved governance grip by the board.

With reference to the requirements of our Standing Orders, the Director of Finance and Investment has 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.

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 executive lead for improving patient experience.

The board is taking forward the development of our quality improvement strategy in partnership with the Virginia Mason Institute. The Trust has published its improvement plan which addresses the CQC recommendations with on-going progress being monitored at our monthly public trust board meetings.

Our quality priorities formed the basis of the Quality Account 2015/16. In preparation of our Quality Account 2015/16, we have a schedule for public and stakeholder engagement which takes into account the required time for our Auditor's assessment and validation of data.

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 are building on the developing divisional structure which we established last year. We have continued to strengthen the divisions' governance and leadership capability. Significant review and developmental effort has been undertaken at the divisional level by RSM, our internal auditors and GGI to help build strong within-division systems and skills, and this will be further developed through on-going investment in organisational development.

During the year we embedded a new committee structure that was recommended by GGI in their review of our governance and board. In 2015/16, the Trust had the following principal committees:

The Quality Assurance Committee monitors and reviews KPIs and national targets for quality and safety risk control. The committee facilitates effective and timely provision of high levels of assurance to the board, local population, stakeholders and regulators, that all aspects of our quality and safety agenda are being met. This includes the review of governance structures and risk management processes and controls to promote safety and excellence in patient care; the identification, prioritisation and management of risk arising from clinical care; ensuring the effective and efficient use of resources through evidence-based clinical practice; and protecting the health and safety of our staff and volunteers.

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

The Remuneration Committee determines our overall remuneration policy, sets the remuneration, allowances and other terms and conditions of office for executive directors and recommends and monitors the structure of remuneration for senior managers.

The Finance and Investment Committee scrutinises our annual operational and financial plan, long-term financial strategy and major investment decisions. The committee reviews monthly financial performance and identifies the key financial and investment issues and risks requiring escalation to the board.

The People and Culture Committee oversees the development and delivery of our people development and organisational development strategy as well as monitoring progress against targets and objectives. The committee provides a formal reporting forum for workforce and education matters, including attendance at mandatory and statutory training, scrutiny of activity and expenditure (particularly related to temporary staffing), and for monitoring and evaluating progress on compliance with regard to workforce equality and diversity.

The Charitable Funds Committee provides additional assurance to the Board that our charitable activities are within the law and regulations set by the Charity Commission for England and Wales. It does not remove from the Board the overall responsibility as corporate trustee; it provides a forum for more detailed consideration of charitable matters.

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

3. RISK MANAGEMENT AND ASSURANCE

We have a Risk Management Policy and Strategy which applies to all our staff. This sets out the risk assessment and management processes agreed by the board in September 2015. It is due for review in July 2016.

At the strategic level, our board assurance framework (BAF) enables us to assess and evaluate the principal risks to achieving our strategic objectives. Acting on the recommendations of auditors, the BAF is a live document being continually refined and updated to provide a current view around the risks to our strategic objectives, and the appropriate controls, assurances, gaps in controls and assurances and planned actions. The board and the audit committee maintain close oversight and scrutiny of the BAF, with specific risks assigned to executive directors and assurances being monitored by the board and specific sub-committees. Our Head of Internal Audit concluded that we have acted positively on recommendations made within our risk management audit from 2015/16 and significant work has been undertaken in developing and embedding risk management arrangements across our Trust.

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

Table 2- Risk responsibilities

ROLE	RISK RESPONSIBILITY
Chief Executive	Designated Accountable Officer and overall accountability for our risk management
Deputy Chief Executive	Senior Information Risk Officer (SIRO) and overall responsibility for information governance risks
Medical Director	Caldicott Guardian and joint lead on the management of quality and patient safety
Chief Nurse	Joint lead on the management of quality and patient safety
Director of Finance and Investment	Financial control and investment risks
Chief Operating Officer	Risk relating to the delivery of clinical services
Director of People and Organisational Development	Workforce and organisational development risks
Director of Planning and Governance	Risks relating to the development of strategy and planning. Central role of the company secretary for the promotion of good corporate governance

Assurance around operational risks is provided to our board through both the management route, direct reports to the board and from additional scrutiny from two key subcommittees of the board:

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

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

During the year, the Trust secured support from the then Trust Development Authority around a significant quality and safety transformation programme which was delivered by GGI. As part of this there was a significant effort to embed risk management. A Risk and Compliance Group was set up that reports up to the Trust Executive Committee through the new Quality and Safety Advisory Group. The Risk and Compliance Group scrutinise key risk management instruments such as the risk register and the operation of the risk escalation process. The entire risk register has been reviewed during the last year, and is authentically a live instrument that is increasingly connected to other risk and safety systems such as incident reporting, serious incident (SI) investigation and patient feedback. As part of the quality and safety transformation programme a new incident and serious incident policy was adopted in November 2015. We have also significantly strengthened our clinical audit function.

A training and development programme has been established to enable staff at all levels to fulfil their responsibilities and work with those systems to minimise risk to staff, patients, visitors and contractors, and to understand how the risk management policy and strategy operates, as well as 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, Local Representatives' Panel and the National Patient Survey Programme and the results of real time feedback on wards and departments, complaints, compliments and ia social media.

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

Our staff are entitled to membership of the NHS Pension scheme and control measures are in place to ensure that we comply with all employer obligations contained within the scheme's regulations.

4. REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance and on the controls reviewed as part of the work that Internal Audit has undertaken. The Head of Internal Audit Opinion concludes that the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Our internal auditors, RSM, have completed a number of audits in the year and the Trust has achieved a 90% implementation rate for follow up actions identified from previously completed audits. No red (no assurance) assurance reports have been issued to the Trust, and two audit reports which are amber red (partial assurance). These referred to medicines management and the management of temporary staffing. In both cases, management actions are in place to reach a higher state of assurance.

A review of medicines management was carried out to determine the strength of the controls and processes in place within the Trust to ensure the safe storage and security of the Controlled Drugs held, with particular focus at ward level, to establish that legislation has been adopted, and controls are in place to ensure accuracy of recording. Internal audit provided partial assurance that controls existed, although further work was identified to

ensure these controls were strengthened, in particular in terms of stock checks, physical controls and release of controlled drugs to patients in care homes.

A review of the management of temporary staffing, where again partial assurance was provided, identified that controls are suitably designed and consistently applied. The audit recognised that significant work has been undertaken to improve process and controls in the year, although the size of the temporary staffing challenges remain. The Trust has reduced its agency rate of expenditure, which is a positive development, along with the introduction of agency rate price caps. Further work remains to ensure shifts are processed in a timely and accurate manner and rates are closely monitored.

Regarding our improvement plan, Internal Audit confirmed that the Trust could take reasonable assurance that the controls in place to manage the associated risks are suitably designed and consistently applied, including good progress against the 'must do' actions. In addition, the audit found positive evidence showing that robust processes had been put in place showing how items had been closed off and around escalation.

Freedom of Information
We are aware of our responsibilities under the Freedom of Information Act 2000 (FOI). Our aim is to respond to each request within the 20 working days deadline. In 2015/16 we received 666 FOI requests, of which 399 were answered within deadline.

Following an external review of our FOI systems and procedures, a weekly report is provided to each executive director, highlighting those requests which have breached the deadline. We have strengthened our procedures in order to focus on responses due during the following week; the aim being to increase the proportion of requests responded to within the deadline.

FOI training sessions have been co-ordinated with leads from divisions/departments who co-ordinate/answer requests, and executive directors from the approval perspective, to support areas in understanding the requirements of FOI and focusing on the quality of our responses. In addition, we are working on expanding the data routinely available on our website that is included in our Publication Scheme and as part of a disclosure log on our website.

Financial position
The Trust had a deficit financial plan agreed with the then Trust Development Agency and, for the second year running, has achieved its financial target. These targets include its overall control total, its External Financing Limit, its Capital Resource Limit, and its Quality and Cost Improvement Programme Target. In the year it has consistently delivered against in-monthly financial performance requirements, including delivery of further savings and expenditure reductions required mid-way through the financial year. Controls have been strengthened for management of expenditure, along with improvements in forecasting.

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

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

I have been advised on the implications of the result of my review into the effectiveness of the system of internal control by the various committees of the board and most of all by the Audit Committee. Individual plans to address identified weaknesses are in place and the significant actions are consolidated into our Improvement Plan, Unlocking our Potential.

Compliance
Our key compliance issues are detailed below.

Care Quality Commission (CQC)
The Trust is working on addressing the key recommendations included within the letter (and report) from Professor Sir Mike Richards, Chief Inspector of Hospitals, dated July 2015. The full report can be accessed on the CQC's website. The Trust is compliant with CQC registration requirements.

National performance standards
The Trust's operational performance has continued to improve, but performance was not fully achieved with regard to the national four hour emergency access, the 18 week referral to treatment (RTT) or the 62 day cancer pathway standards. These areas are being vigorously addressed as part of the Trust's improvement plan.

Never events
There were no reportable never events during 2015/16.

Regulation 28 reports - Coroners' (Investigations) Regulations 2013
We received four Regulation 28 reports from HM Coroner to prevent future deaths. Regular reports on inquests and Regulation 28 actions are now included within the incident and serious incident data reports which are received by the Trust Executive Committee, the Quality Governance Steering Group, and in summary to the Quality Assurance Committee. We have improved our processes for the management of inquests and follow-up of actions related to Regulation 28 reports and will continue to improve throughout 2016/17.

Equality, diversity, and human rights
Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with.

Information governance toolkit
Our Information Governance Assessment Report for the period 2015/16 was 67% and was rated as satisfactory. We have been able to meet the target that at least 95% of staff are up to date with their level 2 information governance training, and we are seeking to complete the remainder. This target was achieved by 31 March 2016.

The information governance incidents scoring system relating to the identification of serious incidents changed on 1 June 2013 with new published guidance issued by the Health and Social Care Information Centre (HSCIC). Under the revised system, any Information Governance Serious Incident score at level two or above is reported on the Information Governance Toolkit Incident Reporting Tool, which is automatically escalated to the Department of Health, the Information Commissioner's Office and other relevant bodies. During 2015/16 there was one Serious Incident (SI) involving personal data, which we reported to the Information Commissioner's Office, the details of which are as follows:

A generic email was sent to 248 individuals and due to a failure to "blind copy" recipients' mail addresses, all recipients were able to see the personal email addresses of all other recipients. A thorough investigation was undertaken and all recipients were contacted. The ICO decided not to take further action as they concluded the data has relatively low sensitivity and the incident occurred as a result of "human error".

We continue to take steps to ensure the secure management of patient and staff information. This is facilitated through enhancements to our information security systems and processes, embedding clear policies and procedures in our daily work and ensuring staff receive annual information governance training.

Core skills training
During 2015/16 there has been a continued effort to refine e-learning subjects ensuring they are up to date and help us achieve core skills compliance of 85% in all subjects other than Information governance where 95% is the expectation.
We have successfully improved our core skills compliance as part of the pan-London streamlining project which was recognised by a certificate of achievement award. This means that we are able to capture prior learning at other trusts as part of the induction process and prevent repetition.
As part of preparatory in-year work, in advance of the introduction of a new e-learning platform in 2016/17, a concerted effort has been made in making compliance with core skills a high priority for the Trust.

Additional capacity has been created to accommodate staff undertaking their training and the majority of statutory and mandatory training has been converted into e-learning packages. The new, remote access e-learning system next year will address issues in respect of the current system being complicated to navigate and with limited accessibility.

Alongside a refreshed Trust 'corporate welcome', the Registered Nurse and Healthcare Assistant Programmes have been reviewed and capacity increased by 35% to take into account an increase in recruitment. This improves the experience for new starters, ensures they have the right training to commence their roles, and introduces them to the organisation with PRIDE values and expectations clearly defined.

Conclusion
The internal control issues that I have outlined in this statement confirm we have achieved improvements in our system of internal control to help assure compliance of our policies and to ensure we achieve our aims and objectives of providing great care to patients. I am pleased to note that the Head of Internal Audit has issued an 'unqualified' opinion in respect of the 2015/16 year. We will continue to make progress and improve our operation and management of controls.

Steve Russell, Deputy Chief Executive

For and on behalf of the Chief Executive as Accountable Officer

Barking, Havering and Redbridge University Hospitals NHS Trust

REMUNERATION AND STAFF REPORT

REMUNERATION REPORT

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

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

Each year the Remuneration Committee considers the contribution of each director against the responsibilities of the role and objectives set through performance plans and the leadership qualities framework. The Remuneration Committee considers the matter of succession planning, although all executive directors hold permanent contracts.

The notice period for executive directors is six months and there 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 1

Salary and Pension entitlements of senior managers
Remuneration

	2015-16						2014-15
Name and Title	Salary (bands of £5,000) £000	Taxable expenses payments to nearest £100	Performance pay & bonuses (bands of £5,000) £000	Long term performance pay (bands of £5,000) £000	All Pension-related benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Total (bands of £5,000) £000
Dr Maureen Dalziel - Chairman 1st April 2015 to 31st March 2016	35-40	0	0	0	-	35-40	20-25
Matthew Hopkins - Chief Executive 1st April 2015 to 31st March 2016	185-190	0	0	0	32.5 - 35.0	220-225	480-485
Stephen Russell - Deputy Chief Executive 1st April 2015 to 31st March 2016	170-175	0	0	0	232.5 - 235.0	400-405	85-90
Jason Seez - Director of Planning & Governance 1st April 2015 to 31st March 2016	120-125	59.15	0	0	82.5 - 85.0	205-210	140-145
Deborah Tarrant -Director of People & Organ. Development 1st April 2015 to 31st March 2016	125-130	0	0	0	150.0 - 152.5	275-280	235-240
Sarah Tedford - Chief Operating Officer 1st April 2015 to 31st March 2016	165-170	32.40	0	0	217.5 - 220.0	385-390	160-165
Jeff Buggle - Director of Finance & Investment 1st April 2015 to 31st March 2016	180-185	0	0	0	130.0 - 132.5	310-315	220-225
Wendy Matthews Interim Chief Nurse 1st April 2015 to 18th January 2016	100-105	0	0	0	167.5 - 170.0	270-275	-
Kathryn Halford Chief Nurse from 4th January 2016 to 31st March 2016	30-35	0	0	0	92.5 - 95.0	125-130	-
Dr Nadeem Moghal - Medical Director 1st April 2015 to 31st March 2016	180-185	0	0	0	420.0 - 422.5	600-605	185-190
Rachel Royall - Director of Communications/Marketing 1st April 2015 to 31st March 2016	105-110	0	0	0	47.5 - 50.0	155-160	80-85
Simon Mills Director of Estates from 3rd August 2015 to 31st March 2016	75-80	0	0	0	25.0 - 27.5	100-105	-
Eric Sorensen - Non-executive Director 1st April 2015 to 31st March 2016	5-10	0	-	-	0	5-10	0-5
Robert Whiteman - Non-executive Director 1st April 2015 to 31st March 2016	5-10	0	-	-	0	5-10	0-5
Professor Anthony Warrens - Non-executive Director 1st April 2015 to 31st March 2016	5-10	0	-	-	0	5-10	5-10
Dusty Amroliwala - Non-executive Director 1st April 2015 to 31st March 2016	5-10	0	-	-	0	5-10	0-5
Mark Lam - Non-executive Director 1st April 2015 to 31st March 2016	5-10	0	-	-	0	5-10	0-5
Joan Saddler - Non-executive Director 1st April 2015 to 31st March 2016	5-10	0	-	-	0	5-10	0-5
Ros Gray (TDA Improvement Director) until 17th December 2015				See Note 1			
Claire Pacey (TDA Improvement Director) 3rd February 2016 to 31st March 2016				See Note 2			
Angela Helleur (TDA Improvement Director) (to 29th July 2014)				See Note 3			
Median remuneration of all staff in the Trust (£)				**32,407**			**32,366**
Highest paid director of the Trust (£5k band)				**185-190**			**185-190**
Ratio of the above two figures				**5.8**			**5.8**

Notes

(1) Ros Gray (TDA Improvement Director) was appointed by and employed by the NHS Trust Development Authority (NTDA) who met her salary cost in full as her employer. Those costs are not shown above.

(2) Claire Pacey (TDA Improvement Director) was appointed by and works through the NHS Trust Development Authority (NTDA) for 2 days a week. The NTDA meet her salary cost in full as her employer. Those costs are not shown above.

(3) Angela Helleur (TDA Improvement Director) was appointed by and employed by the NHS Trust Development Authority (NTDA) who met her salary cost in full as her employer. Those costs are not shown above.

(4) 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. Total remuneration includes salary, performance related pay and benefits as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. This is detailed in table 2 below.

Steve Russell,
Deputy Chief Executive

For and on behalf of the Chief Executive

PENSION ENTITLEMENT TABLE

TABLE 2
Salary and Pension entitlements of senior managers (continued)
Pension Benefits

Name and title	Real increase in pension as at pension age (bands of £2,500) £000	Real increase in lump sum as at pension age (bands of £2,500) £000	Total accrued pension as at pension age at 31 March 2016 (bands of £5,000) £000	Total related lump sum as at pension age at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2015 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Matthew Hopkins - Chief Executive	0.0 - 2.5	2.5 - 5.0	70.0 - 75.0	215.0 - 220.0	1,205	1,252	33	0
Stephen Russell - Deputy Chief Executive	10.0 - 12.5	20.0 - 22.5	40.0 - 45.0	110.0 - 115.0	383	508	121	0
Jason Seez - Director of Planning & Governance	2.5 - 5.0	2.5 - 5.0	35.0 - 40.0	100.0 - 105.0	474	526	47	0
Deborah Tarrant - Director of People & Organ. Development	5.0 - 7.5	17.5 - 20.0	35.0 - 40.0	115.0 - 120.0	573	706	126	0
Sarah Tedford - Chief Operating Officer	7.5- 10.0	27.5 - 30.0	40.0 - 45.0	120.0 - 125.0	582	772	183	0
Dr Nadeem Moghal - Medical Director	17.5 - 20.0	52.5 - 55.0	65.0 - 70.0	195.0 - 200.0	909	1,279	359	0
Jeff Buggle - Director of Finance & Investment	5.0 - 7.5	7.5- 10.0	70.0 - 75.0	205.0 - 210.0	1,142	1,246	91	0
Wendy Matthews - Interim Chief Nurse	5.0 - 7.5	20.0 - 22.5	45.0 - 50.0	135.0 - 140.0	685	850	157	0
Kathryn Halford Chief Nurse	2.5 - 5.0	10.0 - 12.5	40.0 - 45.0	130.0 - 135.0	710	803	84	0
Rachel Royall - Director of Communications/Marketing	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	20	38	18	0
Simon Mills - Director of Estates	0.0 - 2.5	0	10.0 - 15.0	10.0 - 15.0	151	173	20	0

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

CASH EQUIVALENT TRANSFER VALUES

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) regulations 2008.

REAL INCREASE IN CETV

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

Steve Russell,
Deputy Chief Executive

For and on behalf of the
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.

	2015-16	2014-15
Band of the highest paid director's total remuneration (£000)	185-190	185-190
Median pay remuneration (£)	32,407	32,366
Median pay multiple	5.8	5.8
Range of staff remuneration	18,583-189,500	17,742 – 189,500

The highest paid director salary was the same as the previous year with the median salary also being static, resulting in no change to the median pay multiple.

The banded remuneration of the highest-paid director in the Trust in the financial year 2015/16 was in the band £185k-£190k (2014/15, £185k-£190k). This was 5.8 times (2014/15, 5.8) the median remuneration of the workforce, which was £32,407 (2014/15, £32,366). 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 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 are key to good patient and staff experience.

Ethnicity	Headcount
White - British	2801
White - Irish	159
White - Any other White background	246
White Northern Irish	2
White Unspecified	5
White English	44
White Scottish	6
White Cypriot (non specific)	1
White Greek	11
White Greek Cypriot	5
White Turkish	4
White Italian	56
White Traveller	1
White Gypsy/Romany	1
White Polish	29
White ex-USSR	10
White Kosovan	2
White Albanian	2
White Croatian	3
White Serbian	1
White Other Ex-Yugoslav	1
White Mixed	3
White Other European	63
Mixed - White & Black Caribbean	31
Mixed - White & Black African	29
Mixed - White & Asian	23
Mixed - Any other mixed background	46
Mixed - Black & Asian	1
Mixed - Black & Chinese	1
Mixed - Asian & Chinese	1
Mixed - Other/Unspecified	13
Asian or Asian British - Indian	468
Asian or Asian British - Pakistani	172
Asian or Asian British - Bangladeshi	96
Asian or Asian British - Any other Asian background	211
Asian Mixed	4
Asian Punjabi	15
Asian Kashmiri	3
Asian East African	3
Asian Sri Lankan	19
Asian Tamil	15
Asian Sinhalese	3
Asian British	72
Asian Caribbean	5
Asian Unspecified	16
Black or Black British - Caribbean	185
Black or Black British - African	707
Black or Black British - Any other Black background	30
Black Somali	5
Black Nigerian	76
Black British	37
Black Unspecified	7
Chinese	61
Any Other Ethnic Group	125
Filipino	281
Malaysian	9
Other Specified	4
Undefined	8
Not Stated	107
Mixed - Chinese & White	1
Grand Total	**6346**

The table below gives the gender breakdown within the Trust.

	Female	Male
Number of people from each gender who were directors	4	4
Non Execs and Chair	2	5
Senior managers	62	55
Employees	4,897	1,449

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:

Staff Group	Total	%
Additional professional scientific and technical	188	3.0%
Additional clinical services	1,198	18.9%
Administrative and clerical	1,278	20.2%
Allied Health Professionals	374	5.9%
Estates and ancillary	18	0.3%
Healthcare scientists	189	3.0%
Medical and dental	965	15.2%
Registered nurses and midwives	2,092	33.0%
Students	44	0.7%

Our target for staff sickness levels over the course of the year stood at 4%. We came in within that target at 3.6% and aim to decrease it further in 2016/17.

No new staff policies were applied during 2015/16.

OFF-PAYROLL ENGAGEMENTS

During the year the Trust entered into a number of off-payroll engagement for services. These are detailed below:

TABLE 1-For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016 *Of which, the number that have existed:*	5
for less than one year at the time of reporting	3
for between 1 and 2 years at the time of reporting	2
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

TABLE 2- For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last: longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	3
Number of new engagements which include contractual clauses giving BH&R University Hospitals NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	3
Number for whom assurance has been requested *Of which:*	3
assurance has been received	3
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

TABLE 3-Off-payroll engagements with significant financial responsibility

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	20

Expenditure on consultancy
In 2015/16 the Trust spent £1,957k on Consultancy services. This related to support for governance, service development, and analysis of systems and coding.

Exit Packages
Details of exit packages are detailed in note 10.4 in the financial statements.

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

We have audited the financial statements of Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

RESPECTIVERESPECTIVE RESPONSIBILITIES OF DIRECTORS, THE ACCOUNTABLE OFFICER AND AUDITOR

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

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 1O(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

SCOPE OF THE AUDIT OF THE FINANCIAL STATEMENTS

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

OPINION ON FINANCIAL STATEMENTS

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Emphasis of Matter - financial position

In forming our opinion on the financial statements, which is not qualified, we have considered the adequacy of the disclosure made in Note 1.2 to the financial statements concerning the Trust's financial position. The Trust incurred a deficit of £33.7m during the year ended 31 March 2016. This was delivered through the receipt of loan funding together with one-off in year transactions. The requirement placed on public sector bodies require that judgements on going concern are reached with reference to the continuance of service provision by the public sector and measured with reference to public confirmation of funding for those services.

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

OPINION ON OTHER MATTERS

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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

We have nothing to report in respect of the above responsibilities.

Other matters on which we report by exception: Referral to 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 or deficiency.

On 5 May 2016 we wrote to the Secretary of State in accordance with section 30 of the 2014 Act in respect of the Trusts failure to deliver its breakeven duty as set out at paragraph 2(1) of Schedule 5 to the National Health Service Act 2006. The Trust's draft financial statements for the financial year ended 31 March 2016 identify a cumulative deficit of £348.8 million, with £33.7 million of that incurred in the 2015/16 period.

Other matters on which we report by exception: Adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources.

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, we identified that the points above relating to the in-year and cumulative deficit. In addition, the Trust has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit in 2016/17 which is awaiting TOA approval.

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

Except for the matters referred to above, we are satisfied that, in all significant respects, Barking, Havering and Redbridge University Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

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
Canary Wharf
London E14 5GL

2 June 2016

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

We have examined the summarisation schedules designated TRU01 to TRU22 and TRU25 of Barking, Havering and Redbridge University Hospitals NHS Trust for the year ended 31 March 2016, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This report is made solely to the Board of Directors of Barking, Havering and Redbridge University Hcspitals NHS Trust as a body, in accordance with 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.

For the purpose of this report, the agreement of figures between the statutory financial statements and the summarisation schedules extends only to those figures within the audited financial statements which are also published in the summarisation schedules. Auditors are required to report on any differences over £250,000 between the final audited statutory financial statements and the summarisation schedules.

The audit opinion on the financial statements includes an Emphasis of Matter paragraph; no differences identified:

In our opinion the figures reported in the final audited statutory financial statements agree to the figures reported in the summarisation schedules.

Our opinion on the statutory financial statements included an emphasis of matter paragraph because of the fundamental uncertainty relating to the Trusts financial position. For the year ended 31 March 2016, the Trust's financial deficit was £33.7 million, with a cumulative deficit of £348.8 million. These conditions and other matters explained in Note 1.2 to the financial statements indicate the existence of a material uncertainty which may place significant doubt on the Trust's ability to achieve long term financial stability.

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

Chartered Accountants
15 Canada Square
Canary Wharf
London E14 5GL

2 June 2016

SECTION THREE:

FINANCIAL STATEMENTS AND NOTES

ACCOUNTS 2015-16

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	**2015-16 £000s**	2014-15 £000s
Gross employee benefits	10.1	**(332,851)**	(317,757)
Other operating costs	8	**(208,286)**	(157,502)
Revenue from patient care activities	5	**474,939**	455,228
Other Operating revenue	6	**30,300**	22,765
Operating surplus/(deficit)		**(35,898)**	2,734
Investment revenue	12	**258**	405
Other gains and (losses)	13	**0**	0
Finance costs	14	**(26,262)**	(25,575)
Deficit for the financial year		**(61,902)**	(22,436)
Public dividend capital dividends payable		**(952)**	(2,872)
Retained deficit for the year		**(62,854)**	(25,308)

Other Comprehensive Income	**2015-16**	2014-15
Impairments and reversals taken to the revaluation reserve	**(25,938)**	0
Net gain on revaluation of property, plant & equipment	**690**	17,130
Total Other Comprehensive Income	**(25,248)**	17,130
Total comprehensive income for the year	**(88,102)**	(8,178)

Financial performance for the year	**2015-16**	2014-15
Retained surplus/(deficit) for the year	**(62,854)**	(25,190)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**20,125**	607
Impairments (excluding IFRIC 12 impairments)	**9,083**	(13,380)
Adjustments in respect of donated gov't grant asset reserve elimination	**(73)**	13
Adjusted retained deficit	**(33,719)**	(37,950)

The notes on pages 6 to 34 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	**31 March 2016 £000s**	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	**314,185**	372,855
Intangible assets	16	**6,957**	7,128
Trade and other receivables	22.1	**3,821**	7,442
Total non-current assets		**324,963**	387,425
Current assets:			
Inventories	21	**9,230**	7,109
Trade and other receivables	22.1	**49,680**	35,380
Cash and cash equivalents	23	**1,118**	666
Sub-total current assets		**60,028**	43,155
Non-current assets held for sale	24	**0**	0
Total current assets		**60,028**	43,155
Total assets		**384,991**	430,580
Current liabilities			
Trade and other payables	25	**(64,436)**	(48,624)
Provisions	31	**(629)**	(1,305)
Borrowings	26	**(8,453)**	(7,810)
DH Capital loan	26	**(602)**	(602)
Total current liabilities		**(74,120)**	(58,341)
Net-current assets/(liabilities)		**(14,092)**	(15,186)
Non-current assets plus/less net current assets/liabilities		**310,871**	372,239
Non-current liabilities			
Trade and other payables	25	**(4,064)**	(4,277)
Provisions	31	**(2,993)**	(2,926)
Borrowings	26	**(239,941)**	(247,321)
DH revenue support loan	26	**(31,500)**	0
DH capital loan	26	**(8,177)**	(5,417)
Total non-current liabilities		**(286,675)**	(259,941)
Total assets Employed:		**24,196**	112,298
FINANCED BY			
Public Dividend Capital		**477,076**	477,076
Retained earnings		**(455,347)**	(392,493)
Revaluation reserve		**2,467**	27,715
Other reserves		**0**	0
Total Taxpayers' Equity:		**24,196**	112,298

The notes on pages 6 to 34 form part of this account.

The financial statements on pages 2 to 5 were approved by the Board on 1st June 2016 and signed on its behalf by Deputy Chief Executive:

Steve Russell
For and on behalf of the Chief Executive
1 June 2016

Statement of Changes in Taxpayers' Equity For the year ended 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**477,076**	**(392,493)**	**27,715**	**112,298**
Changes in taxpayers' equity for 2015-16				
Retained deficit for the year		(62,854)		**(62,854)**
Net gain on revaluation of property, plant, equipment			690	**690**
Impairments and reversals			(25,938)	**(25,938)**
Reclassification Adjustments	0	0	0	**0**
Net recognised expense for the year	**0**	**(62,854)**	**(25,248)**	**(88,102)**
Balance at 31 March 2016	**477,076**	**(455,347)**	**2,467**	**24,196**

Balance at 1 April 2014	**438,447**	**(367,303)**	**10,585**	**81,729**
Changes in taxpayers' equity for the year ended 31 March 2015				
Retained deficit for the year		(25,190)		(25,190)
Net gain on revaluation of property, plant, equipment			17,130	17,130
Reclassification Adjustments				
New temporary and permanent PDC received - cash	76,599			76,599
New temporary and permanent PDC repaid in year	(37,970)			(37,970)
Net recognised revenue/(expense) for the year	**38,629**	**(25,190)**	**17,130**	**30,569**
Balance at 31 March 2015	**477,076**	**(392,493)**	**27,715**	**112,298**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2016

	NOTE	2014-16	2013-15
		£000s	£000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		**(35,898)**	2,852
Depreciation and amortisation	8	**15,691**	16,469
Impairments and reversals	17	**29,208**	(13,380)
Donated Assets received credited to revenue but non-cash	6	**(126)**	(72)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(26,232)**	(25,369)
PDC Dividend paid		**(2,841)**	(2,499)
Increase in Inventories		**(2,121)**	(913)
(Increase)/Decrease in Trade and Other Receivables		**(8,780)**	2,156
Increase/(Decrease) in Trade and Other Payables		**16,437**	73
Provisions Utilised		**(946)**	(909)
Increase/(Decrease) in movement in non cash provisions		**292**	(3,241)
Net Cash Outflow from Operating Activities		**(15,316)**	(24,833)
Cash Flows from Investing Activities			
Interest Received		**258**	405
Payments for Property, Plant and Equipment		**(10,914)**	(13,631)
Net Cash Outflow from Investing Activities		**(10,656)**	(13,226)
Net Cash outflow before Financing		**(25,972)**	(38,059)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**0**	76,599
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**0**	(37,970)
Loans received from DH - New Capital Investment Loans		**3,362**	6,019
Loans received from DH - New Revenue Support Loans		**62,596**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(602)**	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(31,096)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(7,836)**	0
Net Cash Inflow from Financing Activities		**26,424**	37,424
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**452**	(635)
Cash and Cash Equivalents at Beginning of the Period		**666**	1,301
Cash and Cash Equivalents at year end	**23**	**1,118**	666

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health (DH) Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015/16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 ACCOUNTING CONVENTION

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

1.2 FINANCIAL POSITION

These accounts have been prepared on the basis the Trust is a going concern.

This year the Trust has continued to meet its financial targets, against a backdrop of increased financial pressure across the NHS. In achieving these, we delivered our agreed deficit target of £34m and have managed to find more than £21m in savings through our Quality and Cost Improvement (QCIP) Programme.

The Trust has submitted a 2016/17 plan to NHS Improvement for an in-year deficit of £11.9m. The Trust's financial priority for the year is to reduce the deficit, whilst further embedding processes for Quality and Cost Improvement, as part of its longer term financial strategy.

In 2016/17 the Trust will be continuing the implementation of its strategy to include

- development of a resilience service
- a service improvement plan
- delivery of sustainability and transformation plan with wider economy
- review of estate configuration
- implementation of Lord Carter's recommendation on procurement strategy

2016/17 healthcare contracts with Clinical Commissioning Groups (CCGs) in NE London and Essex have been agreed, with contract sign-offs anticipated before the beginning of May. Discussions are also ongoing with NHS England regarding agreement of the contract for specialist services

The 2016/17 cash flow forecast is based on the assumptions in the 2016/17 Plan with monthly reporting of cash flow to the Finance & Investment Committee and the Board. Internally, 12 month rolling cash flow forecasts are updated daily and reviewed. Key assumptions are:

a) Receipt of £12m revenue support loan, to finance the revenue deficit

b) Receipt of £16.8m PFI revenue support from NHS England

c) Receipt of the Sustainability and Transformation Plan funding of £20m

Taking into account the following factors, and the intention that the healthcare and other services will continue to be provided by the public sector for the foreseeable future, the Directors consider the Trust will continue to operate as a going concern:

- The Trust is planning to reduce its financial deficit position in 2016/17 as part of its long term financial plan.
- Embedding cost control measures developed through 2015, with specific focus on temporary staffing, consumables and fixed costs as part of a more robust performance management framework.
- The QCIP and service improvement plans include key workstream targets to improve productivity in theatres and outpatients, as well improving efficiency in resourcing and medicines management.
- The Trust is working with other health economy partners as part of the development of an Accountable Care Organisation (ACO) to identify service improvements and deliver long term financial sustainability.
- The Trust has agreed contracts with its lead commissioners; North East London (NELC), NHS England and Essex. These are all on a 'cost and volume' basis for 2016/17, with an aggregate plan value of approximate £440m .

1.3 MOVEMENT OF ASSETS WITHIN THE DH GROUP

Transfers as part of reorganisation are accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 CHARITABLE FUNDS

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

At the end of the financial year the charity held capital and reserves of £2.07m, a reduction in year of £0.4m.

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 2015/16 income and total funds are viewed below materiality. The Charity continues to publish a separate set of accounts for 2015/16 in accordance with the Statement of Recommended Accounting Practice "Accounting and Reporting by Charities"; FRS 102.

1.5 CRITICAL ACCOUNTING JUDGEMENTS AND KEY SOURCES OF ESTIMATION UNCERTAINTY

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

1.5.1 CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

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

The NHS Pensions Scheme provides cover for past and present employees, and is subject to a full actuarial valuation every five years (see note 10.6). The Trust carries provisions in certain instances relating to early retirement, based on latest actuarial information provided by the NHS Pensions Agency. This is therefore subject to change which is recognised in the period to which it arises.

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

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

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

a liability is recognised at the modelled asset replacement year and is measured at the implied cost to the Trust according to the MES provider's financial model. The implied rate of interest used is taken directly from the MES provider's financial model.

Land and building assets are valued on the basis explained in Notes 1.9 and 15. A professional firm of valuers has provided the Trust with a valuation based on estimated fair value and remaining useful life. As the Trust's land and buildings are infrastructural in nature, and thus do not have a conventional market value in use; the valuations are based on estimates provided by suitably qualified professionals in accordance with HM Treasury guidance. Future revaluations of property may result in further changes to the carrying values of non-current assets.

1.5.2 KEY SOURCES OF ESTIMATION UNCERTAINTY

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

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

The Trust has a number of operating leases and a Private Finance Initiative (PFI) Agreement where the Trust is the lessee. The PFI assets are held on-balance sheet, and are valued at current value, either by obtaining market valuations from appropriately qualified independent valuers, or on a depreciated replacement cost basis (see note 1.10). Valuations are therefore subject to market fluctuation, which could result in unforeseeable increases or decreases in valuation in future periods. Any known impairments which are not likely to be reversed in the near term are accounted for in the period in which they arise. Operating leases are expensed in accordance with IAS 17 on a straight-line line basis over the term of the lease.

1.6 REVENUE

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

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

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

1.7 EMPLOYEE BENEFITS

SHORT-TERM EMPLOYEE BENEFITS

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

RETIREMENT BENEFIT COSTS

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.8 OTHER EXPENSES

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

1.9 PROPERTY, PLANT AND EQUIPMENT

RECOGNITION

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

VALUATION

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

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

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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

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

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

SUBSEQUENT EXPENDITURE

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

1.10 INTANGIBLE ASSETS

RECOGNITION

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in

which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

MEASUREMENT

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

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

1.11 DEPRECIATION, AMORTISATION AND IMPAIRMENTS

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

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

1.12 DONATED ASSETS

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 GOVERNMENT GRANTS

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

1.14 NON-CURRENT ASSETS HELD FOR SALE

The Trust has no non-current assets held for sale.

1.15 LEASES

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

THE TRUST AS LESSEE

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

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

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

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

THE TRUST AS LESSOR

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

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

1.16 PRIVATE FINANCE INITIATIVE (PFI) TRANSACTIONS

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

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

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

SERVICES RECEIVED

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

PFI ASSET

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI LIABILITY

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

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

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

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

LIFECYCLE REPLACEMENT

The Trust pays a contribution to the lifecycle replacement costs of building assets requiring replacement through the annual unitary payment.

In return, the PFI operator maintains a contractual obligation to maintain the facility to an agreed standard, but is under no direct obligation to spend the lifecycle funds at pre-determined intervals. The Trust receives no financial benefit for any lifecycle savings derived during the duration of the PFI agreement. Conversely, the Trust does not bear the risk of additional lifecycle costs should the facility require additional work. As a result, these lifecycle replacement charges are recognised as an expense in the period they arise.

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

ASSETS CONTRIBUTED BY THE NHS TRUST TO THE OPERATOR FOR USE IN THE SCHEME

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

OTHER ASSETS CONTRIBUTED BY THE TRUST TO THE OPERATOR

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

1.17 INVENTORIES

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

1.18 CASH AND CASH EQUIVALENTS

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

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

1.19 PROVISIONS

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.37% in real terms (also 1.37% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.20 CLINICAL NEGLIGENCE COSTS

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 36.

1.21 NON-CLINICAL RISK POOLING

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

1.22 CARBON REDUCTION COMMITMENT SCHEME (CRC)

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

1.23 CONTINGENCIES

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

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

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

1.24 FINANCIAL ASSETS

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

Financial assets are initially recognised at fair value.

There are no Assets held to maturity or available for sale.

There are no Financial assets held at fair value through profit and loss.

LOANS AND RECEIVABLES

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

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

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

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

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.25 FINANCIAL LIABILITIES

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Interim Revolving Working Capital Facility Loans from the Department of Health are recognised at historical cost at an effective interest rate of 3.5%.

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

1.26 VALUE ADDED TAX

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

1.27 FOREIGN CURRENCIES

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

1.28 THIRD PARTY ASSETS

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.29 PUBLIC DIVIDEND CAPITAL (PDC) AND PDC DIVIDEND

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.30 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).

1.31 SUBSIDIARIES, ASSOCIATES AND JOINT ARRANGEMENTS

The only subsidiary of the Trust is the NHS Charity Fund, referred to in Note 1.4 above. The Trust has no other associate or joint venture organisations or legal entities.

1.32 RESEARCH AND DEVELOPMENT

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

1.33 ACCOUNTING STANDARDS THAT HAVE BEEN ISSUED BUT HAVE NOT YET BEEN ADOPTED

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 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 for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, 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 POOLED BUDGETS

The Trust had no pooled budgets during the year.

3 OPERATING SEGMENTS

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

4 INCOME GENERATION ACTIVITIES

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material. This income generation is rental income for space at Queen's Hospital from a private healthcare provider performing oncology medical services and the provision of oncology medical services by the Trust to this private provider (HCA Hospitals). It also includes visitor car parking at King George Hospital, and staff car parking across all sites.

Summary Table - aggregate of all schemes	**2015-16 £000s**	2014-15 £000s
Income	**5,105**	4,490
Full cost	**2,579**	2,382
Surplus/(deficit)	**2,526**	2,108

5 REVENUE FROM PATIENT CARE ACTIVITIES

	2015-16 £000s	2014-15 £000s
NHS Trusts	**2,151**	1,898
NHS England	**90,613**	86,068
Clinical Commissioning Groups	**367,086**	356,555
NHS Foundation Trusts	**2,427**	1,567
Department of Health	**93**	54
NHS Other (including Public Health England and NHS Property Services Ltd)	**1,156**	40
Other (including Public H	**1,500**	0
Non-NHS:		
Local Authorities	**4,320**	3,595
Private patients	**210**	331
Overseas patients (non-reciprocal)	**2,703**	1,615
Injury costs recovery	**2,549**	2,894
Other	**131**	611
Total Revenue from patient care activities	**474,939**	455,228

6 OTHER OPERATING REVENUE

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**1,342**	318
Patient transport services	**0**	0
Education, training and research	**16,711**	14,501
Charitable and other contributions to revenue expenditure - NHS	**263**	297
Charitable and other contributions to revenue expenditure - non - NHS	**0**	0
Receipt of donations for capital acquisitions - Charity	**126**	**72**
Receipt of Government grants for capital acquisitions	**81**	52
Non-patient care services to other bodies	**702**	44
Income generation (Other fees and charges)	**5,105**	4,941
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**2,319**	2,540
Other revenue	**3,651**	0
Total Other Operating Revenue	**30,300**	22,765
Total operating revenue	**505,239**	477,993

7 OVERSEAS VISITORS DISCLOSURE

	2015-16 £000s	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**2,703**	1,615
Cash payments received in-year (re receivables at 31 March 2015)	**92**	81
Cash payments received in-year (iro invoices issued 2015-16)	**216**	263
Amounts added to provision for impairment of receivables (re receivables at 31 March 2015)	**1,410**	232
Amounts added to provision for impairment of receivables (iro invoices issued 2015-16)	**1,173**	664
Amounts written off in-year (irrespective of year of recognition)	**136**	489

8 OPERATING EXPENSES

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**1,042**	657
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**17**	26
Services from NHS Foundation Trusts	**1,556**	1,704
Total Services from NHS bodies*	**2,625**	2,387
Purchase of healthcare from non-NHS bodies	**2,460**	4,110
Purchase of Social Care	**0**	0
Trust Chair and Non-executive Directors	**119**	61
Supplies and services - clinical	**76,613**	73,505
Supplies and services - general	**10,484**	9,922
Consultancy services	**1,957**	4,841
Establishment	**3,421**	3,139
Transport	**4,252**	5,219
Service charges - On-SOFP PFIs and other service concession arrangements	**14,326**	13,363
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**3,423**	3,286
Premises	**13,892**	13,527
Hospitality	**69**	59
Insurance	**32**	31
Legal Fees	**895**	861
Impairments and Reversals of Receivables	**605**	674
Inventories write down	**0**	0
Depreciation	**13,990**	15,359
Amortisation	**1,701**	1,110
Impairments and reversals of property, plant and equipment	**29,208**	(14,789)
Impairments and reversals of intangible assets	**0**	1,409
Internal Audit fees	**135**	118
Audit fees	**155**	208
Other auditor's remuneration	**0**	0
Clinical negligence	**25,499**	16,605
Research and development (excluding staff costs)	**0**	0
Education and Training	**667**	1,002
Change in Discount Rate	**0**	0
Other	**1,758**	1,495
Total Operating expenses (excluding employee benefits)	**208,286**	157,502
Employee Benefits		
Employee benefits excluding Board members	**330,952**	316,030
Board members	**1,899**	1,727
Total Employee Benefits	**332,851**	317,757
Total Operating Expenses	**541,137**	475,259

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

9 OPERATING LEASES

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

The Trust acts as an operating lessee for a number of leases under five years, which include laundry, linen and sterile services, and accommodation in Romford and Dagenham.

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**238**	228
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total Payable				**238**	228
No later than one year	0	256	133	**389**	534
Between one and five years	0	907	244	**1,151**	1,301
After five years	0	95	0	0**95**	95
Total	**0**	**1,258**	**377**	**1,635**	1,930
Total future sublease payments expected to be received:				0	0

Total future sublease payments expected to be received:

9.2 TRUST AS LESSOR

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

1) A 60 year land lease at King George Hospital, Redbridge, granted in 2006 to operate an Independent Sector Treatment Centre.

2) A 10 year space lease at Queen's Hospital, granted in 2009 for a private healthcare provider to provide oncology medical services.

3) The Trust leases ward space at King George Hospital to an NHS Foundation Trust.

4) The Trust leases space at both hospitals to Barts Health NHS Trust for renal services.

5) The Trust leases space at King George Hospital for GP services.

6) The Trust leases space at King George Hospital to a private provider to operate its Pregnancy Advisory Clinic.

7) The Trust leases two staff accommodation blocks at King George Hospital to a Housing Association which manages tenancy occupation to NHS employees, keyworkers or other public sector workers.

	2015-16 £000s	2014-15 £000s
Recognised as revenue		
Rental revenue	2,172	2,380
Contingent rents	147	160
Total	**2,319**	2,540
Receivable:		
No later than one year	2,266	2,539
Between one and five years	3,100	5,414
After five years	1,952	3,102
Total	**7,318**	11,055

10 EMPLOYEE BENEFITS AND STAFF NUMBERS

10.1 EMPLOYEE BENEFITS

	2015-16 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**285,547**	231,099	54,448
Social security costs	**20,798**	20,798	0
Employer Contributions to NHS BSA - Pensions Division	**27,514**	27,514	0
Other pension costs	**0**	0	0
Termination benefits	**71**	71	0
Total employee benefits	**333,930**	**279,482**	**54,448**
Less: Employee costs capitalised	**1,079**	852	227
Gross Employee Benefits excluding capitalised costs	**332,851**	**278,630**	**54,221**

	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	273,138	222,578	50,560
Social security costs	20,257	20,257	0
Employer Contributions to NHS BSA - Pensions Division	25,981	25,981	0
Other pension costs	0	0	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	319,376	268,816	50,560
Employee costs capitalised	1,619	831	788
Gross Employee Benefits excluding capitalised costs	317,757	267,985	49,772

10.2 STAFF NUMBERS

	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	**1,030**	913	117	1,030
Ambulance staff	**0**	0	0	0
Administration and estates	**1,216**	1,079	137	1,212
Healthcare assistants and other support staff	**1,357**	1,212	145	1,344
Nursing, midwifery and health visiting staff	**2,177**	1,921	256	2,171
Nursing, midwifery and health visiting learners	**47**	47	0	43
Scientific, therapeutic and technical staff	**757**	704	53	743
Social Care Staff	**0**	0	0	0
Healthcare Science Staff	**0**	0	0	0
Other	**0**	0	0	0
Total	**6,584**	**5,876**	**708**	6,543
Of the above - staff engaged on capital projects	**37**	21	16	26

10.3 STAFF SICKNESS ABSENCE AND ILL HEALTH RETIREMENTS

	2015-16 Number	2014-15 Number
Total Days Lost	48,182	49,436
Total Staff Years (equivalent no of staff per year)	5,580	5,384
Average working Days Lost	8.63	9.18

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	5	5

	£000s	£000s
Total additional pensions liabilities accrued in the year	**396**	459

10.4 EXIT PACKAGES AGREED IN 2015-16

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	**0**	**0**	0	0
£10,000-£25,000	0	0	3	71,000	**3**	**71,000**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**0**	**0**	**3**	**71,000**	**3**	**71,000**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	**0**	**0**	0	0
£10,000-£25,000	0	0	0	0	**0**	**0**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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

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

10.5 EXIT PACKAGES - OTHER DEPARTURES ANALYSIS

	2014-15 *Number of other departures agreed	**2014-15** *Number of other departures agreed	2013-14 *Number of compulsory redundancies	2013-14 *Number of other departures agreed
	Number	**Number**	Number	Number
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	3	71	1	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**71**	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

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

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals. There were no exit payments made to individuals named in the Remuneration Report in this financial year.

10.7 PENSION COSTS

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

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 five years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

11 BETTER PAYMENT PRACTICE CODE

11.1 MEASURE OF COMPLIANCE

	2015-16 Number	**2015-16 £000s**	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**63,770**	**223,024**	65,350	230,076
Total Non-NHS Trade Invoices Paid Within Target	**37,626**	**172,623**	53,542	205,150
Percentage of NHS Trade Invoices Paid Within Target	**59.00%**	**77.40%**	81.93%	89.17%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,319**	**8,585**	2,889	**9,964**
Total NHS Trade Invoices Paid Within Target	**1,097**	**3,586**	1,846	**7,158**
Percentage of NHS Trade Invoices Paid Within Target	**47.30%**	**41.77%**	63.90%	71.84%

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

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

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**2**	1
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**2**	1

12 INVESTMENT REVENUE

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**258**	405
Total investment revenue	**258**	405

13 OTHER GAINS AND LOSSES

The Trust has no other gains and losses in the current year

14 FINANCE COSTS

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**976**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**18,644**	19,176
- contingent finance cost	**6,595**	6,328
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Total interest expense	**26,217**	25,505
Other finance costs	**0**	0
Provisions - unwinding of discount	**45**	70
Total	**26,262**	25,575

15.1 PROPERTY, PLANT AND EQUIPMENT

2015-16	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
Cost or valuation:									
At 1 April 2015	32,152	305,447	9,782	5,930	97,415	57	29,059	3,977	**483,819**
Additions of Assets Under Construction				8,469					**8,469**
Additions Purchased	0	0	0		1,100	0	0	0	**1,100**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	126	0	0	0	**126**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	81	0	0	0	0	**81**
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	2,800	0	(10,420)	2,685	0	3,937	998	**0**
Upward revaluation/positive indexation	437	690	0	0	0	0	0	0	**1,127**
Impairment/reversals charged to operating expenses	(1,331)	(46,698)	0	0	0	0	0	0	**(48,029)**
Impairments/reversals charged to reserves	(638)	(25,300)	0	0	0	0	0	0	**(25,938)**
At 31 March 2016	**30,620**	**236,939**	**9,782**	**4,060**	**101,326**	**57**	**32,996**	**4,975**	**420,755**
Depreciation									
At 1 April 2015	(437)	18,821	9,772		62,356	57	17,870	2,525	**110,964**
Upward revaluation/positive indexation	437	0	0	0	0	0	0	0	**437**
Impairment/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	(18,821)	0	0	0	0	0	0	**(18,821)**
Charged During the Year	0	3,791	0	0	7,201	0	2,716	282	**13,990**
At 31 March 2016	**0**	**3,791**	**9,772**	**0**	**69,557**	**57**	**20,586**	**2,807**	**106,570**
Net Book Value at 31 March 2016	**30,620**	**233,148**	**10**	**4,060**	**31,769**	**0**	**12,410**	**2,168**	**314,185**
Asset financing:									
Owned - Purchased	30,620	58,444	10	4,060	18,691	0	12,410	2,168	**126,403**
Owned - Donated	0	512	0	0	591	0	0	0	**1,103**
On-SOFP PFI contracts	0	174,192	0	0	12,487	0	0	0	**186,679**
Total at 31 March 2016	**30,620**	**233,148**	**10**	**4,060**	**31,769**	**0**	**12,410**	**2,168**	**314,185**
Revaluation Reserve Balance for Property, Plant & Equipment									
At 1 April 2015	641	25,697	0	0	1,377	0	0	0	**27,715**
Movements (specify)	(638)	(24,610)	0	0	0	0	0	0	**(25,248)**
At 31 March 2016	**3**	**1,087**	**0**	**0**	**1,377**	**0**	**0**	**0**	**2,467**
Additions to Assets Under Construction in 2014/15									
Land	0	0	0	0	0	0	0	0	**0**
Buildings excl Dwellings	0	0	0	2,133	0	0	0	0	**2,133**
Dwellings	0	0	0	0	0	0	0	0	**0**
Plant & Machinery	0	0	0	6,336	0	0	0	0	**6,336**
Balance as at YTD	**0**	**0**	**0**	**8,469**	**0**	**0**	**0**	**0**	**8,469**

15.2 PROPERTY, PLANT AND EQUIPMENT PRIOR-YEAR

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2014	31,514	285,121	9,782	4,285	92,578	57	25,751	3,084	**452,172**
Additions of Assets Under Construction	0	0	0	16,043	0	0	0	0	**16,043**
Additions Purchased	0	0	0	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	72	0	0	0	**72**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased (including PFI/LIFT)	0	0	0	0	1,942	0	0	0	**1,942**
Reclassifications	0	3,834	0	(14,086)	2,823	0	3,308	893	**(3,228)**
Revaluation	638	16,492	0	0	0	0	0	0	**17,130**
At 31 March 2015	**32,152**	**305,447**	**9,782**	**6,242**	**97,415**	**57**	**29,059**	**3,977**	**484,131**
Depreciation									
At 1 April 2014	2,314	26,633	9,772	312	54,399	55	14,940	2,281	**110,706**
Revaluation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments charged to operating expenses	(2,751)	(12,038)	0	0	0	0	0	0	**(14,789)**
Charged During the Year	0	4,226	0	0	7,957	2	2,930	244	**15,359**
At 31 March 2015	**(437)**	**18,821**	**9,772**	**312**	**62,356**	**57**	**17,870**	**2,525**	**111,276**
Net Book Value at 31 March 2015	**32,589**	**286,626**	**10**	**5,930**	**35,059**	**0**	**11,189**	**1,452**	**372,855**
Asset financing:									
Owned - Purchased	32,589	72,154	10	5,930	18,927	0	11,189	1,452	**142,251**
Owned - Donated	0	659	0	0	771	0	0	0	**1,430**
On-SOFP PFI contracts	0	213,813	0	0	15,361	0	0	0	**229,174**
Total at 31 March 2015	**32,589**	**286,626**	**10**	**5,930**	**35,059**	**0**	**11,189**	**1,452**	**372,855**

15.3 (CONT). PROPERTY, PLANT AND EQUIPMENT

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

Life	**Yrs**	**Yrs**
Category	**Min**	**Max**
Buildings (non dwelling)	15	70
Dwellings	15	50
Plant and Machinery	7	15
Transport	7	15
Information Technology	4	10
Furniture and Fittings	7	15
Intangibles	3	5

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

In view of property price changes in the London region Land and Buildings were revalued as at 1st April 2015 by professional valuers. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal & Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any 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 EVU. For non-operational land including surplus land, the valuations are carried out at Market Value.

The Department of Health has adopted the Modern Equivalent Asset (MEA) approach 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. In the past, functional obsolescence has not been reflected in asset valuations for the NHS.

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, would have the following accounting impacts:

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

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

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

In 2015-16, in line with Trust policy of valuation based on modern equivalent assets, and reflecting representations from the TDA, the Trust's sites were valued by applying the MEA on an alternate site basis. This approach is consistent with HM Treasury and the Royal Institute of Chartered Surveyors (RICS) guidance, and does not represent a change in accounting policy.

16.1 INTANGIBLE NON-CURRENT ASSETS

2015-16	**IT - in-house & 3rd party software**	**Computer Licenses**	**Licenses and Trademarks**	**Patents**	**Development Expenditure - Internally Generated**	**Total**
Cost or valuation	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
At 1 April 2015	13,786	(257)	263	0	0	**13,792**
Additions Purchased	551	0	0	0	979	**1,530**
Reclassifications	(257)	257	0	0	0	**0**
At 31 March 2016	**14,080**	**0**	**263**	**0**	**979**	**15,322**
Amortisation						
At 1 April 2015	**6,658**	**(257)**	**263**	**0**	**0**	**6,664**
Reclassifications	(257)	257	0	0	0	**0**
Charged During the Year	1,701	0	0	0	0	**1,701**
At 31 March 2016	**8,102**	**0**	**263**	**0**	**0**	**8,365**
Net Book Value at 31 March 2016	**5,978**	**0**	**0**	**0**	**979**	**6,957**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	5,960	0	0	0	979	**6,939**
Donated	18	0	0	0	0	**18**
Total at 31 March 2016	**5,978**	**0**	**0**	**0**	**979**	**6,957**

16.2 INTANGIBLE NON-CURRENT ASSETS PRIOR YEAR

2014-15	**IT - in-house & 3rd party software**	**Computer Licenses**	**Licenses and Trademarks**	**Patents**	**Development Expenditure - Internally Generated**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Cost or valuation:						
At 1 April 2014	10,558	(257)	263	0	0	**10,564**
Reclassifications	3,228	0	0	0	0	**3,228**
At 31 March 2015	**13,786**	**(257)**	**263**	**0**	**0**	**13,792**
Amortisation						
At 1 April 2014	4,139	(257)	263	0	0	**4,145**
Impairments charged to operating expenses	1,409	0	0	0	0	**1,409**
Charged during the year	1,110	0	0	0	0	**1,110**
At 31 March 2015	**6,658**	**(257)**	**263**	**0**	**0**	**6,664**
Net book value at 31 March 2015	7,128	0	0	0	0	**7,128**
Asset Financing: Net book value at 31 March 2015 comprises:						
Purchased	7,128					**7,128**
Donated						**0**
Total at 31 March 2015	**7,128**	**0**	**0**	**0**	**0**	**7,128**

17 ANALYSIS OF IMPAIRMENTS AND REVERSALS RECOGNISED IN 2015-16

	Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	0
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	425
Loss as a result of catastrophe	0
Changes in market price	28,783
Total charged to Annually Managed Expenditure	**29,208**
Total Impairments of Property, Plant and Equipment changed to SoCI	**29,208**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**29,208**
Overall Total Impairments	**29,208**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

18 INVESTMENT PROPERTY

The Trust has no investment property in the current financial year.

19 COMMITMENTS

19.1 Capital commitments

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

	31 March 2016 £000s	31 March 2015 £000s
Property, plant and equipment	**3,754**	2,933
Intangible assets	**0**	453
Total	**3,754**	3,386

19.2 Other financial commitments

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

20 INTRA-GOVERNMENT AND OTHER BALANCES

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	0	0	6,562	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	288	0
Balances with NHS bodies inside the Departmental Group	38,572	0	8,994	39,677
Balances with Bodies External to Government	11,108	3,821	57,647	244,005
At 31 March 2016	**49,680**	**3,821**	**73,491**	**283,682**
prior period:				
Balances with other Central Government Bodies	0	0	0	0
Balances with Local Authorities	2,039	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	677	0
Balances with NHS bodies inside the Departmental Group	16,518	0	4,885	5,417
Balances with Bodies External to Government	16,823	7,442	51,474	251,598
At 31 March 2015	**35,380**	**7,442**	**57,036**	**257,015**

21 INVENTORIES

	Drugs rty £000s	Consumables £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2015	**2,678**	**4,187**	**244**	**0**	**0**	**7,109**	**0**
Additions	43,235	23,674	17	0	0	66,926	0
Inventories recognised as an expense in the period	(43,135)	(21,523)	(147)	0	0	(64,805)	0
Balance at 31 March 2016	**2,778**	**6,338**	**114**	**0**	**0**	**9,230**	**0**

22.1 TRADE AND OTHER RECEIVABLES

	Current		Non-Current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS receivables - revenue	**36,570**	16,405	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**3,074**	6,795	**3,676**	7,291
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,911**	5,176	**0**	0
PDC Dividend prepaid to DH	**2,002**	113	**0**	0
Provision for the impairment of receivables	**(2,995)**	(2,528)	**0**	0
VAT	**562**	1,478	**0**	0
PFI prepayments	**1,886**	1,881	**145**	151
Other receivables	**5,670**	6,060	**0**	0
Total	**49,680**	35,380	**3,821**	7,442
Total current and non current	**53,501**	42,822		
Included in NHS receivables are prepaid pension contributions:	0			

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

22.2 RECEIVABLES PAST THEIR DUE DATE BUT NOT IMPAIRED

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	**5,387**	3,780
By three to six months	**3,480**	1,440
By more than six months	**7,031**	2,571
Total	**15,898**	7,791

22.3 PROVISION FOR IMPAIRMENT OF RECEIVABLES

	31 March 2016 £000s	31 March 2015 £000s
Balance at 1 April 2015	**(2,528)**	(2,355)
Amount written off during the year	**138**	501
Amount recovered during the year	**1,160**	0
(Increase)/decrease in receivables impaired	**(1,765)**	(674)
Balance at 31 March 2016	**(2,995)**	(2,528)

23 CASH AND CASH EQUIVALENTS

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**666**	1,301
Net change in year	**452**	(635)
Closing balance	**1,118**	666
Made up of		
Cash with Government Banking Service	**1,106**	654
Cash in hand	**12**	12
Cash and cash equivalents as in statement of financial position	**1,118**	666
Cash and cash equivalents as in statement of cash flows	**1,118**	666
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	**5**	0

24 NON-CURRENT ASSETS HELD FOR SALE

The Trust has no non-current assets held for sale as at 31 March 2016 (nil at 31 March 2015).

25 TRADE AND OTHER PAYABLES

	Current		Non-Current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**5,321**	4,132	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**3,359**	828	**0**	0
Non-NHS payables - revenue	**36,488**	15,305	**0**	0
Non-NHS payables - capital	**1,875**	2,709	**0**	0
Non-NHS accruals and deferred income	**6,659**	21,019	**4,064**	4,277
Social security costs	**3,161**	0	**0**	0
Accrued Interest on DH Loans	**107**		**0**	0
VAT	**0**	0	**0**	0
Tax	**3,401**	0	**0**	
Other	**4,065**	4,631	**0**	0
Total	**64,436**	48,624	**4,064**	4,277
Total payables (current and non-current)	**68,500**	**52,901 I**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**6,567**	0		

26 BORROWINGS

	Current		Non-Current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Loans from Department of Health	**602**	602	**39,677**	5,417
PFI liabilities:				
Main liability	**8,453**	7,810	**239,941**	247,321
Lifecycle replacement received in advance	**0**	0	**0**	0
Total	**9,055**	**8,412**	**279,618**	**252,738**
Total borrowings (current and non-current)	**288,673**	**261,150**		

Borrowings/Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	602	8,235	**8,837**
1 - 2 Years	976	8,525	**9,501**
2 - 5 Years	34,427	21,034	**55,461**
Over 5 Years	4,274	210,600	**214,874**
TOTAL	**40,279**	**248,394**	**288,673**

27 OTHER FINANCIAL LIABILITIES

The Trust has no other financial liabilities

28 DEFERRED INCOME

	Current		Non-Current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**4,486**	5,692	**4,277**	4,490
Deferred revenue addition	**0**	0	**0**	0
Transfer of deferred revenue	**(952)**	(1,206)	**(213)**	(213)
Current deferred Income at 31 March 2016	**3,534**	4,486	**4,064**	4,277
Total deferred income (current and non-current)	**7,598**	8,763		

29 FINANCE LEASE OBLIGATIONS AS LESSEE

The Trust has no finance lease obligations other than Queen's Hospital Private Finance Initiative.

30 FINANCE LEASE RECEIVABLES AS LESSOR

The Trust has no Finance Lease receivables as a lessor

31 PROVISIONS

	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**4,231**	3,108	236	400	264	223
Arising during the year	**777**	0	558	0	219	0
Utilised during the year	**(946)**	(467)	(142)	0	(298)	(39)
Reversed unused	**(485)**	0	0	(400)	(85)	0
Unwinding of discount	**45**	36	9	0	0	0
Change in discount rate	**0**	0	0	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0
Balance at 31 March 2016	**3,622**	**2,677**	**661**	**0**	**100**	**184**
Expected Timing of Cash Flows:						
No Later than One Year	**629**	488	101	0	0	40
Later than One Year and not later than Five Years	**1,672**	1,213	315	0	0	144
Later than Five Years	**1,321**	976	245	0	100	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	304,420
As at 31 March 2015	161,496

Provisions for early departure staff relate to other staff (i.e., excluding Trust directors) payable for the lifetime of the former staff .
Legal claims (£661k) are comprised of provisions for injury benefits (£576k), employers' liability (£77k) and public liability (£8k).
Other provisions (£100k) relates to a provision for the potential costs of recruiting registered medical officers (RMOs) for the HCA private patient wing.

30 CONTINGENCIES

The Trust has no contingent liabilities or assets at 31 March 2016 (nil at 31 March 2015)

33 PFI - ADDITIONAL INFORMATION

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

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2015-16 £000s**	2014-15 £000s
Total charge to operating expenses in year - Off SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**14,326**	13,363
Total	**14,326**	13,363

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI	**2015-16 £000s**	2014-15 £000s
No Later than One Year	**23,103**	23,040
Later than One Year, No Later than Five Years	**98,332**	98,067
Later than Five Years	**625,909**	665,903
Total	**747,344**	787,010

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2015-16 £000s**	2014-15 £000s
No Later than One Year	**26,523**	26,129
Later than One Year, No Later than Five Years	**103,761**	104,606
Later than Five Years	**384,963**	427,822
Subtotal	**515,247**	558,557
Less: Interest Element	**(266,853)**	(303,426)
Total	**248,394**	255,131

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2015-16 £000s**	2014-15 £000s
Analysed by when PFI payments are due		
No Later than One Year	**8,453**	7,235
Later than One Year, No Later than Five Years	**29,341**	34,593
Later than Five Years	**210,600**	213,303
Total	**248,394**	255,131

Number of on SOFP PFI Contracts

Total Number of on PFI contracts 1

Number of on PFI contracts which individually have a total commitments value in excess of £500m 1

* 2014/15 Present Value comparatives have been updated to reflect a consistent discounting approach with 2015/6

which discounts the minimum "finance lease" payments by the implicit rate of interest.

34 IMPACT OF IFRS TREATMENT - CURRENT YEAR

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

	2015-16 Income £000s	**Expenditure £000s**	2014-15 Income £000s	Expenditure £000s
Revenue costs of IFRS: PFI Arrangements reported on SoFP under IFRIC12				
Depreciation charges		6,847		6,901
Interest Expense		25,255		25,516
Impairment charge - AME		20,125		0
Impairment charge - DEL		0		0
Other Expenditure		14,326		0
Revenue Receivable from subleasing	0		0	
Impact on PDC dividend payable		(3,109)		(2,363)
Total IFRS Expenditure (IFRIC12)	**0**	**63,444**	**0**	**30,054**
Revenue consequences of PFI schemes under UK GAAP / ESA95 (net of any sublease revenue)		43,983		29,447
Net IFRS change (IFRIC12)		**19,461**		**607**
Capital Consequences of IFRS : PFI and other items under IFRIC12				
Capital expenditure 2015-16		1,100		1,942
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		3,504		3,383

	2015-16 Income/ Expenditure IFRIC 12 YTD **£000s**	**2015-16** Income/ Expenditure ESA 10 YTD **£000s**
Revenue costs of IFRS12 compared with ESA10		
Depreciation charges	**6,847**	
Interest Expense	**25,255**	
Impairment charge - AME	**20,125**	
Impairment charge - DEL	**0**	
Other Expenditure		
Service Charge	**14,326**	43,983
Contingent Rent	**0**	
Lifecycle	**0**	
Impact on PDC Dividend Payable	**(3,109)**	
Total Revenue Cost under IFRIC12 vs ESA10	**63,444**	**43,983**
Revenue Receivable from subleasing	**0**	0
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**63,444**	**43,983**

35 FINANCIAL INSTRUMENTS

The Trust has no other financial liabilities

35.1 FINANCIAL RISK MANAGEMENT

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

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

Currency risk
The Trust is not principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

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

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at "&This_year_end&" 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.

35.2 FINANCIAL ASSETS

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS	0	44,971	0	**44,971**
Receivables - non-NHS	0	15,903	0	**15,903**
Cash at bank and in hand	0	1,118	0	**1,118**
Other financial assets	0	0	0	**0**
Total at 31 March 2016	**0**	**61,992**	**0**	**61,992**
Receivables - NHS	0	19,042	0	19,042
Receivables - non-NHS	0	16,180	0	16,180
Cash at bank and in hand	0	666	0	666
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**35,888**	**0**	**35,888**

35.3 FINANCIAL LIABILITIES

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables	0	46,328	**46,328**
Non-NHS payables	0	62,465	**62,465**
Other borrowings	0	40,279	**40,279**
PFI & finance lease obligations	0	248,394	**248,394**
Other financial liabilities	0	0	**0**
Total at 31 March 2016	**0**	**397,466**	**397,466**
Embedded derivatives	0		0
NHS payables	0	3,154	3,154
Non-NHS payables	0	49,606	49,606
Other borrowings	0	6,019	6,019
PFI & finance lease obligations	0	255,131	255,131
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**313,910**	**313,910**

36 EVENTS AFTER THE END OF THE REPORTING PERIOD

There are no reportable events after the end of the reporting period, up to date of signing these statements other than these financial statements were approved at the Board of Directors meeting on 1 June 2016.

37 RELATED PARTY TRANSACTIONS

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, have directly undertaken any material transactions with Barking, Havering & Redbridge University Hospitals NHS Trust. However the Trust recorded the following transactions with organisations that some members of the board were associated with:

Organisation	Payables £000s	Receivables £000s	Income £000s	Expenditure £000s
Barking and Dagenham College	0	0	0	1
Capsticks Solicitors LLP	30	0	0	86
Department of Health	0	20	78	0
Human Tissue Authority	0	0	0	5
ICNARC	0	0	0	6
NHS Confederation	6	0	0	7
Queen Mary University of London	4	0	58	56
St Georges University Hospitals Nhs Foundation Trust	3	27	98	38

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:

	Payables £000s	Receivables £000s	Income £000s	Expenditure £000s
Havering CCG	3,395	3,017	136,501	0
Redbridge CCG	0	2,607	91,534	0
Barking & Dagenham CCG	0	1,726	93,907	0
Basildon and Brentwood CCG	0	1,477	18,104	0
Barts Health NHS Trust	1,030	2,128	2,373	1,123
Health Education England	0	11	11,016	0
Homerton University Hospital NHS Foundation Trust	121	86	333	116
Imperial College Healthcare NHS Trust	159	21	21	49
NHS Blood and Transplant (NHSBT)	288	0	52	2,252
NHS Business Services Authority (NHSBSA)	728	0	0	447
NHS England	160	17,621	22,745	146
NHS Litigation Authority (NHSLA)	1	0	0	25,509
NHS Property Services Limited	237	0	0	91
North East London NHS Foundation Trust	1,285	2,412	3,141	1,238
University College London NHS Foundation Trust (UCL)	490	355	490	243

The Trust has one related party which is non-NHS or government departmental. It is the Barking Havering University Hospitals NHS Charity which recorded income of £338k, expenditure of £574k, year end receivables £259k and payables of £234k.

38 LOSSES AND SPECIAL PAYMENTS

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	245,738	168
Special payments	0	0
Total losses and special payments	245,738	168

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	508,406	294
Special payments	42,713	51
Total losses and special payments	551,119	345

Details of cases individually over £300,000

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

39 FINANCIAL PERFORMANCE TARGETS

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

39.1 BREAKEVEN PERFORMANCE

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	**2015-16 £000s**
Turnover	351,780	345,451	378,400	397,456	407,107	419,121	438,354	457,495	477,993	**505,239**
Retained surplus/(deficit) for the year	(16,844)	(35,621)	(35,674)	(56,243)	(25,436)	(49,662)	(66,647)	(38,216)	(25,190)	**(62,854)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			9,460	31,862	(8,670)	(1,133)	27,219	589	(13,380)	**29,208**
Adjustments for impact of policy change re donated/government grants assets						(124) (	874)	(388)	13	**(73)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				2,100	1,120	1,006	810	261	607	**0**
Absorption accounting adjustment								0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	0	0	**0**
Break-even in-year position	(16,844)	(35,621)	(26,214)	(22,281)	(32,986)	(49,913)	(39,492)	(37,754)	(37,950)	**(33,719)**
Break-even cumulative position	(32,833)	(68,454)	(94,668)	(116,949)	(149,935)	(199,848)	(239,340)	(277,094)	(315,044)	**(348,763)**

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

The Trust's Improvement Plan does not currently show a break even position in the forseeable future (the latest Long Term Financial Model (LTFM) indicates break-even by 2020/21).

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	**2015-16 %**
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-4.79	-10.31	-6.93	-5.61	-8.10	-11.91	-9.01	-8.25	-7.94	**-6.67**
Break-even cumulative position as a percentage of turnover	-9.33	-19.82	-25.02	-29.42	-36.83	-47.68	-54.60	-60.57	-65.91	**-69.03**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

39.2 CAPITAL COST ABSORPTION RATE

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

39.3 EXTERNAL FINANCING

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

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**26,132**	40,096
Cash flow financing	**25,972**	38,059
Finance leases taken out in the year in respect of PFI scheme	**0**	1,942
Other capital receipts	**0**	0
External financing requirement	**25,972**	40,001
Under/(over) spend against EFL	**160**	95

39.4 CAPITAL RESOURCE LIMIT

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

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**11,306**	18,057
Less: book value of assets disposed of	**0**	0
Less: capital grants	**(81)**	0
Less: donations towards the acquisition of non-current assets	(**126)**	(72)
Charge against the capital resource limit	**11,099**	17,985
Capital resource limit	**11,100**	17,985
(over)/underspend against the capital resource limit	**1**	0

40 THIRD PARTY ASSETS

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016 £000s	31 March 2015 £000s
Third party assets held by the trust	**5**	0

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