Basildon and Thurrock University Hospitals
NHS Foundation Trust

Annual Report and Accounts

for the year ended 31 March 2018

safe caring excellent ...together

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University Hospitals
NHS Foundation Trust

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Presented to Parliament pursuant
to Schedule 7, paragraph 25(4)(a)
of the National Health Service Act 2006.

Contents

Performance report

Overview

The purpose of the Overview to the Performance Report is to provide a short summary with sufficient information to understand the organisation, its purpose, the keys risks to the achievement of its objectives and how it has performance during the year

Overview – a word from our chair and chief executive

It has generally been another good year for our Trust, with continued positive news about the quality of the services that we provide. In common with the majority of acute trusts across the UK, there is increasing demand for our emergency services and a deep-rooted financial challenge that needs to be addressed as a health and care system.

Increasing demand for urgent and emergency care

The levels of demand for our urgent and emergency care continues to increase year-on-year. In 2017/18, there were 143,193 attendances to our A&E Department or our other urgent and emergency care services such as GP streaming and the Medical Assessment Unit. This figure represents an increase of 6% compared to 2016/17.

For the second successive year, the seasonally higher level of emergency demand that we see in winter did not decrease during summer 2017 and, like the vast majority of acute trusts, our hospital services were under unprecedented levels of pressure in the winter period.

A key part of coping with this demand is not only our ability to see people promptly when they arrive in A&E, but finding a bed for those who need to be admitted. Considerable effort goes into ensuring timely and safe discharges from hospital to free up beds. We continue to make improvements as an acute trust and in collaboration with our wider health and social care partners in mid and south Essex. In 2017/18 we have seen the benefits of innovative schemes developed with partners to improve the flow of patients through our hospitals, including GP Streaming and Hospital@Home.

The levels of demand for emergency and urgent care had an impact on our ability to achieve the waiting time standards set out in the NHS Constitution for elective care, cancer care and diagnostic services. During 2017/18, the Trust did not meet a number of key access standards as explained on page 14. These ongoing difficulties in balancing our duty to care for those patients who attend our hospital needing immediate attention with those who need other types of assessment and treatment underlines the need for us to transform the way we work with other local hospitals, as well as commissioners and social care providers.

On behalf of the Board, we would like to pay tribute to the front-line staff who have kept our hospitals operating at the high standards we expect during times of ever-growing demand.

Financial position

The Trust did not meet its control total agreed with NHS Improvement in April 2017 of a £23.4m deficit by year-end. However we improved upon the revised forecast position of £29.7m which was approved by the Board of Directors in January 2018. We ended the year with a recorded deficit of £25.7m after technical adjustments, following receipt of Sustainability and Transformation (STF) monies from NHS Improvement. This compared to a recorded deficit of £13.8m in 2016/17 (prior to technical adjustments for the revaluation of land and buildings).

Looking to the future

It has become increasingly clear in recent years with most NHS commissioners and providers in recurrent financial deficit, as well as other systemic problems such as shortages in the clinical workforce, the NHS requires fundamental changes if it is to be clinically and financially sustainable. We have seen the need for this in

our Trust with the ongoing increase in demand for care at levels which, ten years ago, were only experienced in winter.

It has been estimated that without transformational change, the current financial deficits in mid and south Essex are likely to rise significantly in the coming years. If this happens, then the local NHS would be unable to meet year-on-year growth in demand for services. These increases in demand and the financial deficits are amongst the key risks to the Trust achieving its short and long term objectives.

The Mid and South Essex Sustainability and Transformation Partnership (STP), formerly known as the Success Regime, has the overarching aim of restoring the health and social care system to financial balance within the next five years by delivering the best joined up, evidence-based and personalised care for patients. It incorporates six priority areas in which to accelerate change to sustain local services and improve care. These include increasing collaboration and service redesign across the three acute trusts (Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust), utilising a flexible workforce that can work across organisational and geographic boundaries; accelerating plans for change in urgent and emergency care such as doing more to help people avoid health problems and to get help at the right time, developing centres of excellence; developing joined-up community services around defined localities or hubs; and simplifying commissioning to reduce the associated transaction costs.

Following an extensive period of engagement with clinical leaders, staff, partner organisations, regulators and other internal and external stakeholders over a near two year period, a pre-consultation business case (PCBC) for the transformation of clinical services across the Mid and South Essex STP was developed. This was formally assessed by NHS England as being suitably robust for a public consultation and approved by the Joint Committee of the five Clinical Commissioning Groups (CCGs) in the STP area. The public consultation took place from 30 November 2017 to 23 March 2018. The outcome will be systematically analysed and proposals for service change will be presented to the CCG Joint Committee for decision during summer 2018. Patients will start to see changes being implemented in certain clinical pathways towards the end of the 2018/19 and then in earnest in 2019/20.

In January 2018, the Boards of the three acute trusts agreed to progress a formal merger, subject to regulatory approval. Whilst this decision is separate from the consultation and decisions around clinical transformation, the Trust Boards are clear that a merger, leading to a single acute trust in mid and south Essex, will bring specific benefits to patients and to staff. Our target timescale for establishing a new merged organisation is 1 April 2019. Over the forthcoming year, there will be extensive engagement and involvement with our staff and our Governors to design an organisation which will be in the best place to deliver the benefits arising from clinical change.

The collaborative working that the three trusts have been undertaking since early 2016 has taken us to a point where we can deliver more joined-up care which crosses organisational and geographic boundaries. We would like to commend the professionalism and commitment to partnership working in the interests of patients which continues to be shown by colleagues at our Trust and those at Mid Essex and Southend Hospitals.

Changes to the Board of Directors

This year has seen an embedding and ongoing development of the joint executive team. This team was established in February 2017 to provide executive leadership to the three acute trusts in Mid and South Essex. Further detail on the joint executives can be found on page 73.

To provide additional resilience within the joint executive team, a deputy chief executive role was created during 2017/18 as an enhancement to an existing executive position. Tom Abell, chief transformation officer, was appointed as deputy chief executive in July 2017.

Carin Charlton left her position as chief estates and facilities officer in December 2017. We were pleased to welcome Paul Kingsmore who is fulfilling this position on an interim basis.

Rita Greenwood joined the Trust as a non-executive director in April 2017. Rita is a qualified accountant with a strong background in local government finance and in shared financial services. Rita left the Trust in late April 2018. Over the year that she was with the Trust, Rita made an excellent contribution to the Board, particularly in relation to the scrutiny of financial matters.

We were sorry to say goodbye to Elaine Maxwell at the end of March 2018. Elaine has been a non-executive director with the Trust since April 2014. Elaine was reappointed by the Council of Governors for her second term which commenced in April 2017 for a standard term of three years, although she indicated at the time that she was only able to commit to one further year. Elaine's unique contribution and wide skill base as a registered nurse, former executive director, academic and author on the topic of quality improvement will be missed by the organisation.

Barbara Riddell reached the end of her second (and final eligible) term as non-executive director at the end of March 2018. Since joining us in April 2012, Barbara has successfully fulfilled several high profile roles in the Trust including as deputy chair of the Board of Directors and as chair of the Audit Committee and the Charitable Funds Committee.

The Council of Governors co-ordinated the process in the closing months of 2017/18 for recruiting to the vacant non-executive director positions to ensure the appropriate level of governance and scrutiny in relation to all aspects of our business as we progress towards our new organisational form. We are pleased to welcome Margaret Pratt and Barbara Stuttle CBE to the Board as non-executive directors from 1 April 2018.

We would like to thank all members of the Board, both executive and non-executive, as well our site leadership team, led by managing director Clare Culpin, for their commitment and flexibility during this year of significant operational pressure and of progress towards transformational change.

Closing remarks

The 2017/18 annual report reflects another challenging but rewarding year in the life of our Trust. In the coming year, we look forward to working ever more closely with our partner organisations in mid and south Essex to build a future for healthcare which is clinically and financially sustainable in the long term.

Nigel Beverley
Chairman

Date: 29 May 2018

Clare Panniker
Chief executive

Date: 29 May 2018

Overview – going concern statement

The Trust will incur a sizeable financial deficit in delivering its services in 2017/18 and it anticipates that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors has carefully considered the principle of 'Going Concern' and the directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

Nevertheless, the going concern basis remains appropriate. This is because the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006, s42a) to continue to deliver the full range of mandatory services for the foreseeable future.

The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual and the Department of Health Group Accounting Manual (GAM).

Overview – statement of purpose and activities of the Trust

The Annual Report and Accounts 2017/18 have been prepared under the direction issued by NHS Improvement under the National Health Service Act 2006

Introduction to the Trust

Trust profile and history

In April 2004, the Trust was authorised as one of the first ten NHS foundation trusts in the country. Foundation status gives us more control over how we spend our money and plan our services. We remain firmly part of the NHS and are subject to NHS standards, performance ratings and inspections.

The Trust has a Council of Governors with local, elected public and staff governors and appointed stakeholder governors. The Council of Governors is responsible for holding the Board of Directors to account through the non-executive directors and for the appointment of the chairman and non-executive directors. The Trust has a duty to consult and involve the governors in the strategic plans of the organisation. The governors act as a communications channel for our foundation trust members, ensuring their views are represented when important decisions are taken about services and the future direction of the organisation.

The Trust is regulated and licensed by Monitor (operating as part of NHS Improvement), the independent regulator of foundation trusts and is registered with the Care Quality Commission (CQC) for the services we provide.

The Trust's main purpose continues to be the provision of healthcare. There have been no significant changes in the range of services provided during 2017/18, but many quality improvements have been made, building on the progress in 2016/17. These improvements are detailed in the Quality Report (see page 85).

Our services

We provide an extensive range of acute healthcare services at Basildon and Orsett Hospitals, as well as x-ray and blood testing facilities at the St Andrews Centre in Billericay.

We primarily serve the 406,000 (based on 2011 census) population of south-west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. We also continue to provide dermatology services from seven sites across the south Essex area.

The Essex Cardiothoracic Centre is part of the Trust and provides a full range of specialist cardiothoracic services for the whole county and further afield.

With income of £320.9m, in 2017/18 the Trust treated 92,100 (1%) inpatients and day cases, provided 327,748 outpatient consultations (5%) and attended to 143,193 (6%) patients in A&E

or other urgent and emergency services. The numbers in brackets represent the percentage increase compared to 2016/17.

The environment we operate in

NHS Basildon and Brentwood Clinical Commissioning Group and NHS Thurrock Clinical Commissioning Group were the Trust's main commissioners during 2017/18, with cardiothoracic services and renal dialysis commissioned by specialist commissioners, hosted by NHS England.

Performance analysis - operational

This section reviews how we have performed during the 2017/18 year. This section also explains how the Trust maintains an integrated approach to performance assessment management, ensuring that data about key performance indicator (KPI), risks and uncertainties are triangulated to ensure that the Board of Directors and Trust Management have a holistic view of the Trust's performance at all times.

Key performance measures

Every year, the Board of Directors agree objectives and how they will be measured to review Trust performance. These measures are developed into key performance indicators (KPIs) developed and monitored monthly throughout the year. In setting these measures, the Board takes account of the views of governors, staff, regulators and the priorities of local commissioners and of NHS England, and sets indicators that best fit these priorities.

The Trust is seeking to:

- Make significant progress each year to achieving financial balance;
- Ensure than at least 95% of patients wait four hours or less in A&E;
- Maintain the NHS Constitution standard that at least 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT);
- Deliver the NHS Constitution 62 day cancer wait standard, as well as the two week and 31 day cancer standards;
- Develop and implement affordable plans to make improvements in quality.

In addition, the Trust agreed local areas for improvement which are monitored through KPIs. These include workforce, financial and environmental/sustainability matters. The KPIs are grouped into four domains. During 2017/18, the Trust introduced a Balanced Scorecard approach. The four domains of the Balanced Scorecard are:

- Quality and patient safety (incorporating risk management);
- Finance and use of resources;
- Operations;
- Workforce.

The Balanced Scorecard approach ensures that all aspects of performance have equal focus and informed by their impact upon all areas of performance including patient care outcomes, staff, operational performance and finances. This helps to ensure that no particular dimension of performance "trumps" any other.

The consistent use of a balanced scorecard in performance reports at all levels of the organisation from "ward to board" ensures that risk assessments, decisions and analysis of sources of assurance are fully informed, minimising the risk of unintended consequences of decisions and links between datasets not being fully understood.

By way of illustration, the Trust operates a well-developed cost improvement programme (CIP) governance. In the event of a proposal from a clinical division to make an efficiency saving by changing to a different type of prosthesis, this proposal would be examined by a multi-professional group of senior leaders to ensure that the change of supplier would impact negatively upon clinical outcomes and length of stay.

Another example of how the Trust ensures linkage between different types of performance data using the Balanced Scorecard approach is

shown by the requirement for divisions seeking to submit a business case for new consultant posts to Directors Forum for peer review. If there was a proposal to recruit a new orthopaedic consultant to reduce waiting times for elective surgery, the business case would need to demonstrate how the anticipated improvement in elective waits would not have an adverse impact on waiting times for cancer surgery given the finite theatre capacity in the Trust.

The clinical divisions are expected to maintain a regular review of their performance against the Balanced Scorecard and against their annual business plans. This includes the agreement, review and completion of actions they are taking to deliver their plan and addressing areas of under-performance. Business partner teams support the divisions by analysing data from divisional level through to ward, patient, staff and transactional level.

Divisions are monitored on an ongoing basis against the actions and measures agreed with them as part of the monthly performance monitoring cycle, which includes face-to-face divisional performance meetings between the divisional leadership triumvirate and the site leadership team. The divisions are required to provide assurance that there are adequate governance arrangements within the division, through the production of meeting minutes and action logs.

Targets achieved

There were some areas of significant improvement in the Trust's performance during 2017/18, particularly in the area of quality and patient safety:

- Suspected cancer two week wait (breast symptoms and all cancers) was achieved in five months of the year;
- Mortality has remained within the expected range;
- 20% reduction in harm from injurious falls;
- Pressure ulcer incidents less than 0.25% per 1000 bed days;
- Reduction in avoidable venous thromboembolism (VTE) incidents and increases in VTE screening rates;
- Reduction in the number of cardiac arrests;
- Patient Friend and Family Test recommender score – met the national average
- Revised forecast deficit at year-end was improved upon by £0.4m;
- CIP target of £16.3m exceeded by £0.2m by year-end;
- Significant 30% reduction in agency spend between 2016/17 and 2017/18, contributing to the Trust's financial position and improving patient experience

Targets not achieved

- Patients attending A&E seen within 4 hours;
- Referral to Treatment (RTT) times for admitted and non-admitted patients;
- Cancer 62-day waits for first treatment;
- Cancer 31-day wait for second or subsequent treatment (surgery and drug treatments);
- 6 week wait for diagnostics;
- Staff Friends and Family Test proportion of staff uptake v staff recommender score
- Control total agreed with NHSI in April 2017 of £23.4m year-end deficit was not achieved;
- Staff turnover target of 10% was not achieved (16.51%), although registered nursing turnover improved slightly between 2016/17 and 2017/18.

Emergency care performance

In common with our partner acute trusts in Mid and South Essex and across the country we continue to experience very high levels of demand for emergency care during 2017/18. This has placed considerable pressure on our services and has necessitated increasingly innovative ways of attempting to reduce demand, in collaboration with our commissioners, community providers and social care partners. A persistently high level of emergency demand severely compromises out ability to maintain flow through our hospitals and to protect beds for those patients requiring non-urgent inpatient care such as joint surgery.

To manage the pressures upon our services and to improve patient flow, the following measures were in place during 2017/18:

- Establishment and development of an 'emergency hub' model of care by bringing together medical, surgical and frailty pathways for ambulatory care in specially designed areas which see and assess patients, and on most occasions avoid admission to an inpatient bed;
- The Paediatric Assessment Unit (PAU) has improved the assessment of children within A&E;
- Introduction of a GP Streaming Service which assesses and treats around 45 patients per day;
- Operation of a Strategic Control Room over the Winter period to assist the Trust in proactively identifying factors which were blocking flow and opportunities to improve the experience of our patients;
- Extensive work with our acute trust partners to collectively manage demand for emergency care and to redesign patient pathways.

Cancer performance

During 2017/18, the Trust joined a newly created Midlands and East Cancer Collaborative supported by NHS Improvement and NHS Elect. This brought together 15 trusts across the region with access to expert support in a range of workshops and web-based events. During the year, the three trusts also created a new position of Group Director of Cancer Services to increase senior leadership capacity to this key service priority. Access to regional and group-wide support and learning has introduced innovations and improvements in a number of areas of cancer care including:

- Investment in additional doctors to diagnose and treat cancer (this has included consultants in dermatology, colorectal surgery and urology);
- Investment in additional nurses, allied health professional and other staff to support cancer pathways (this has included cancer nurse specialists, radiographers and pathway navigators);
- Investment in equipment for cancer care (including specialist pathology equipment and hysteroscopes);
- Improved clinical pathways based upon local, regional and national best practice(including innovations in lung cancer diagnostics which have reduced the time to diagnosis)

Performance against the 62-day cancer wait standard has not been achieved during 2017/18. There have been improvements in cancer waiting times during the year. The Trust achieved compliance with the 2-week wait standard from first appointment from September 2017 to March 2018. The March 2018 performance was adversely affected by the extreme weather which meant that some patients were unable to attend their appointments.

The number of patients on a cancer pathway waiting over 62 days (often referred to as the backlog) considerably reduced across the year from over 240 to 100 patients.

The Trust has agreed a trajectory for achieving the 62-day standard by July 2018. Cancer recovery is monitored very closely by the Board of Directors, the Finance, Resources and Performance Committee and the Directors Forum and by our Regulators.

A root cause analysis and harm review is completed for each breach of this standard on a patient-by-patient basis. The main themes arising from these reviews include lack of capacity for inpatients and outpatients and in some cases patients decline to be treated within the timescales.

Referral to Treatment (RTT) performance

2017/18 was another challenging year for delivery against the 18-week RTT standard. Our efforts to improve RTT performance have been made more difficult by the increasing pressures for urgent and emergency care as noted above which have led to cancellations of elective care due to pressures on beds and staff. However even at the peak period of emergency demand in January and Febru1ry 2018, we maintained our day case activity ensuring that as few elective patients as possible had their treatment delayed.

Performance trend analysis

The Trust uses a wider range of information to monitor performance and the quality of our services. The table below shows a summary of indicatory, with a trend analysis by quarter and the average as part of the NHS Improvement Single Oversight Framework.

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Indicator	Target YTD	Q1	Q2	Q3	Q4	2017/18 average
*Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	65.4%	67.0%	66.3%	69.6%	67.1%
*Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	85.8%	84.7%	84.0%	85.5%	85.0%
*Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	84.1%	82.7%	83.3%	81.7%	82.9%
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	91.1%	90.6%	86.5%	82.7%	87.7%
*Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	64.9%	72.3%	74.2%	67.8%	69.8%
*Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	87.5%	61.9%	40.0%	50.0%	59.9%
*Cancer 31 day wait for second or subsequent treatment - surgery	94%	81.8%	95.3%	97.3%	87.9%	90.6%
*Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100.0%	100.0%	100.0%	92.9%	98.2%
*Cancer 31 day wait from diagnosis to first treatment	96%	94.8%	94.8%	95.5%	94.8%	95.0%
*Cancer 2 week (all cancers)	93%	87.8%	87.7%	94.7%	93.0%	90.8%
*Cancer 2 week (breast symptoms)	93%	87.7%	86.0%	96.0%	93.9%	90.9%
Cumulative total Codify (including: cases deemed not to be due to lapse in care and cases under review)	99%	98.9%	98.4%	99.0%	97.6%	98.5%
	31	**8**	**12**	**19**	**28**	**17**

Key issues and risks that could affect the Trust in delivering its objectives

The local health economy is in a difficult financial position. The local clinical commissioning groups (CCGs) and the Trust had a deficit for 2017/18 and have challenging cost improvement programmes for at least the next two years.

In common with most acute providers, the Trust has significant ongoing challenges recruiting and retaining clinical staff, particularly registered nurses

In common with most acute providers, the Trust has significant ongoing challenges recruiting and retaining clinical staff, particularly registered nurses.

Locally there is a lower than average prevalence of chronic obstructive pulmonary disease (COPD), asthma and obesity, while social deprivation indicators including levels of academic attainment are lower than the national average and surrounding areas.

In common with many parts of the country, the increasing health and social care needs of an ageing population is highlighting a lack of system integration and continue to influence Trust development and performance. The proportion and number of elderly residents in our area continues to have a significant impact on demand for our services. The cost of acute healthcare is higher for older people, mainly because they experience a higher number of minor health conditions as they approach the latter stages of their lives.

In response to these trends, the Trust has developed a new clinical strategy together

with our partners in the Mid and South Essex Sustainability and Transformation Partnership (STP) which will drive the changes needed to improve local services and make them more sustainable. The key focus of the strategy is to develop and deliver high quality healthcare which is available 24/7 and which is able to respond flexibly to local demand. The strategy focusses on those areas of performance where the Trust is known to be outside national averages and plans to establish alternative pathways for patients, not all of which will be in hospital.

Further details on the key risks and issues that could affect the Trust in delivering its objectives can be found in the Annual Governance Statement on page 72. Such risks are managed via the Board Assurance Framework.

Performance analysis - financial

The financial year finished with the Trust achieving a net deficit of £25.7m.

The 2017/18 deficit was driven by six main factors:

- Recurrent investment in quality and safety within clinical areas;
- RTT Targets resulting in additional payments to staff;
- Continued use of agency and bank staff arising from vacancies;
- Reduction of Sustainability and Transformation Fund income of £9.4m against 2016/17
- Introduction of the apprentice levy;
- Investment in the joint working across the three trusts and the transformation of clinical services

Income from operations for the year was £320.9million, a marginal reduction of £2.5million (0.8%) on 2017/18, reflecting the tariff for the block contracts with our main commissioners and a reduction in the Sustainability and Transformation Fund income.

Related expenses including depreciation were higher at £341.4million, up £6.8million (2 %) due to the reasons outlined above. This caused an operating deficit of £20.5million in the year, compared with a deficit of £11.2million in 2016/17. After allowing for interest payable and other financing costs of £5.2million, the overall deficit increased to £25.7million.

The savings planned through the Trust's cost improvement programme (CIP) was £16.3million. The Trust actually delivered £16.5million of savings. Capital expenditure amounted to £12.3million. This was £6.1million lower than the original plan due to slippage on two of the redevelopment schemes due to a delay in securing funding. Approval of a capital loan was granted in March 2018 for the radiology and women's and children's redevelopment works.

The cash balance at 31 March 2018 was £13.8million, (£7.1million on 31 March 2017). The balance this year includes £25.7 million working capital support received from the Department of Health throughout the financial year.

The Trust finished the year with a Finance and Use of Resources Rating (FUR) '4' at 31 March 2018.

Looking forward to 2018/19

Looking forward to 2018/19, in April 2018 the Trust agreed a challenging financial plan for an income and expenditure deficit of £27million, on turnover of £334.2million. Work will continue to identify further opportunities to improve the financial position in partnership with our acute partners in Mid and South Essex. The 2018/19 plan is underpinned by a cost improvement programme of £16.5million.

Financial governance and working practices across the Trust continue to be strengthened to ensure the financial plan is achieved, without compromising quality and safety of services.

The Trust has a dedicated programme management office to support and monitor key aspects of Cost Improvement Programme (CIP) delivery and ensure no adverse impact on quality.

Performance analysis - sustainability

Introduction

Sustainable development aims to ensure the basic needs and quality of life for everyone is met now, and for future generations. Climate change is the biggest global health threat of the 21st century and without action now it will continue to affect the health and wellbeing of people across the world. Supporting sustainable actions is a global responsibility, and in 2015 the Paris Agreement was adopted at the United Nations Climate Change Conference in order to reduce climate change associated carbon emissions.

Increased joint working with partners in the Mid and South Essex Sustainability and Transformation Partnership will bring health and care organisations across mid and south Essex together, developing strong partnerships to sustain a healthy population. A collaborative approach will bring opportunities, including alignment of sustainability agendas.

Sustainable Development Unit

For the NHS as a whole, the latest carbon footprint report from the NHS Sustainable Development Unit (SDU) was published in January 2016 and is based on 2015 data.

It shows that the NHS carbon footprint in England was 22.8 million tonnes of carbon dioxide equivalents (MtCO2e). Between 2007 and 2015 the NHS carbon footprint has reduced by 11%. Even though this is an encouraging achievement, all NHS organisations must take this agenda seriously by making significant local changes that will contribute to the overall challenge of an 80% carbon reduction by 2050 as targeted by the SDU.

Sustainability reporting analysis

The SDU conducts annual analysis of all health provider and Clinical Commissioning Group (CCG) annual reports to evaluate their sustainability agendas within a reporting structure. 'Excellent' sustainability reporting is recognised as helping to demonstrate good use of resources, mitigating negative environmental impacts and maximising the positive impact locally for patients and public health. Scores from 450 organisations across the country are calculated; and, from 25 set indicators, with annual comparisons allowing for targets and achievements to be conveyed. Our Trust's reporting score has improved by 7% from 2015/16 to 2016/17, illustrating continued investment in the sustainability agenda.

Sustainable estate development

Embracing the Trust's strategic vision of maintaining robust infrastructure to support excellence in patient care and safety, with a comfortable environment to visit and work, the Estates Strategy is to improve the energy efficiency of the Trust's operational plant infrastructure.

With this aim, the Trust has been working with central government funding partners, the Carbon and Energy Fund (CEF), for the replacement of one of its existing conventional heating boilers at the Basildon site with a Combined Heat and Power (CHP) plant. This will enable the Trust to produce electricity on site and utilise waste heat typically produced as a by-product of the combustion process for additional heating purposes. The proposed commencement of this project is in the latter stages of 2018, with full benefits realised within the 2019/20 financial year. The scheme has environmental and financial energy savings of approximately £900,000 gross annually, and reducing energy consumption by around 15-20%.

Energy reduction is a key focus, with improving the operational efficiency of ventilation and heating pumps forming another fundamental area of work, and is conducted through the Trust's maintenance renewal programme.

Sustainability strategy

The Trust's sustainability vision reflects that of the Bruntland report (2009) which described sustainable development as:

"Development that meets the needs of the

present without compromising the ability of future generations to meet their own needs."

A comprehensive rationalisation plan has been proposed, with removal of pre-fabricated buildings to reduce their number. Utilisation of local goods and services will reduce resource consumption with the emphasis on environmentally friendly materials. Sourcing locally will potentially increase the economic prosperity of the community. These initiatives show that carbon reduction is a continued priority and the Trust is committed to achieving the national targets as set out in the NHS Carbon Reduction Strategy (2010 update); which requires all NHS organisations to reduce their carbon emissions by 34% by 2020 based on the 2007 baseline, as well as working towards a reduction of 80% by 2050.

Mid and South Essex Sustainability and Transformation Plan (STP)

Development of the Trust's estate will be significantly influenced by the STP, resulting in probable estate reconfiguration as the three acute Trusts consolidate and support the communities and services available throughout the mid and south Essex region.

Collaboration between the three acute trusts will provide opportunities to align a core focus in sustainable development, sharing knowledge and expertise to allow for one central sustainable agenda, becoming a leading role model in climate change-associated emission reduction.

Cooperative preparation and reconfiguration of services, sharing personnel and initiatives and integrated green travel planning are areas of focus, along with successful implementation of a joint sustainability strategy.

Summary of performance – non-financial and financial indicator

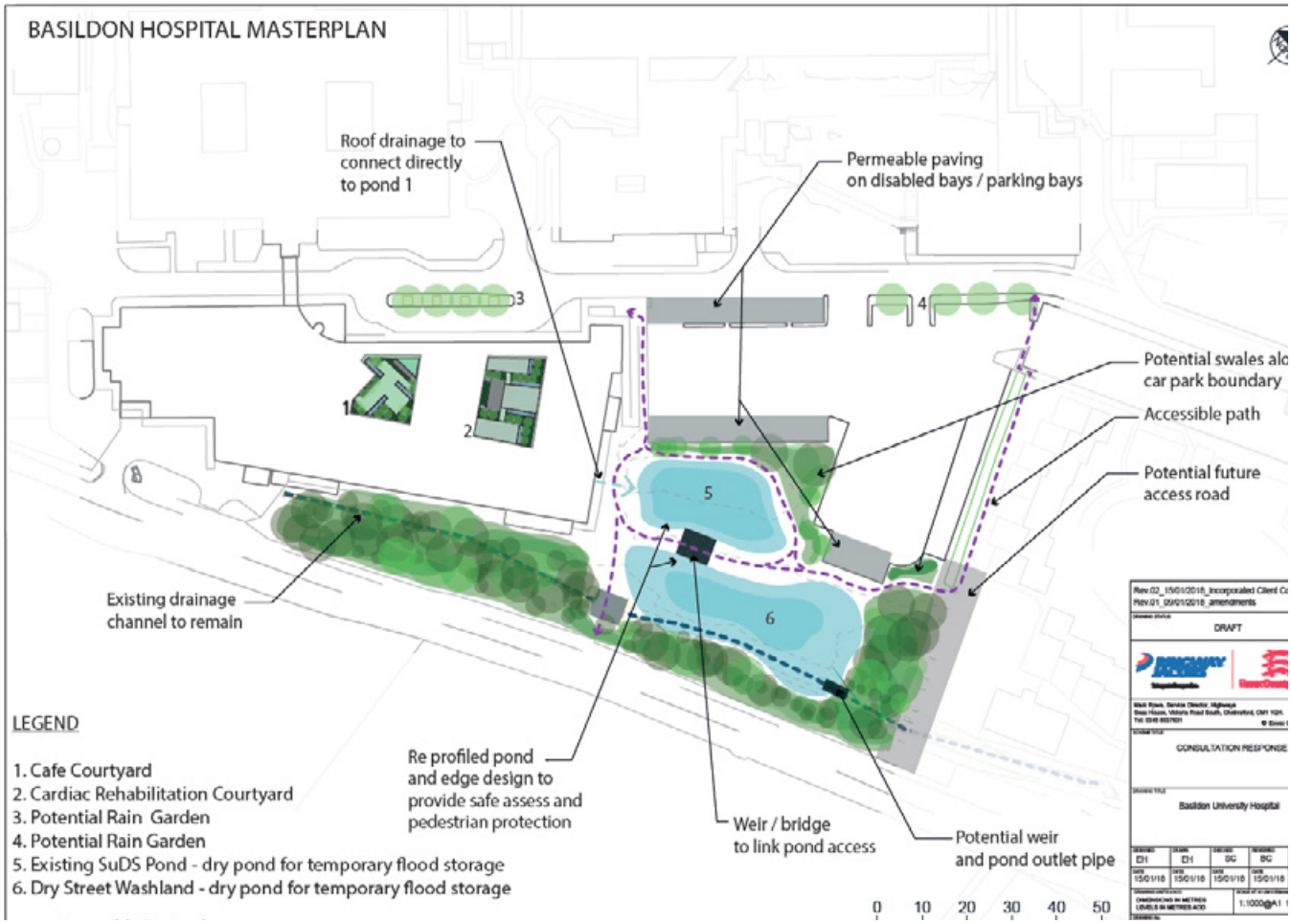
The sustainability key performance indicators (KPIs) have continued to be monitored and are updated below. Reporting inaccuracies have been adjusted where identified.

The baselines were selected as they provide the most complete historical data set on each category, for annual comparisons. Analysing inpatient activity is also important to establish long-term energy demands; annual increases have occurred (37.65% increase by 2015/16), with directs impacts on energy requirements. This is likely to be a contributing factor in the 3.77% combined energy consumption increase. Despite this rise, the energy footprint has fallen by a significant 7.63%, illustrating the successes of sustainable development. Over recent years the Trust has invested in energy efficient appliance switch-overs, LED lighting, and a more resourceful use of space.

Though the overall energy consumption has increased since 2007/08, declines in electricity and gas usage have occurred when compared to 2016/17; also positively reflecting technological and estate advances. The CHP will bring around a further 15-20% energy consumption reduction alongside associated emission decline. Water consumption has witnessed a general decline since 2013/14, with implemented measures including a Legionella Control Regime flushing reduction and staff awareness campaign.

Theme	Category	Indicator	How are we doing 2017/18			Baseline	Baseline year
			Total	Unit	Change		
Energy and carbon management	Electricity	Total Energy	18,720,348	kWh	10.39%	16,958,658	2007/08
		Total Carbon	6,581,326	tCO2	-16.85%	7,915,114	2007/08
	Gas	Total Energy	47,410,855	kWh	1.37%	46,769,949	2007/08
		Total Carbon	8,731,183	tCO2	0.80%	8,662,262	2007/08
	Combined	Total Energy	66,131,203	kWh	3.77%	63,728,607	2007/08
		Total Carbon	15,312,509	tCO2	-7.63%	16,577,377	2007/08
Water	Water	Total use	204,023	m³	-24.33%	269,624	2007/08
Waste	All waste	Total waste	1,578,639	t	-14.94%	1,855,974	2015/16
	Recycled	Waste recovered/ recycled	53,504	%	8%	49,510	2015/16

Climate change adaptation and mitigation



The Trust is fully committed in tackling the effects of climate change, alongside mitigation against the likely impacts on its estate, including extreme weather events.

The Trust has been offered EU funding through partnership with Essex County Council (ECC) for flood risk mitigation infrastructure works across the Basildon Hospital site. Located on ECC's Critical Drainage Area, the hospital is at high risk of surface water flooding, heightened by changing extreme climatic conditions. Infrastructure improvement works, known as Sustainable Drainage Systems (SUDS), are designed to manage risks from urban surface water run-off, and offer the Trust the opportunity to integrate accessible and usable landscaping areas for patient and staff access.

Aiming to replicate the natural drainage from before site development, SUDS incorporate vegetation and water retention ponds into the

urban landscape, enhancing environmental values, contributing to biodiversity and improving natural aesthetics.

The SUDS design will allow for a garden to be created on the hospital grounds, offering a therapeutic space for those on site. In-depth research into the therapeutic benefits of green space is well known, with this proposed area likely to also positively impact on local air quality and ecosystem services around Basildon. The impacts of SUDS will also reach biodiversity, providing a diverse habitat range in an otherwise urban landscape. The project is currently being finalised with commencement on site likely to be summer 2018, for completion by September 2018.Green travel

The Trust is committed to developing green travel initiatives, with recent successes in:

- Replacing existing Trust diesel fleet vans with electric vehicles
- Encouraging a healthier workforce through facilitation of cycle to work schemes, walking and exercise groups, introduction of secure bike shelters for over 60 pedal cycles and increased staff changing facilities
- Implementation of delivering care closer to home, reducing transport emissions, air pollution, and travel costs for the Trust
- Planned installation of electric charge points

The Trust will be working with the other two Trusts to develop a Green Travel Plan that will support the future STP agenda

People (Public Health Improvement)

Employees are our largest and most valuable asset in delivering, and maintaining high quality patient care. Having a sustainable team is essential, with the Trust committed to ensuring a healthy lifestyle and general wellbeing during, and outside of working hours. Evaluating the annual NHS Staff Survey will provide insights into the initiatives already in place, and highlight areas of improvement to ensure that we can continue to promote a healthy staff environment

Healthy Food Choices

There are CQUIN targets to promote staff health and wellbeing and we have action plans in place on how these can be achieved. We are already working to reduce high sugar and fat products and offer an increased selection of healthy food choices. The Trust is aiming for 100% compliance.

Performance analysis – addressing inequalities and promoting diversity

The Trust is committed to providing equality of opportunity and freedom from discrimination, as well as dealing effectively with any proven act of discrimination, abuse or harassment to patients or staff.

The Trust's equality commitment communicates our approach to equality and diversity, conveying how employees should be treated with respect and dignity at all times. Significant work was undertaken over the course of the year to ensure that agreed outcomes against the NHS equality delivery system were being achieved.

The Trust has a robust policy framework which supports the recruitment, retention, promotion and development of staff with disabilities. These policies reflect the legal requirements upon employers. The policies include making reasonable adjustments to support staff to remain in work or to return to work following a disability, all of which are applied following an assessment of individual need and circumstances.

Examples of where such policies support staff include:

- Adjusted or flexible working patterns to meet individual needs
- Fully disabled accessible sites for wheelchair users
- The installation of digital hearing loops in our main meeting rooms for staff and visitors
- The purchase and use of specialist software packages to support staff with dyslexia

We are fully aware of our legal and moral responsibilities in respect of eliminating unfair and unlawful discrimination, promoting equality of opportunity and good relations between all groups and involving our staff and members of our community in the development of our action plans.

The gender make-up of the Board of Directors as at 31 March 2018 is shown in the table below, with comparative figures for the two previous years.

	2017/18	2016/17	2015/16
Male	6 (40%)	6 (40%)	9 (60%)
Female	9 (60%)	9 (60%)	6 (40%)

Performance analysis - social, community and human rights issues

The Trust takes its legal and ethical obligations as a key member of the local community very seriously. Our corporate approach to sustainability and addressing inequalities and promoting diversity is summarised in the sections above.

We comply with procurement regulations with regard to ensuring that suppliers observe human rights issues.

Our approach to tackling fraud and bribery is explained in the Annual Governance Statement (page 72).

As we move towards a new organisational form in April 2019, we will ensure that these values of social and community responsibility is embedded in the new organisation.

Nigel Beverley
Chairman

Date: 29 May 2018

Clare Panniker
Chief executive

Date: 29 May 2018

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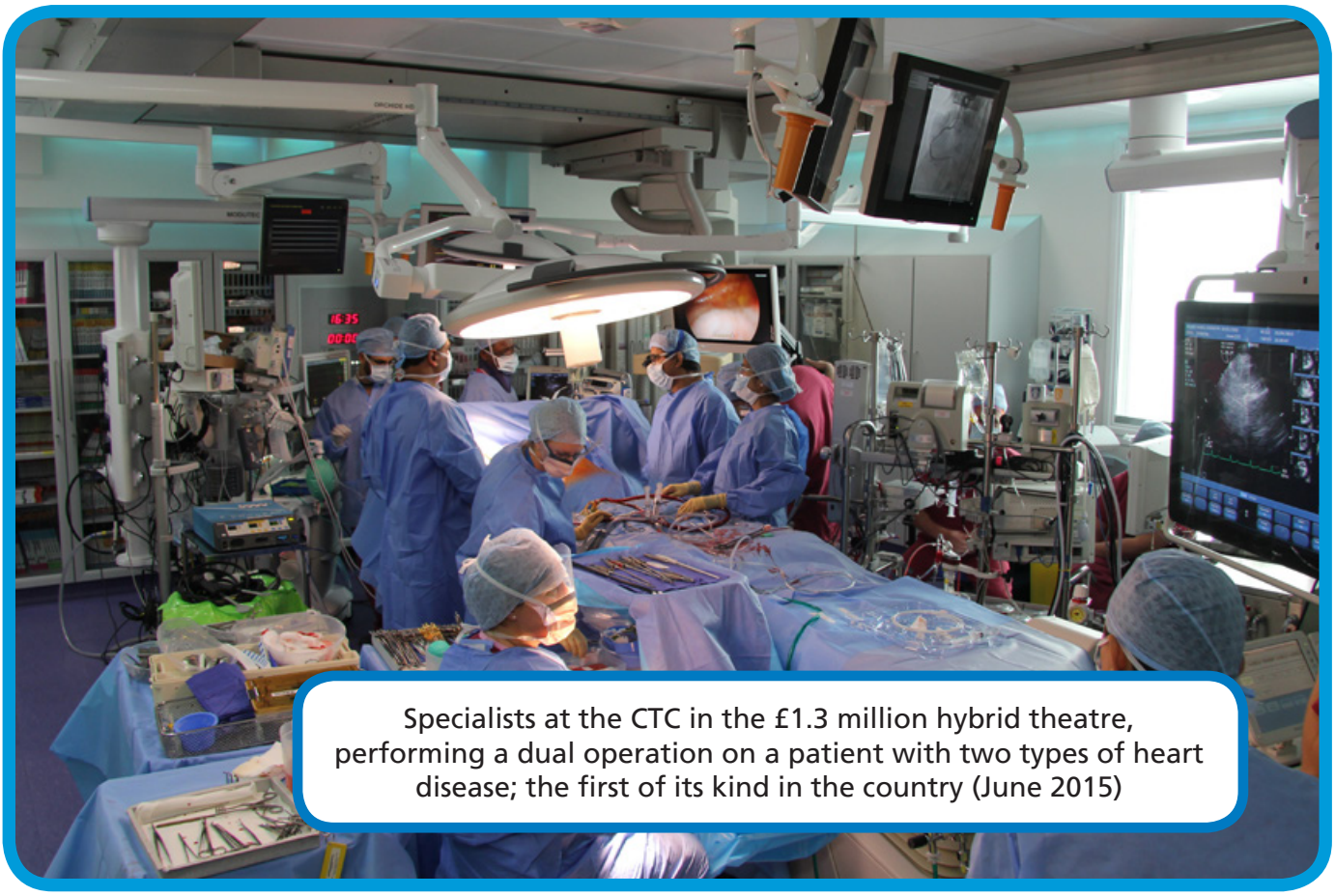
The Essex Cardiothoracic Centre celebrates 10 years of world-class heart and lung treatment



Specialists at the CTC in the £1.3 million hybrid theatre, performing a dual operation on a patient with two types of heart disease; the first of its kind in the country (June 2015)

In 2017, The Essex Cardiothoracic Centre (CTC) marked a decade of providing world-class, pioneering treatment for heart and lung patients from Essex and the whole country.

The centre opened to patients in July 2007, and rapidly established a strong track record for excellence and innovation and some of the best outcomes for patients, compared to other similar centres in Britain.

Surgeons and cardiologists have outstanding expertise in minimally invasive keyhole surgery and advanced cardiology procedures, including emergency angioplasty to unblock arteries in heart attack patients. The CTC is one of the few specialist centres where keyhole mitral valve surgery is performed, and recognised as one of the most advanced hospitals in the country treating high risk patients with heart valve problems.

Data shows that emergency patients taken to the CTC after a cardiac arrest have one of the highest chances in the country of making a good recovery.

Ellie Gudde, matron, has worked at the CTC since it opened in July 2007. She said: "One of the many reasons why this centre is a fantastic place to work is the enthusiasm and opportunities for offering patients ground-breaking treatments, in the most up-to-date facilities."

Accountability report

Directors Report

This section provides information on the way the Trust is run and improvements made to services during the year.

The Board of Directors

The people who have served on the Board of Directors during the year are set out below, together with a brief biography, their term of office and membership of Trust committees.

The Directors' Register of Interests, which is updated annually, is available on the Trust website at http://www.basildonandthurrock.nhs.uk/board-of-directora2/board-declarations

For details of board committees, please see page 31.

Composition and completeness of the Board of Directors

The Board of Directors considered its composition, skills, balance and completeness and was satisfied that its composition was appropriate for the leadership of the Trust during 2017/18.

How our Foundation Trust is run

This section explains how we make decisions and manage the services that we provide to the local community.

The Trust is run by the Board of Directors, who are collectively responsible for the quality of healthcare delivery and financial performance. The Board of Directors is held to account for stewardship of public money and delivery of services by the independent regulator of NHS foundation trusts, NHS Improvement, and locally by the Council of Governors. The Board of Directors is held to account for quality of services by the Care Quality Commission (CQC).

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

Leadership

The chairman is responsible for leadership of both the Board of Directors and the Council of Governors.

As chairman of the Board of Directors, the chairman 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 the Trust's long-term success and sustainability. He also ensures that there is sufficient and effective communication with stakeholders to understand their issues and concerns.

As chairman of the Council of Governors, the chairman provides a pivotal link between governors and directors especially the non-executive directors (NEDs). Listening to the governors is one of the ways in which the chairman can hear and respond to the views of the local community and local stakeholders. The chairman regularly provides feedback to the Board of Directors on the views of the governors and local people.

The governors routinely invite the chief executive to their meetings and invite attendance by other executive and non-executive directors as required. In these meetings, governors, members and the general public may raise questions of the chairman, or any other director present at the meeting, about the affairs of the Trust. The executive directors attend meetings of the Council of Governors when the agenda includes business where they are well placed to contribute.

The role of the Board of Directors

The Board of Directors sets the strategic direction of the Trust ensuring that the necessary financial and human resources are in place to meet its

priorities and objectives. It operates within a framework of processes, procedures and controls which allows performance and progress to be monitored and its risks carefully assessed and managed.

The Board of Directors is responsible for ensuring compliance with the Licence granted by NHS Improvement (formerly the terms of authorisation), its constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.

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

The chief executive is ultimately responsible for implementing the strategy agreed by the Board and for developing the Trust's objectives through leadership of the executive team. She recommends to the Board any investment or new business opportunities which promote achievement of this strategy. The chief executive also ensures that the Trust's risks are adequately addressed and appropriate internal controls are in place. The Trust seeks the views of the Council of Governors when developing its annual plan.

Providing support to directors

Directors, governors and members are supported by a professionally qualified corporate secretary (as recommended by the NHS Foundation Trust Code of Governance) and a small multi-skilled corporate governance and membership services team. The corporate secretary throughout 2017/18 was Andrew Stride.

Newly appointed directors receive a full, formal and tailored induction on joining the Board of Directors.

The Board of Directors ensures that directors, especially the non-executive directors, have access to independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors or to provide additional assurance on areas of challenge. The corporate secretary facilitates access to this advice and support.

Directors also have access, at the Trust's expense, to training courses and materials that are consistent with their individual and collective development programme. The availability of independent external sources of advice is made clear at the time of appointment.

How the Board of Directors operates

The Trust has maintained its support of the Nolan Principles of Public Life and has continued to make the majority of its decisions at Board meetings in public. To support this, there is the Directors Responsibilities and Code of Conduct, which applies to all directors and has been adopted by all Board members. This Code of Conduct builds on the NHS Code of Conduct and includes the Nolan Principles.

In October 2015, the Board of Directors approved a policy on Meeting the Requirements of the Fit and Proper Person Test. This policy requires the chair to ensure that 'appropriate checks' have been undertaken in reaching a judgement that all directors are deemed to be fit and that none meet any of the unfit criteria. This applies to all members of the Board of Directors, including the corporate secretary. The remit of this policy was expanded during 2017/18 to encompass the site leadership teams. A process is now in place to ensure that Fit and Proper Person assessments are made as part of the appointment process and on an annual basis as part of the appraisal process. This policy enables the Trust to meet the relevant provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Trust held six formal meetings of the Board during 2017/18. Four of these meetings incorporated a session held in public. Items of business are only discussed in private session where they are either commercially or patient sensitive. The Board has also met in common with the Boards of Southend and Mid Essex Trusts on two occasions, also with public sessions.

To help the Council of Governors fulfil their role of holding the Board of Directors to account through the non-executive directors, the Board has appointed two governor observers on the following committees:

- Audit Committee
- Quality and Patient Safety Committee
- Finance and Resources Committee
- Charitable Funds Committee (one governor observer)

The Council of Governors also receives the agenda and minutes of all Board meetings held in private.

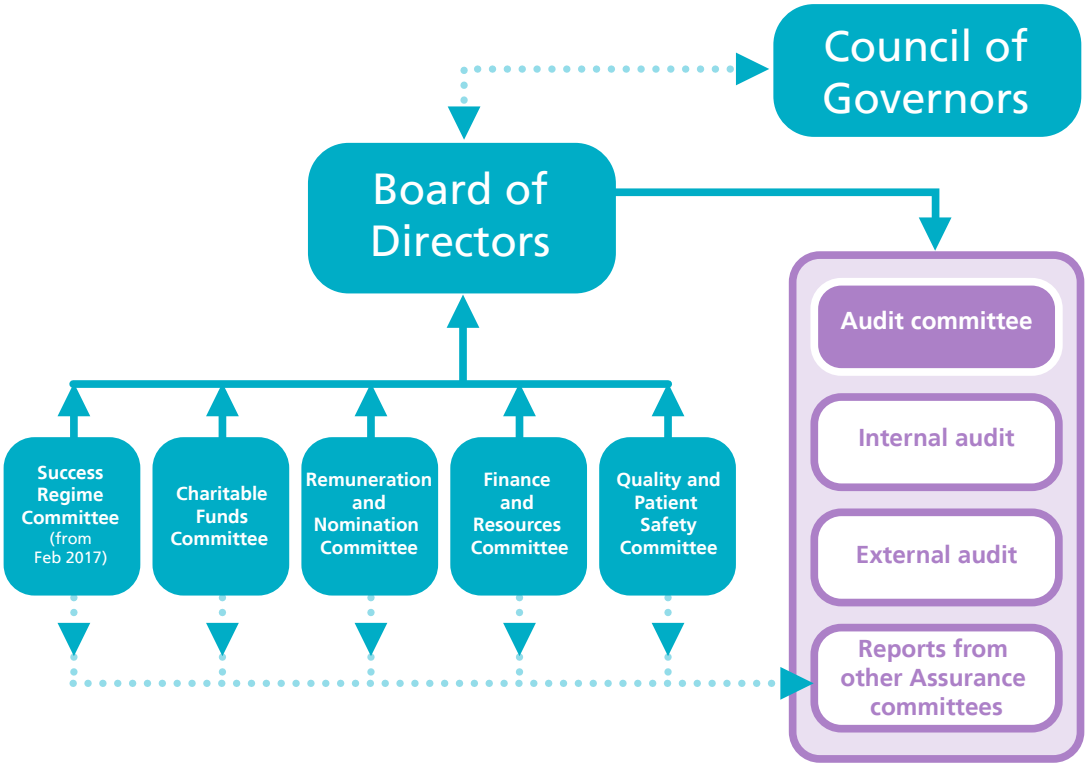
The Board of Directors conduct 'walkabouts' where executive and non-executive directors visit clinical areas on the day of the board meeting. Governors participate in these visits and find them worthwhile. Board members and governors provide feedback on their visits at the start of the Board meetings in public and findings of good practice and areas for improvement are followed-up.

The Trust Constitution details how disagreements between the Board of Directors and the Council of Governors will be resolved. Alongside this, a specific Engagement (Disputes) Policy was approved and introduced in 2013. This policy was not used in 2017/18.

The Scheme of Reservation and Delegation details what type of decisions are to be taken by the Board and which decisions are to be delegated to management by the Board of Directors. These were reviewed during 2017/18.

The Board of Directors also has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. The Board of Directors keeps the performance of its committees under regular review and requires that each committee considers its performance and effectiveness throughout the year. These assessments, together with committee meetings, are used for shaping individual and collective professional development programmes for directors as relevant to their duties as Board members.

During 2017/18, the Trust's Board Committee structure was as set out below:



Collaborative Governance Framework

In December 2016, the Boards of Directors of the three acute trusts in mid and south Essex agreed to enter into a collaborative governance framework with a contractual joint venture to enable them to work more closely together to redesign clinical services, clinical support services and corporate support services as part of the Mid and South Essex STP, whilst remaining three

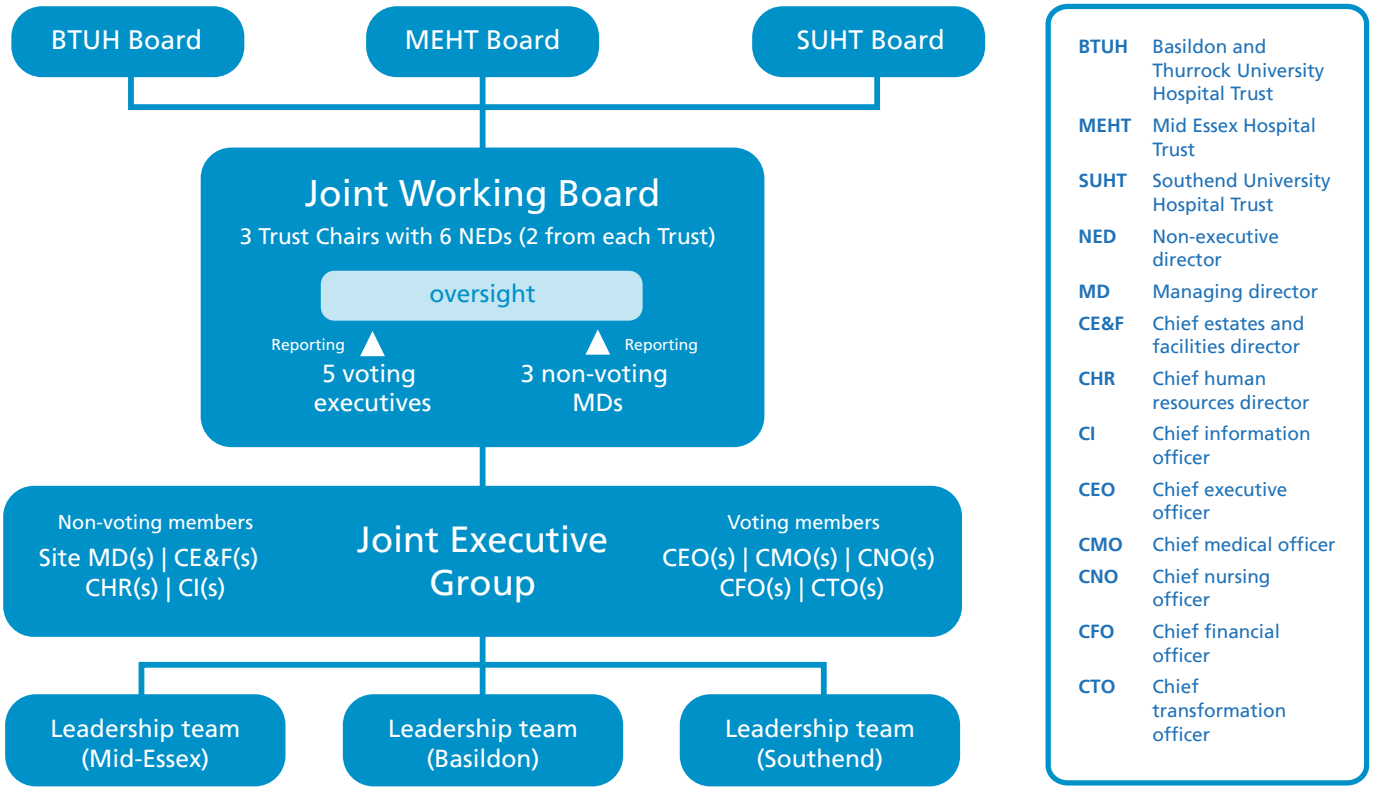
separate and sovereign statutory organisations. The contractual joint venture agreement was signed on 1 January 2017 and it came into effect on 1 February 2017.

The Boards agreed to create a 'committees in common' governance model, whereby each Board of Directors created a Success Regime Committee (SRC), to which all powers which could, within the confines of law and good governance, be delegated, were delegated. Meetings of these committees take place in common under the operating name of the 'Joint Working Board'.

The Joint Working Board (JWB) met for the first time in February 2017 and will continue to do so on a monthly basis. JWB conducts the majority of its business in public.

The Board of Directors of each Trust remains ultimately accountable for the performance of that particular Trust. However the Boards now meet less frequently than previously, focussing upon the exercise of those functions and governance responsibilities which cannot be delegated and receiving assurance about the performance of the Trust and the effectiveness of the Success Regime Committee and other committees that report to the Board.

The key elements of the collaborative governance framework are shown in the following diagram:



The members of the Trust Success Regime Committee throughout 2017/18 were :

- Nigel Beverley – chairman
- Elaine Maxwell – non executive director
- John Govett – non executive director / senior independent director
- The joint executive group members

Please see information on page 28 for further details about the Joint Executive Group.

Reviewing the effectiveness of the collaborative governance framework

The collaborative governance arrangement is subject to a programme of scheduled reviews, overseen by a specially convened oversight committee, comprising the Chairs of the three Audit Committees and an additional NED from each Trust. In May 2017, the Oversight Committee developed a questionnaire to gather views and feedback from the non-executive directors, joint executives, site leadership teams and Governors across the three trusts to enable

the collaborative governance processes to be reviewed, adapted and changed as required to improve effectiveness. The Joint Working Board received a presentation in October 2017 showing the outcome of the review and an action plan was developed to expand upon the broad recommendations which encompassed vision, communication, visibility, accountability, relationships, reporting and workload pressures

The Board of Directors

The people who have served on the Board of Directors during the year are set out below, together with a brief biography, their term of office and membership of Trust committees. The Directors' Register of Interests, which is updated annually, is available on the Trust website at http://www.basildonandthurrock.nhs.uk/board-of-directora2/board-declarations

For key committees, please see page 24.

Chairman and Non-Executive Board Members

Nigel Beverley, chairman

Nigel has a long and successful career in health management, mainly in the NHS, having held a number of chief executive positions in hospitals in Essex and London. He also has experience in commissioner roles at a regional level and healthcare business development.

Nigel's experience in the NHS has provided him with a range of areas of expertise including performance improvement, change management and transformation.

Appointed initially in July 2015, Nigel was successfully reappointed by the Governors for a further term of three years up to June 2021.

Membership of Committees : FRC, QPSC, RN (chair)

John Govett, non-executive director, senior independent director

John was group chief executive of Ixion Holdings (Contracts) Ltd (Anglia Ruskin University) and chairman of Paragon Concord Ltd. He has led company-wide root and branch reviews for organisations including P&O Ferries (as UK and worldwide commercial and marketing director) and Surrey County Council (as acting deputy CEO). A former head of marketing at Tesco, John has held various non-executive director and governance roles. John was initially appointed in April 2012 for a three-year term, and was successfully reappointed to March 2018. The Council of Governors extended John's term for a further twelve months to provide continuity as the Trust progresses to a new organisational form. His term will now expire in March 2019.

Membership of Committees: FRC (Chair), RN

Renata Drinkwater, non-executive director

Renata's background is in business strategy consulting, initially with KPMG, subsequently as a Partner at EY (formerly Ernst and Young) and latterly as a director at the Capita Group plc. She has a long standing interest in health sector issues. She was an elected trustee at Diabetes UK, and also at National Voices. She has also held non-executive directorships at a primary care trust and at three acute hospital trusts, including Basildon and Thurrock. She was also Chief Executive and Trustee of self-management UK, the country's leading provider of self-management programmes for people with long term health conditions. Renata is currently also a Self-Care Forum Board member, and a non-executive director of the Professional Standards Authority for Health and Social Care.

Appointed as a non-executive director in April 2016, her term runs until March 2019.

Membership of Committees: AC, CF, RN, FRC, QPSC

Rita Greenwood, non-executive director

Rita's background is in local government having worked at several London boroughs. She left her last post as a group director of finance and commerce in 2009.

She continues to work in the sector on a freelance basis with an interest in sharing services across organisations. As a qualified accountant, Rita has been a financial advisor for local government and was president of the Society of London Treasurers.

Appointed as a non-executive director in April 2017, she left the Trust on 27 April 2018.

Membership of Committees: FRC, AC, RN

Elaine Maxwell, non-executive director

Elaine Maxwell was appointed as a non-executive director in April 2014. Elaine is a registered nurse and worked in hospitals and as a health visitor before moving into quality management. She was executive director of nursing at Dorset County Hospital NHS Foundation Trust from 1999 to 2003 and at Barking, Havering and Redbridge University Hospitals NHS Trust from 2004 to 2007 before undertaking her PhD and moving into academic roles. Elaine is currently clinical adviser for the National Institute of Health Research Dissemination Centre within the University of Southampton. Elaine is also a member of the editorial board of the Journal of Research in Nursing. Elaine left the Trust at the end of March 2018.

Membership of Committees: QPSC, AC, CF, RN

Barbara Riddell, non-executive director, deputy chairman

Appointed in April 2012, Barbara was director of resources at London Fire Brigade, where she was responsible for finance, HR, procurement and property from 2001-2010. A civil servant working in central government and then the Property Services Agency/English Partnerships for two decades, she was also head of corporate services for the Metropolitan Police. Barbara has served as a non-executive director on boards in the public and not-for-profit sectors and was chairman of Housing for Women. She is also a school governor. Barbara was awarded an OBE in 2008. She left the Trust at the end of March 2018

Membership of Committees: AC (Chair from January 2017), CF (Chair), RN, Joint Negotiating Committee (Chair), Staff Council

Executive Board Members

The latter part of the 2016/17 year saw a significant change in the leadership structure of the Trust. As part of the joint working between our Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust, a single joint executive group (JEG) was established following consultation and a formal appointments process, including the use of external expert assessors.

With effect from 1 February 2017, the appointees became the executive members of each of the Trust Boards. These arrangements are in the form of secondments from the postholders' substantive roles, currently expiring on 31 March 2019.

Individuals who served as executive members of the Board of Directors between 1 April 2017 and 31 March 2018 were as follows:

Clare Panniker, chief executive

Clare Panniker joined the Trust as chief executive in September 2012. Prior to joining Basildon and Thurrock University Hospiptals NHS Foundation Trust, Clare was CEO of North Middlesex University Hospital for nine years.

A registered nurse, Clare also has a business degree, and has worked in the NHS for more than 25 years.

Clare mentors other aspiring NHS leaders, from both clinical and management backgrounds. The chief executive is the accounting officer for the Trust and carries full responsibility for the Trust's performance, forward planning and leadership of the executive team and clinical directors.

Tom Abell, chief transformation officer and deputy chief executive

Tom Abell joined the Trust in October 2015 as deputy chief executive.

He was previously chief officer of NHS Basildon and Brentwood Clinical Commissioning Group, bringing valuable experience of health commissioning to the Board.

Tom has been involved in several major service transformation and improvement programmes during his career. He has a special interest in the role that technology and new ways of working can play in improving health outcomes for patients, while making maximum use of valuable resources.

Tom also became deputy chief executive of the

three trusts with effect from July 2017 following a formal appointment process.

Membership of Committees: FRC

Martin Callingham, chief information officer (non-voting)

Martin initially trained as a nurse at the Royal London Hospital, working in A&E departments in north east London and Harlow. He made the move into site management and discharge planning at Whipps Cross Hospital before moving to Newham as head of modernisation, implementing the first electronic patient records 2004. He progressed to the role of chief information officer at Newham responsible for IT, Information coding and data quality and following the merger of Bart's Hospital and Whipps Cross Martin was responsible for clinical systems across six hospital sites.

Martin joined Mid Essex Hospitals NHS Trust in August 2014 to help deliver, maintain and grow the use of technology and information across the Trust.

James O'Sullivan, BA, ACMA, chief financial officer

James joined Southend Hospital as chief financial officer in April 2014.

During his early career James qualified as an accountant while working in the oil industry. He has also worked in other sectors, latterly spending 18 years with EDF Energy, and has held a number of finance director roles over the years.

Diane Sarkar, chief nursing officer

Diane's experience spans the NHS and private healthcare. After training at The Royal Free Hospital in London, she worked in a number of London's large acute hospitals and progressed through several operational and corporate management positions. In1996, Diane worked in the private sector at the Wellington Hospital, setting up new governance frameworks and leading on the quality agenda. Having completed a Master's degree, Diane returned to the NHS in 2001 at Southend Hospital, as associate director of operations for medicine and then associate director of nursing. Appointed in 2010, her focus has been particularly around developing the nursing workforce, as well as leading on a number of corporate agendas, including quality improvement and the patient safety and patient experience agenda.

Celia Skinner, chief medical officer

Celia obtained her Fellowship from the Royal College of Physicians in 2001 and has specialised in genito-urinary medicine, particularly the treatment of HIV/Aids. She was previously deputy medical director at Barts Health where she had worked since 1995, having previously been associate medical director and a divisional director.

Carin Charlton, chief estates and facilities director (non-voting) (April 2017 to December 2017)

Carin Charlton joined the Trust in October 2016 as director of environment and infrastructure. This post was originally shared with Mid Essex Hospital Services NHS Trust before becoming the JEG position of Chief Estates and Facilities Director in February 2017. Having worked 17 years in the NHS, Carin has considerable operational experience having worked as a dietitian as well as holding a range of director and senior manager positions.

Clare Culpin, managing director (non-voting)

Clare joined the Trust in March 2017 from Kettering General Hospital NHS Trust where has worked for more than four years, most recently as acting chief executive. A trained nurse, Clare has worked in both hospital and community services in the UK and overseas. She has held a number of deputy director and executive director roles in the NHS, including director of nursing and quality, director of strategy and corporate governance and deputy chief executive.

Mary Foulkes, OBE, FCIPD, chief human resources director (non-voting)

Mary joined Southend Hospital as the director of human resources and organisational development in January 2015.

Mary has over 25 years' experience at the director level in a variety of private, public and

third sector industries. This includes eight years working in the NHS in both the acute and mental health sector.

Mary is a Fellow of the Chartered Institute of Personnel and Development and was awarded an OBE in 2003 for her charitable work.

Paul Kingsmore, chief estates and facilities director (interim, from December 2017)

Paul joined the JEG in December 2017 as chief estates and facilities director and is covering this role on an interim basis whilst recruitment to a substantive postholder takes place.

Prior to joining the group he was director of services at Manchester Metropolitan University from June 2017 to November 2017.

Paul is a Chartered Mechanical Engineer who undertook his engineering training at Short Brothers, Belfast. He joined the NHS in 1982 and has held a number of posts in the NHS in England, Scotland and Northern Ireland. He has been an executive director for over 17 years.

Paul has served on a number of national bodies including the HAI taskforce in Scotland and the Department of Health's Patient Care Forum.

He is a past President of the Institution of Healthcare Engineering and Estate Management. He is currently also a director of HBE Ltd and First EFM Ltd.

Site leadership team

With effect from 1 February 2017, site leadership teams were established for the three trusts, each headed by a managing director. While the joint executives take a group-wide strategic view, the site leadership teams ensure that the leadership in each trust, and the focus on its own unique challenges and opportunities, is not compromised. The three managing directors are also members of the JEG and are non-voting members of the board of directors of their own trusts.

The BTUH site leadership team comprised the following for the 2017/18 year (except where noted):

Clare Culpin
Managing director

Liz Edelman
Head of human resources
(from 8 December 2017)

Danny Hariram
Director of workforce and organisational development (until 8 December 2017)

Dawn Patience
Director of nursing

Tayyab Haider
Medical director

Carolyn Lewis
Interim estates and facilities site manager (from 7 November 2017)

Sharon Salthouse
Estates and facilities site manager
(until 13 November 2017)
Director of operations - planned and scheduled care (from 13 November 2017)

Stephanie Watson
Director of finance

Liz Wells
Director of operations - urgent, emergency and unplanned care (from 6 April 2017)

Andrew Stride
Corporate secretary

Directors' attendance

Membership and attendance at Board of Directors and committee meetings is summarised below. The values shown are the number of attendances against the number of meetings held during the year that the non-executive director or executive director was eligible to attend. Where there is no entry, this means that the director is not a member of that committee.

Committee	BoD	SRC	AC	QPSC	FRPC	CF	RN
Chair	NB	NB	BR	RD	JG	BR	NB
Nigel Beverley	8 of 8	8 of 9	n/a	5 of 9	n/a	n/a	3 of 3
Clare Panniker	6 of 8	7 of 9	n/a	n/a	n/a	n/a	n/a
Tom Abell	5 of 8	8 of 9	n/a	n/a	n/a	n/a	n/a
Martin Callingham	5 of 8	9 of 9	n/a	n/a	n/a	n/a	n/a
Carin Charlton (to Dec 2017)	3 of 5	6 of 7	n/a	n/a	n/a	n/a	n/a
Clare Culpin	6 of 8	6 of 9	n/a	5 of 9	9 of 11	n/a	n/a
Renata Drinkwater	6 of 8	n/a	n/a	9 of 9	10 of 11	3	0 of 3
Mary Foulkes	4 of 8	8 of 9	n/a	n/a	n/a	n/a	n/a
John Govett	4 of 8	5 of 9	n/a	n/a	11 of 11	n/a	1 of 3
Rita Greenwood	6 of 8	n/a	3 of 5	n/a	9 of 11	n/a	2 of 3
Paul Kingsmore (from Dec 2017)	1 of 3	2 of 2	n/a	n/a	n/a	n/a	n/a
Elaine Maxwell	6 of 8	7 of 9	4 of 5	5 of 8	n/a	2	1 of 3
James O'Sullivan	8 of 8	9 of 9	n/a	n/a	n/a	2 of 3	n/a
Barbara Riddell	6 of 8	n/a	4 of 5	n/a	n/a	3 of 4	1 of 3
Diane Sarkar	6 of 8	8 of 9	n/a	n/a	n/a	n/a	n/a
Celia Skinner	7 of 8	9 of 9	n/a	n/a	n/a	n/a	n/a

Key:
(BoD) Board of Directors
(SRC) Success regime committee
(AC) Audit committee
(CF) Charitable funds committee
(QPS) Quality and patient safety committee
(RN) Remuneration and nominations committee
(FRC) Finance and resources committee

Directors' additional activities

No executive directors were appointed as a non-executive director of another organisational during the year. No Board director is a governor or director of another NHS Foundation Trust, except for the members of the joint executive group who are, by definition, executive directors of Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust.

Board committees

Remuneration and Nominations Committee (RN)

The Remuneration and Nominations Committee (RemNom) serves a number of purposes:

- Determines the remuneration and terms of service of the Trust's chief executive and of other executive directors
- Considers the pay and conditions of any termination arrangements
- Appoints executive directors (including the chief executive) following a formal, rigorous open and transparent process
- Advises the Council of Governors on the skills and experience required for non-executive director appointments
- The committee comprises all non-executive directors and is chaired by the Trust chairman. The Committee's terms of reference are compliant with all Code Provisions relating to it within the NHS Foundation Trust Code of Governors 2010 (revised in 2013).

The chief executive and the director with responsibility for human resources are invited to attend the committee when relevant to provide professional advice. Neither will attend any meeting at which the terms of office or remuneration for their posts are under discussion. In the event that an external advisor to the committee is appointed, that person is not a member of the committee.

During Summer 2017, the Joint Working Board (JWB) agreed that the RemNoms of the three trusts should meet and transact their business in common, as part of the collaborative governance arrangements. This made sense strategically

given that the executive directors (including the chief executive) held those positions on the Boards of all three trusts. In the interests of clarity and governance, the JWB approved a mode of working document that set out those issues which were within and outside scope when the committees met in common rather than when they met alone.

The RemNoms in Common retained their own terms of reference and accountability to their own Trust Board by whom their authority was delegated.

During 2017/18, the RemNoms in Common met in Common on two occasions. At these meetings, the following items of business were transacted:

- The objectives for the joint executives were discussed, refined by the Committee and approved
- The outcome of the mid-year appraisals for the joint executives, including the chief executive, were noted by the Committees
- The potential for introducing a performance-related pay scheme for joint executives was debated in depth by the Committees. A decision was reached that such an independent review of suitable schemes and a proposal should be commissioned for the committees to consider in Autumn 2018, with a view to introducing from April 2019
- Oversight of the recruitment process for the chief commercial officer and the chief estates and facilities director
- Oversight of the capacity and capability of the site leadership teams, in recognition of the crucial role of these teams in the delivery of safe and effective care at each site

The Trust RemNom also met alone on one occasion during 2017/18 to provide a forum for the managing director to engage with the non-executive directors on changes to the site leadership team. Whilst outside the formal scope of the Trust RemNom terms of reference as RemNoms do not ordinarily consider posts below Board-level, this arrangement has added value during this first full year of operation of the collaborative governance framework.

Charitable Funds Committee (CF)

The Charitable Funds Committee ensures that the Trust complies with its responsibilities as a corporate trustee and reviews the performance of charitable funds.

Key achievements of this committee during 2017/18 included:

- Monitoring the reserves of the charity in compliance with the Reserves Policy, review of fundraising activities and consideration of fundraising resources and appropriately appeals and improved engagement with fundholders
- Review of the charity accounts for 2016/17
- Consideration of a presentation and report from the independent Investment Manager
- Commencement of discussions with the charitable funds committees of Mid Essex Hospitals and Southend Hospital about greater collaboration of the three charities over the coming year

Audit Committee (AC)

The Board has a well-established Audit Committee whose membership comprises solely non-executive directors. In 2017/18, membership of the committee comprised three NEDs, two of whom were also members of the Finance, Resources and Performance Committee and of the Quality and Patient Safety Committee, in the interests of promoting integrated governance and the flow of information and assurance between committees. Whilst the Trust chairman is able to attend Audit Committee meetings in an ex officio capacity, he not a member of the committee.

The role of the Audit Committee is to assess the adequacy and effective operation of the Trust's overall systems of risk management and internal control. It focusses mainly on the framework of risks, controls and related assurances that underpin the delivery of the Trust's operational and strategic objectives. The Audit Committee reviewed arrangements for Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters (the Trust's Whistleblowing Policy).

In focussing on the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives (the Board Assurance Framework – BAF), the committee takes a particular interest in the processes that underpin the Annual Governance Statement within the Annual Report and Accounts.

Key activities of the Audit Committee during 2017/18 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 findings of internal audit work, the appropriateness and timeliness of management responses and the timeliness of the completion of agreed actions to bring about improvements
- Review of all external audit reports, including the annual governance report to the committee and the annual audit letter to the Council of Governors and any work conducted for the Trust outside the annual audit plan
- Review of the Trust's Annual Report and Financial Statements (Accounts) before approval by the Board of Directors, including the Annual Governance Statement and changes in, and compliance with, accounting practices and policies
- Review of all work related to counter fraud and security as required by NHS Counter Fraud Authority
- Review of the work of other committees whose work can provide assurance on the Trust's overall system of governance and internal control
- The Audit Committee also receives regular reports on losses and special payments, waivers of tendering processes and competitive quotations and any alleged or suspected fraud notified to the Trust or its Local Counter Fraud Specialist.

In line with the NHS Foundation Trust Code of Governance, the Committee has the following items to report to the Board:

- The committee undertook a detailed review of the financial statements prepared for the Annual Report and Accounts 2016/17. The Annual Report and Accounts were consistent with the information provided to the committee throughout the year and with information provided from external assurance reports (for example, the Care Quality Commission reports). The same process took place prior to the Board of Directors receiving the financial, operational and compliance statements within the 2017/18 Annual Report and Accounts
- In reviewing the reports from the external auditors to the committee and to the Council of Governors, and taking into account the committee's private discussions with the external auditors, the committee considers, along with comments from management, whether the Trust received an effective audit from the current external audit provide, BDO LLP. The external auditors' fee was fixed with reference to the contract under which this firm was first appointed, and the committee received confirmation of the fees to be charged for the 2017/18 audit when considering the external audit plan for the year
- In preparing for the review of the 2017/18 financial statements, operations and compliance, the committee spend time assessing the Trust's Going Concern statement, in view of its financial position
- The Trust ensures that the external auditors' independent report has not been compromised where work outside the audit code has been commissioned by referring all such work to the Council of Governors for approval. However the external auditors did not undertake any additional work for the Trust outside the annual audit plan during 2017/18.

The Audit Committee is supported by two assurance committees of the Board of Directors – the Quality and Patient Safety Committee and the Finance, Resources and Performance Committee. Each committee comprises non-executive directors and site directors, supported

by senior officers. Both committees are chaired by non-executive directors. The aim is to ensure in-depth scrutiny and additional assurance on the internal control in these key aspects of the Trust's business and governance responsibilities.

Quality and Patient Safety Committee

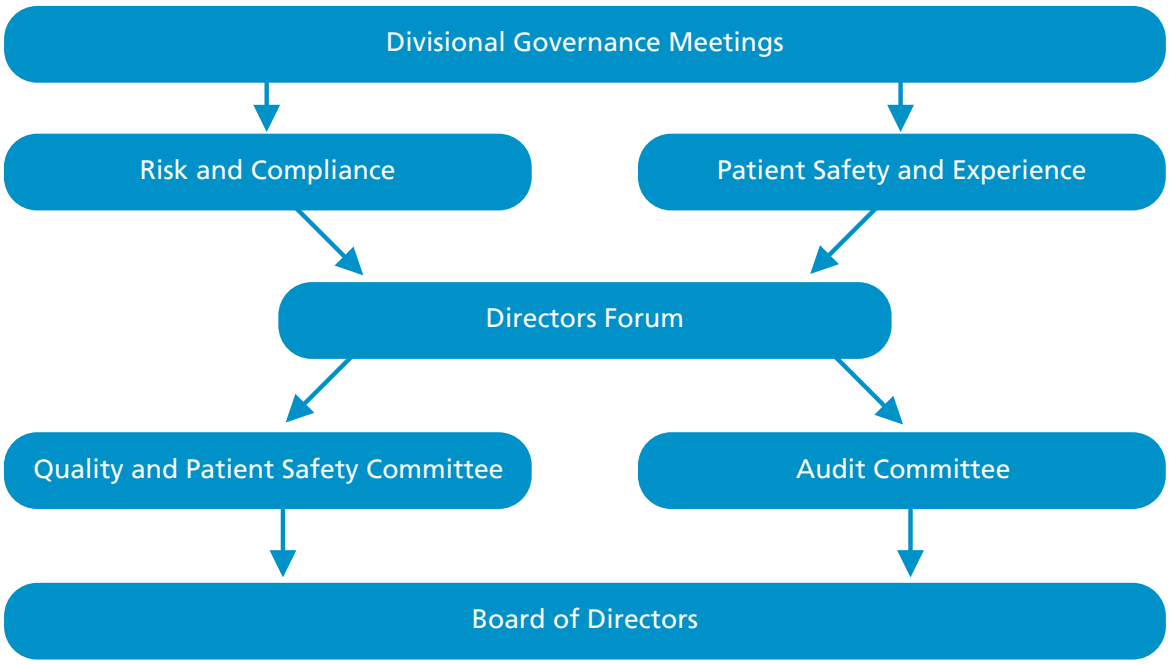
The Trust's umbrella clinical governance committee is the Quality and Patient Safety Committee (QPSC). It is responsible to the Board of Directors for monitoring the implementation of strategic priorities and compliance with regulatory requirements and best practice relating to clinical quality, patient safety and experience. Quality governance and the Trust's performance regarding quality are discussed in more detail in the Annual Governance Statement (page 72) and the Quality Report (page 85).

QPSC ordinarily meets every two months.

However from July 2017 to the end of the 2017/18 year, the committee has been meeting monthly. This was due to a number of issues on which more urgent and frequent assurance was required than was possible at bi-monthly meetings. The Committee took the decision to return to bi-monthly meetings from May 2018 in view of the change in the Trust's quality risk profile, whilst retaining the flexibility within the committee's terms of reference to increase the meeting frequency again on a risk basis.

The focus on quality improvement and outcomes was maintained by an integrated quality report from the chief nursing officer and the chief medical officer to the Trust Board at their quarterly meetings.

The quality governance structure relating to quality improvement and clinical governance is shown below



Two governor observers have provided regular feedback on the work of the committee at the Council of Governors meetings during the year. This is a key step in helping governors to discharge their statutory duty to hold the Board to account through the NEDs.

Key activities of QPSC during 2017/18 included:

- Oversight of reports and resultant action plans from external service reviews and compliance visits
- Monitoring and reviewing areas of poor performance against quality metrics and key performance indicators. During 2017/18 these areas included cleaning quality standards, cervical screening and the timely production of clinic letters
- Review of the Head of Midwifery Annual Report
- Focus on the risk profile of the Trust's Clinical Care Unit
- Review of the Trust's whistleblowing policy and arrangements

- Review of benchmarking data in relation to a number of areas including falls

In addition to the Trust-only QPSC meetings, the quality committees of the three trusts have also met in common on two occasions during 2017/18 under a mode of working document approved by the JWB. The focus of these meetings in common is upon cross-trust quality improvement strategies and the analysis of specific quality issues which benefit from analysis at that level, such as learning from deaths and regulatory compliance.

Finance, Resources and Performance Committee (FRPC)

This committee's remit was expanded during Summer 2017 to include scrutiny of the Trust's operational performance metrics, alongside the committee's traditional focus on the effectiveness of financial management, financial governance and workforce metrics. Key activities during 2017/18 included:

- Considering on a monthly basis the Trust's financial performance including achievement of efficiency savings and cash management by reference to the Annual Plan
- Detailed scrutiny of the 2018/19 plan, making a recommendation to the Board of Directors that the 2018/19 control total proposed by NHSI could not be realistically achieved without compromising patient care
- Review of the Trust's performance at specialty level against the Model Hospital benchmarking data
- Approval of the Trust's business planning process for 2018/19
- Reviewing the capital programme
- Monthly scrutiny of recovery plans against the access standards within the NHS Constitution, including the four-hour A&E wait standard, the 18-weeks referral to treatment (RTT) standard and the cancer wait standards
- Regular review of the workforce plan and key performance indicators relating to the Trust's workforce such as sickness absence, vacancy rates, turnover, agency usage and the completion of appraisals and core skills training
- In addition to monthly Trust-only meetings, the finance and resources committees of the three trusts have met in common on three occasions during 2017/18 as part of the collaborative governance arrangements, under a mode of working document approved by the JWB. The focus of these meetings in common is on financial and workforce strategy and planning for the Mid and South Essex STP with a high level overview of the performance of individual trusts.

How we evaluate the performance of the Board of Directors and its committees

The Trust is committed to ensuring governance best practice and has adopted a mixture of regulator-driven evaluation and self-assessment to evaluate the performance of the Board of Directors.

The annual appraisal/performance review of the chairman is led by the Senior Independent Director (SID), with input from the Council of Governors, Board members and with support from the corporate secretary. The outcome of the appraisal and agreed objectives are shared with the Council of Governors in July each year. The Chairman, with input from the Council of Governors, undertakes in turn the annual appraisals or performance evaluations of the non-executive directors. The objectives of the non-executive directors agreed through this process are also shared with the Council of Governors in July each year.

The chief executive leads the annual appraisal of the executive directors. She is supported in this by the non-executive directors, particularly in relation to the performance of the Executive as members of a unitary board with collective responsibility for the performance of the Trust. The RemNom Committee reviews the appraisal and objectives agreed each year.

Evaluation of the effectiveness of the committees takes place shortly after the end of the financial year, usually as a self-assessment exercise.

The chairman and NEDs meet privately as required to review the performance of the Board of Directors.

Ensuring the Trust is well-led

An internal review of the Trust's compliance with the NHS Improvement Well Led Framework took place in March and April 2018, prior to the formal routine inspection of the Well Led Domain by the Care Quality Commission (CQC) which is anticipated in Summer 2018. The review was carried out using NHS Improvement's Well Led Framework round the eight key lines of enquiry (KLOEs) utilising a variety of methods. These methods included a review of policies and procedures, review of meeting minutes and papers, observations at meetings and interviews with senior leaders at corporate and division level. The divisions also undertook a Well Led assessment of their own areas. The report from the internal Well Led inspection will be considered by the Trust Board meeting in public at the end of May 2018.

An internal peer inspection of the Trust's core services utilising the independent perspective of senior clinical and managerial colleagues from our partner acute trusts in Mid and South Essex took place in 2017. This inspection examined all five CQC domains (Safe, Effective, Caring, Responsive and Well Led) and a rating was applied to each clinical area visited using the CQC ratings framework against the evidence obtained. The report from this inspection was considered by the Directors Forum and the Quality and Patient Safety Committee. With agreement from these committees, a programme of weekly internal compliance action group (ICAG) meetings was established. ICAG meetings focus on a different theme each week, with corporate and divisional representatives presenting the actions they have taken to ensure compliance against the CQC domains. This innovative methodology has proven instrumental in driving forward compliance improvements in a more effective way than traditional action plans.

Details of the internal control systems in place to manage and control risks in addition to the Trust's quality governance structure can be found within the Annual Governance Statement on page 72.

Late payment of commercial debts

The Trust was not required to make any payments of interest under the Late Payment of Commercial Debts (Interest) Act 1998 during 2017/18.

Better Payment Practice Code

The Better Payment Practice Code requires all NHS organisations to achieve a payment standard for valid invoices to be paid within 30 days of the receipt of the goods or services or a valid invoice (whichever is later) unless other payment terms have been agreed. The current target is set at 95%.

Better Payment Practice Code	2017/18 Performance by number	2017/18 Performance by value, £000	2016/17 Performance by number	2016/17 Performance by value, £000
Non NHS				
Total bills paid in the year	63,643	133,106	63,643	142,551
Total bills paid within target	59,451	125,901	61,782	136,528
% paid within target	93.4%	94.6%	97.1%	95.8%
NHS				
Total bills paid in the year	1,901	11,326	1,838	9,000
Total bills paid within target	1,772	10,977	1,617	8,470
% paid within target	93.2%	96.9%	88.0%	94.1%
Total				
Total bills paid in the year	65,544	144,432	65,481	151,551
Total bills paid within target	61,223	136,878	63,399	144,998
% paid within target	93.4%	94.8%	96.8%	95.7%

Directors' Register of Interests

The Directors' Register of interests, which

provides details of all company directorships and other significant interests can be found on the Trust website. The Register of Interests for Governors, providing the same detail, can be obtained from the corporate secretary (01268 524900 ext 1303).

Political and charitable donations

As an NHS Foundation 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, members of staff and the public for their continued support.

Statement as to disclosure to auditors

For each individual who is a director at the time that the report is approved, as far as the directors are aware, there is no relevant information of which the auditors are unaware. The directors have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

Income disclosures required by Section 43 (2A) of the NHS Act 2006

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health services in England must be greater than its income from the provision of goods and services for any other purposes. Of the £320.9m of income generated during 2017/18, £294.1m (91.6%) related directly to the provision of NHS healthcare.

Section 43(3A) of the NHS Act 2006 requires NHS Foundation Trusts to provide information on the impact that other income it has received has had on the provision of the health service in England. The income generated from other sources by the Trust during 2017/18 (noted above) has had no impact on the provision of goods or services for the purpose of the health service in England.

Nigel Beverley
Chairman
Date: 29 May 2018

Clare Panniker
Chief executive
Date: 29 May 2018

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Electronic observations benefit patient safety and care at Basildon Hospital

A new electronic observations (e-Obs) system for monitoring patients' conditions is improving safety and giving nurses at Basildon University Hospital more time to give care and treatment.

Previously, clinical staff took observations such as the patient's temperature, pulse and blood pressure and hand-wrote them in the notes at the end of each bed. The new Patientrack system, or e-Obs, means that nurses and healthcare assistants can log these observations using iPads. As well as eliminating unnecessary paperwork and freeing up nurses' time, the system also flags up when a patient's condition is deteriorating, making sure those who need extra care receive it promptly.

Sam Neville with James Atkinson, healthcare assistant, logging observations on the e-Obs system

Sam Neville, clinical informatics lead nurse, said: "E-Obs has had a big impact on patient care, because the system picks up on any changes in the patient's condition and alerts staff to anything unusual. Medical emergencies for patients within the Trust have dropped as a result."

Other benefits include a reduction in the average length of stay, during March 2017. All adult general inpatient areas use Patientrack. The Essex Cardiothoracic Centre and paediatric departments will be the next areas to adopt the system, followed by the emergency department.

Sam added: "I think the key to the success of e-Obs was having clinical staff teach their peers, in their clinical areas. We included ward managers, ward clerks, healthcare assistants, nurses and doctors and they immediately saw how the system directly benefits patients."

Samantha Priest, healthcare assistant on Florence Nightingale ward, said: "I wasn't sure of e-Obs when it was first mentioned, purely because it felt like another thing we'd have to do. However it has made a real difference to the way I work. I actually have more time to help patients with their personal care, which makes them feel more cared for."

Dr Aroon Lal, lead consultant for the deteriorating patient project, added: "It helps immensely with doctors' ward rounds, as sick patients are more readily identified and they can be assessed in order of priority."

Developments are continuing on the system, to make the wards as paper-light as possible. Future plans include email alerts to specialist nursing teams, alerts to the internal bleep system to escalate problems more quickly and live reporting.

Council of Governors and Membership Report

All governors sign a declaration on election that indicates that they meet the 'fit and proper persons' test as described in the provider license. No governor is a director or governor in another NHS Foundation Trust.

The role of the Council of Governors

The Council of Governors links the Foundation Trust to its members and community to ensure local people are engaged and involved in our services.

The Council of Governors is responsible for representing the interests of Foundation Trust members, the public and partner organisations in the local health and care economy as part of the governance of our Trust. The Council of Governors also holds the Board of Directors to account for the Trust's performance, through the non-executive directors. This includes ensuring that the Board of Directors acts in a way that does not breach the terms of its Licence (formerly its terms of authorisation).

The roles and responsibilities of the Council of Governors are set out in the Trust Constitution and detail in the Governors Governance Handbook. This handbook includes the relevant policies applicable to the Council of Governors, such the policy to be used in the event of a governor persistently failing to attend meetings and the management of conflicts of interest.

The majority of the governors have no external directorships of interests that are relevant or material to NHS business matters. Membership of political parties and declarations that may be material are recorded and updated in the Register of Governors' Interests maintained by the corporate secretary. The full Register of Interests is available on request (01268 524900 ext 1303).

Appointed governors represent their organisation, connecting the Trust and their appointing organisations. Their position within that organisation is not considered as a material interest.

Elected governors are subject to re-election by the members of their constituency at regular intervals not exceeding three years and subject to a maximum term of office. The names of governors submitted for election or re-election are accompanied by biographical details and any other relevant information to enable members to take an informed decision on their election. For governors seeking re-election this included the number of Council of Governors meetings attended during the previous year.

The Council of Governors holds formal meetings in public to make decisions and to ensure the views and priorities of local people inform the Trust's decisions on strategy. In addition, governors hold meetings without officers present to discuss matters amongst themselves and attend informal meetings with directors to develop their own knowledge of the services the Trust provides, discussing issues as they arise. Governors produce a newsletter, the Foundation Times, of which two editions were published during 2017/18. The Governors also use the Trust website and attendance at community events to communicate with members.

A number of committees and working groups of the Council of Governors have been formed. Although responsibility for all decisions is retained by the full Council of Governors, the in-depth work carried out by the committees is valuable. The committees of the Council of Governors review the remuneration and terms of office of the chairman and the non-executive directors (NEDs), appoint and re-appoint the chairman and NEDs, plan the Annual Members Meeting and review the Trust's Membership Strategy.

In addition, governors work with Trust staff to contribute to improvements in the hospital environment. Governors attend board committees as participating observers as well as being represented on operational groups such as the Patient Safety Group, the Nutrition and Hydration Steering Group, the Patient-led Assessment of the Care Environment (PLACE) Steering Group and the Organ and Tissue Donation Committee.

To help the chairman and NEDs gain a greater understanding of the views of governors and

of the Trust's membership, they regularly meet with the governors to discuss the affairs of the Trust. NEDs are invited to attend meetings with the governors and there is an expectation of attendance should it be specifically be requested by the governors.

On joining the Trust, each new governor receives an induction and ongoing training in the affairs of the Trust. Re-elected governors are invited to attend an induction session as a 'refresher' if they so wish. Governors discuss and have the opportunity to comment on the quality goals each year, which are included in the Quality Report. Also governors can choose a quality indicator to be audited.

Our governors have been closely involved in the joint working between the acute trusts in mid and south Essex over the past two years. A dedicated working group, led by the three trust chairs and lead governors, has been meeting since summer 2016 to help the two NHS Foundation Trust Councils of Governors and the Mid Essex Hospitals Patient Council to work more closely together and to ensure that the voice of members and patients is heard at all times as we work towards the anticipated merger. Governors are aware of their statutory responsibility to approve or decline any merger as set out in the NHS Act 2006.

Governors and Patient Council members have a standing invitation to attend and ask questions at the Joint Working Board meetings in public and each meeting has benefited from their input.

Lead Governor

Ron Capes, a public governor for Basildon, was elected as lead governor for a fifth year at the Council of Governors meeting in May 2017. Alan McFadden was re-elected as the deputy lead governor at the same meeting. Alan is a public governor for Basildon. Both Ron and Alan fulfilled their role for the entirety of 2017/18.

Composition of the Council of Governors

The composition of the Council of Governors was amended with effect from 1 January 2018. Between 1 April 2017 and 3 December 2017, the Council of Governors comprised 30 positions as shown below.

Fig 11: Composition of the council of governors Group Apr-Dec 2017		Number of Governors	Totals
Representative governors:			
Partnership organisations	Anglia Ruskin University	1	
	South Essex College	1	
	Basildon, Thurrock and Brentwood CVS representative	1	
	Total partnership organisation governors		3
Staff Governors	Staff employed by BTUH	5	
	Total staff governors		**5**
Local authorities	Thurrock Borough Council	1	
	Essex County Council	1	
	Total local authority governors		**2**
University	Royal Free and University College Medical School	1	
	Total University governors		1
	Total of all representative Governors		**11**
Public governors:			
	Basildon	8	
	Thurrock	6	
	Brentwood	3	
	The rest of England	2	
	Total public/patient Governors		**19**
	Grand total		30

Following a decision by the Board of Directors and of the Council of Governors, the appointed governor position from the Royal Free and University College Medical School was formally removed from the Council. This post was no longer required as its role was fulfilled in a different way. It had been vacant for some time. Therefore between 1st January 2018 and 31 March 2018, the Council comprises 29 positions in total.

The members of the Council of Governors who served during 2017/18 are in Fig. 12 below.

Class	Name	Date elected/ appointed	Date re-elected	Term of office	Date of retirement/ resignation	Meetings attended	Declaration of interest summary	Political party
Public - Thurrock	Julia Harding	Apr 2018		3 years	Mar 2021	5/6	Daughter is employed as a nurse at the Trust	None
Public - Thurrock	Julie Bellinger	Apr 2017		2 years	Mar 2019	5/6		None
Public -Thurrock	Charles Curtis	Apr 2017		3 years	Mar 2020	5/6		None
Public -Thurrock	Russ Allen	Apr 2012	Apr 2015	3 years	Mar 2018	4/6	None	None
Public -Thurrock	James Little	Apr 2017		3 years	Mar 2020	2/6		None
Public Thurrock	Jean Angus	Apr 2017		3 years	Oct 2017	2/3	None	None
Public -Basildon	Marlene Moura	Apr 2010	Apr 2016	3 years	Mar 2019	3/6	Trustee of St Luke's Hospice	None
Public -Basildon	Alan McFadden	Apr 2012	Apr 2018	3 years	Mar 2018	5/6	None	Labour
Public -Basildon	Ron Capes JP	Apr 2010	Apr 2016	3 years	Mar 2019	5/6	None	None
Public -Basildon	Barry Haeger	Apr 2017		1 year	Mar 2018	3/6	None	None
Public -Basildon	Colin Moore	Apr 2016	Apr 2018	3 years	Mar 2021	5/6	Director of BCTS	None
Public -Basildon	Alan Ursell JP	Apr 2016	Apr 2018	3 years	Mar 2021	4/6	None	None
Public -Basildon	Joy Pons	Apr 2016		3 years	Mar 2019	1/6	None	None
Public -Basildon	Peter Hatch	Apr 2016		3 years	Oct 2017	2/3	None	None
Public - Brentwood	Amanda Burton	Apr 2015		3 years	Mar 2018	4/6	Patient Engagement Group Brentwood	None
Public - Brentwood	Neville A Brown	Apr 2016		2 years	Mar 2018	1/6	St Francis Hospice, Trustee and NED	None
Public – Rest of England	Mercedes de Dunewic	Apr 2015	Apr 2018	3 years	Mar 2021	2/6	Powher Citizens Advocate	None
Public – Rest of England	Vacant							
Staff - Basildon	Vacant							
Staff - Basildon	Penny Bryant	Apr 2013	Apr 2016	3 years	Mar 2019	3/6	Husband works at the Trust	
Vol St Johns Ambulance	National Health Action	Apr 2015		3 years	Mar 2018	1/6		
Staff - Basildon	Catherine Crouch	Apr 2015		3 years	Mar 2018	0/6		None
Staff - Basildon	Elizabeth Carpenter	Apr 2014	Apr 2018	3 years	Mar 2021	4/6	None	None
Staff	Dave Bebbington	Apr 2016			Mar 2019	0/6		None
	Paul Butler	Feb 2017		3 years	Mar 2018	1/5		
Partner Organisation - UCL Medical School	Dr Aroon Lal	Jul 2008	July 2014 (3rd term)	3 years	Jul 2017	0/5	None	None
Partner Organisation - Anglia Ruskin University	James Hampton-Till	Oct 2015		3 years	Oct 2018	1/6	None	None
Local Authority - Thurrock Council	Cllr Tunde Ojetola	June 2016	June 2017	1 year	June 2018	2/6	Apr 2018	3 years
Essex County Council	Cllr Roger Hirst	Aug 2016		3 years	Aug 2019	3/5		
CVS Voluntary - Brentwood, Basildon and Thurrock	Dee Truesdale	Apr 2015		3 years	Mar 2018	0/6	None	None

Meetings of the Council of Governors

During 2017/18 there were six formal meetings of the Council of Governors, including the Annual Members Meeting (AMM). Governors are encouraged to attend by varying the times of meetings. Travelling expenses to and from meetings are reimbursed.

The number of attendances by executive and non-executive directors at meetings of the Council of Governors is recorded and show in chart below. One of the six meetings was a closed meeting, comprising only governors. This is why the figures below show a maximum possible attendances of five meetings (or fewer for the one director who did not serve the whole of the 2017/18 year).

Nigel Beverley (chairman)	5/5
Clare Panniker (chief executive)	5/5
Tom Abell (chief transformation officer/deputy chief executive)	2/5
Martin Callingham (chief information officer)	2/5
Carin Charlton (chief estates and facilities officer)	1/3
Clare Culpin (managing director)	4/5
Renata Drinkwater (non-executive director)	2/5
Mary Foulkes (chief human resources director)	0/5
John Govett (non-executive director and senior independent director)	1/5
Rita Greenwood (non-executive director)	3/5
Paul Kingsmore (chief estates and facilities director)	0/2
Elaine Maxwell (non-executive director)	2/5
James O'Sullivan (chief financial officer)	3/5
Barbara Riddell (non-executive director and deputy chair)	4/5
Diane Sarkar (chief nursing officer)	0/5
Celia Skinner (chief medical officer)	0/5

Making appointments

It is the role of the Council of Governors to appoint, re-appoint or remove the chairman and non-executive directors (NEDs).

The NED and Chairman Remuneration and Appointments Committee (NEDRAC) recommended that Nigel Beverley be re-appointed as Chair for his second term from 1 July 2018. A process for reappointing the Chairman, including a panel interview, was agreed by the Council of Governors on the NEDRAC recommendation. Following a successful interview, Nigel was offered and accepted a second term of office.

NEDRAC also considered and recommended to the Council of Governors the process for appointing two new NEDs to the Board from 1 April 2018, including a decision that these appointees should be offered a term of office of one year given the transition to the proposed new organisational form and that the skill sets sought included clinical and financial expertise, to address current and forthcoming gaps in the non-executive team during 2018/19.

All NEDs are considered independent in character and judgement using the criteria for independence listed with in the NHS Foundation Trust Code of Governance (2013) (see section 8 on Code Compliance). The Chairman was considered to be independent when re-appointed for his second term running from 1 July 2018.

NEDRAC considered whether it would be appropriate to extend the term of office of John Govett for a further one year beyond his second term in order to provide continuity of non-executive leadership during the transition year. NEDRAC considered that the risk of compromised independent that extending John's term of office beyond the six years recommended by the Code of Governance would incur was outweighed by the benefits of continuity.

Keeping governors informed and involved

It is the chairman's role to lead the Council of Governors and in this is supported by the deputy chairman Barbara Riddell.

Governors receive the agenda, all papers and minutes for Board of Directors meetings held in public and are able to be present for the public session of these meetings. Governors also receive the agenda and minutes of any Board session held in private. Governors are also invited to participate in the Board of Directors monthly 'walkabout' visits around the Trust.

Governors' achievements 2017/18

A Governors Annual Review is prepared each year to demonstrate how governors are meeting their statutory duties to engage with their constituencies, to hold the Board of Directors to account through the non-executive directors and to approve significant transactions as defined by legislation.

Executive and non-executive directors were available to provide up-to-date information to those governors who had questions or issued to be raised. In some instances, directors were requested to attend Council of Governors meetings to provide updates on a particular issue.

Two issues of the Foundation Times, our members newsletter and one Annual Review were published and circulated to all members during the year. A high proportion are emailed to members to reduce postal costs. Governors play a significant part in contributing to these publications.

During 2017/18, governors attended a number of local community events including Here 2 Hear listening events. These were held in different areas of Basildon and Orsett Hospitals and were an opportunity to meet with patients and the public and to listen to their views about Trust services.

The NEDRAC made recommendations to the Council of Governors, having gone through due process, to re-appoint Nigel Beverley for a second term of three years. NEDRAC also scrutinised the appointment process for two new NEDs from 1 April 2018 as well as the proposed one-year extension of term of office for John Govett. The Council of Governors approved these recommendations. The NEDRAC did not consider it necessary to utilise either an external search consultancy or open advertising for the re-appointment of the Chair or for the appointment of the two new NEDs. The rationale in both cases related to the proposed move to a new organisational form in April 2019. In the case of the Chair, NEDRAC considered that continuity of leadership from Nigel Beverley was crucial during the 2018/19 transition year. Given that NEDRAC and the Council of Governors were satisfied with Nigel's performance during his first term of office and his ongoing independence, they were content that the need for continuity outweighed the potential benefits of external recruitment. Similarly, the NEDRAC considered that the delay and cost of external recruitment for the two NED vacancies was undesirable given the need to fill the two NED vacancies from 1st April 2018 and to the one-year term of office for the appointees.

Many Governors supported the walkabouts to different areas of the Trust alongside Board members and the site leadership team.

A handbook, outlining the role and responsibilities of governors, was updated to support the governor induction programme.

A key strand of achievement for the Trust Governors during 2017/18 was their engagement in the Mid and South Essex STP work. This included involvement in the public consultation period on clinical service transformation which ran from November 2017 to March 2018 and in the groundwork for the future organisational form.

Looking forward to the proposed new Foundation Trust

During 2018/19 the Trust will work with our partner trusts in mid and south Essex to undertake the following priorities as we move towards a new organisational form in April 2019:

- To develop and make recommendations on the form of the public constituencies and the shape and size of Council of Governors for the proposed new Foundation Trust

- To develop a membership strategy for the proposed new Trust
- To develop a draft constitution for the proposed new organisation
- To build up the membership base of all three acute trusts in mid and south Essex, with a particular intense focus on assisting Mid Essex Hospital Services NHS Trust to develop its shadow membership to as similar a size as possible to the existing membership bases of the two Foundation Trusts

Throughout this transition year, we will ensure that the Council of Governors of this Trust remains able to discharge its full range of statutory responsibilities. This will be achieved through:

- Maximising opportunities to participate in recruitment and engagement events by targeting local communities with governor support
- Ensuring that robust electoral processes are in place and that elections are appropriately advertised to encourage more members to stand for election to the Council of Governors or to vote for others who they would like to represent them
- Continuing to provide a programme of induction and ongoing training for new and existing governors

Our members

There are two categories of membership – public and staff.

Public members are individuals who live in one of the four constituencies – Basildon, Thurrock, Brentwood and the Rest of England – are aged 12 and above and have registered to become members.

Staff members are employees, including contract staff where the contract with the Trust extends beyond 12 months, and volunteers. Staff members are 'opted in' to membership. Although retaining the right to opt out of membership, in practice very few have over the eleven years since the Foundation Trust was established. There is one staff group 'Staff employed by BTUH'.

Building our membership

The Council of Governors Annual Members Meeting (AMM) and Membership Strategy Working Group reviewed the Trust Membership Strategy in 2017 and updated it in line with the membership targets set for the 2017/18 year.

The Membership Strategy provides the framework for the continued targeted development of membership recruitment, engagement and retention in line with statutory requirement. This strategy describes the involvement of members patients, clients and the local community.

The public membership by constituency as at 31 March 2018 is shown below:

Fig 14. Current public membership by constituencies as at 31 March 2018

Area	Members
Basildon	6,653
Brentwood	820
Thurrock	3,219
Rest of England	4,096
Total	**14,788**

For the first time since becoming a Foundation Trust in 2004, we achieved all of our membership targets in 2017/18. This is a significant credit to all of our dedicated governors and to the corporate governance and membership services team who support them.

A key objective for 2017/18 was to recruit at least 600 new public membersd by the end of the year. We were very pleased to have exceeded that target. Having taken account of leavers during the year, we ended 2017/18 with a net increase of 547 public members compared to the same point the previous year.

The other targets that we met were:

- Recruiting members aged 66 years and over
- Improving the number of members of the Brentwood public constituency
- Increasing the number of male members across all public constituencies
- Identifying and attending events that would target hard-to-reach groups

Membership numbers

Fig 15. Membership size and movements	2017/18 Planned	2017/18 Actual	2018/19 Planned
Public constituency: At year start (April 1)	14420	14241	14788
New members	600	899	1089
Members leaving	-400	-352	-350
At year end (31 March)	**14440**	**14788**	**15527**
Minimum required under Annex 1 of Constitution	40	40	40
Staff constituency: At year start (April 1)	4109	4109	4551
New members	700	639	800
Members leaving	700	-729	800
At year end (31 March)	**4109**	**4551**	**4551**
Minimum required under Annex 2 of Constitution	10	10	10

NB - The number of leavers is slightly disproportionate to the number of starters above, as there are a number of employees who were fixed term who have later been made permanent employees within the Trust

Staff constituency

Membership of the staff constituency is open to any individual who is employed by the Trust under a contract of employment. They may become, or continue as, a member of the Trust provided they:

- are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- have been continuously employed by the Trust under a contract of employment for at least 12 months
- Those individuals who are eligible for membership of the Trust are referred to collectively as the staff constituency.

The staff constituency is based on an opt-in arrangement. All staff eligible for membership are contacted on joining the Trust to confirm their membership and they are given the opportunity to opt out. No staff members opted out in 2017/18.

Work to recruit new members

Governors attended a number of events within and outside their constituencies to engage with the public, to support and to encourage Trust membership. We were pleased to attend those events within our calendar each year as well as some new opportunities to engage, including:

- The St Luke's Hospice fete in June 2017
- The Family Fun Day in Brentwood in August 2017
- The South Essex College Freshers Fayre (Thurrock Campus) in September 2017
- The Ford Warley Diversity Plaza in Brentwood in September 2017
- The Thurrock Over Fifties (TOFFS) Conference in Thurrock in November 2017
- Contact cards are sent out to patients with their first outpatient appointment letters, who provide name and contact details and post back to us. This is followed up by a call from the Membership Office to sign them up as members. Over 800 members have been signed up since this system started.

Communication with members

Governors work to:

- Eensure members receive appropriate communications to promote a better understanding and have a say in healthcare services the Trust provides
- Maximise opportunities to participate in recruitment and engagement events by targeting local communities, with governor support provided to Trust officers

Membership engagement

- The Annual Members' Meeting (AMM) and Membership Strategy Working Group is the overarching sub group of the Council of Governors that monitors the effectiveness of the Membership Strategy ensuring that:
- it remains a relevant and meaningful document;
- action is taken in growing a representative membership as this is a key element of the Trust's governance arrangements and reporting on the progress at the Annual Members Meeting
- The Council and Board of Directors approved the revised Trust Membership Strategy in 2014 and it was reviewed again in 2016, with minimal changes made.

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20 years of lifesaving treatment at Basildon Hospital renal unit

Staff celebrate 20 years of the renal unit (inset Sue Pickard)

It is 20 years since the renal unit opened at Basildon University Hospital, offering lifesaving treatment for patients with kidney failure, who before would have to travel into London three times a week for dialysis.

Initially the unit had just eight patients, but now it has 176 patients across three sessions per day, using 24 stations at Basildon Hospital and ten at Orsett Hospital. The service has also expanded to include pre-dialysis services, vascular access, home dialysis and post-transplant services.

Sue Pickard, senior sister for kidney care services, was one of the original nurses when the unit was set up.

She said: "I kind of fell into renal nursing by accident, but I'm so glad that I did. It's a different kind of nursing, because it's a chronic condition, you get to know your patients very well.

"When we started, there were eight patients, three times a week. But things have changed so much, the technological advancements, the dialysis machines and what they can do and the expansion of the services we offer.

"We have identified what has been needed, such as the nurse-led pre-dialysis, kidney care service. And now we're part of their journey before dialysis, giving that continuity of care.

Remuneration Report

Annual statement from the Chair of the Remuneration and Nominations (RemNom) Committee

This information is not subject to audit

As explained on page 28, joint executives were appointed across the three acute trusts in the Mid and South Essex STP in with effect from 1 February 2017. The RemNoms and their equivalents in the other two trusts approved the remuneration packages for the joint executives before the end of March 2017.

The chief transformation officer received an uplift in his salary to reflect his additional duties as deputy chief executive with effect from July 2017.

No other executive director received an increase in their salary during 2017/18 relating to their role with this Trust.

Further information on the work of the RemNom Committee can be found in the Directors Report on page 31.

Senior Managers' Remuneration Policy

The Trust's remuneration policy states that Agenda for Change applies to all directly employed staff except very senior managers (directors), those covered by the Doctors' and Dentists' Pay Review Body and a group of staff who joined the Trust in March 2016 as part of a transfer from an external organisation under the Transfer of Undertakings and Protection of Employment (TUPE) regulations who are employed by the Trust on local terms and conditions.

The remuneration package and conditions of service for executive directors is agreed by the RemNom Committee. In setting the remuneration for directors, the committee takes account of the following factors:

- Market value of similar posts in similar size organisations
- The benchmarking information provided by NHS Providers (formerly the Foundation Trust Network)
- The pay rates for those staff reporting to the director in question

The remuneration for executive directors does not include any performance-related bonuses and none of the executives receive personal pension contributions other than their entitlements under the NHS Pension Scheme.

With regard to those senior managers are paid more than £142,500 (which equates to the Prime Minister's ministerial and parliamentary salary), the Committee satisfies itself that this remuneration is reasonable by taking a number of factors into account. These include benchmarking against comparable organisations and taking independent advice from experts in executive remuneration.

The component parts of the remuneration package for senior managers are summarised below.

Basic salary	Each year, the RemNom Committee considers the contribution of each director against the functions of the post as defined in the current job description and as foreseen for the future. This is carried out in parallel with a review of the individual's career development and potential opportunities for progression.
Pension	The executive directors are able to join the standard NHS Pension Scheme that is available to all NHS staff.
Bonus	Bonuses are not given to staff, including senior managers. The medical director, Dr Celia Skinner, received a clinical excellence award (CEA) during 2017/18. Clinical Excellence Awards recognise and reward NHS consultants and academic GPs who perform 'over and above' the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions. This is a national initiative.
Benefits	The Trust operates a number of salary sacrifice schemes, including childcare vouchers and a car lease scheme. This is open to all permanent members of staff. The individual foregoes an element of their basic pay in return for a defined benefit.

The executive directors all hold permanent contracts. However as explained on page 28, the joint executives undertake these roles on a secondment basis from their substantive roles as employees of one of the three acute trusts in mid and south Essex. The notice period for executive directors is six months and there are no additional arrangements for enhanced termination payments or compensation for early termination of contract. The Trust does not use confidentiality agreements, unless related to patient identifiable information.

The executive directors each have objectives agreed by the RemNom Committee that are in line with the strategic objectives of the Trust.

There are no amounts to be recovered or payments to be withheld from the executive directors.

The Trust does not consult with employees when preparing the senior managers' remuneration policy.

The Trust makes payments for loss of office in accordance with the regulations of established schemes such as the Mutually Agreed Resignation Scheme (MARS) and in line with employment contracts as appropriate to the individual case.

NED contracts are based on a fixed fee as detailed on page 51. Additional fees are payable for the role of deputy chairman, senior independent director and chair of the audit committee as detailed on page 51. NED contracts are summarised in the section below.

Annual report on remuneration

Service contracts

The terms of office for non-executive directors is three years with the possible renewal for a further term up to a maximum of six years. As explained on page 43, the term of office of John Govett was extended for one year to 31 March 2019, making his total service of seven years.

The termination of a NED contract would be the responsibility of the Council of Governors. Suspension or removal of the chairman or another non-executive director would require the approval of three quarters of the members of the Council of Governors, in accordance with the Trust Constitution

Throughout the 2017/18 year, the Trust held contracts with NEDs as shown in the following table:

Name	Appointment date	Start of current term	End of current term
Nigel Beverley	July 2015	July 2018	June 2021
Renata Drinkwater	April 2016	April 2016	March 2019
John Govett	April 2012	April 2015	March 2019 (1 year extension)
Rita Greenwood	April 2017	April 2017	April 2018 (resignation)
Elaine Maxwell	April 2014	April 2017	March 2018 (resignation)
Barbara Riddell	April 2012	April 2015	March 2018

Remuneration and Nominations Committee (RemNom)

The RemNom Committee is responsible for the remuneration of the senior managers of the Trust. Full details of the committee, its members and their attendance at meetings can be found on page 31.

Expenses

Expenses have been paid to both directors and governors during the year, and the previous year, as shown below:

2017/18	Total receiving expenses	Total expenses (£)
Directors	10	13,944
Governors	6	1,633
Total	16	15,577

2016/17	Total receiving expenses	Total expenses (£)
Directors	10	12,504
Governors	8	2,400
Total	18	14,904

Note – the value of directors' expenses is the total expenses paid and the amount attributable to the Trust is a third of these costs. The numbers include all directors or governors who have served for any part of the year shown.

Directors' remuneration report

This information is subject to audit

Directors' remuneration 2017/18		Salary and Fees (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Bonus* (bands of £5,000)	Benefits**	Total (bands of £5,000)
Name and title		£000s	£000s	£000s	£s	£000s
Chairman						
Nigel Beverley	Chairman	45 - 50	-	-	-	45 - 50
Non-executive directors						
Renata Drinkwater	Non-executive director	10 - 15	-	-	-	10 - 15
John Govett	Non-executive director	15 - 20	-	-	-	15 - 20
Rita Greenwood	Non-executive director	10 - 15	-	-	-	10 - 15
Elaine Maxwell	Non-executive director	10 - 15	-	-	-	10 - 15
Barbara Riddell	Non-executive director	15 - 20	-	-	-	15 - 20
Executive directors						
Clare Panniker	Chief executive	75 - 80	-	-	600	75 - 80
Tom Abell	Chief transformation officer	50 - 55	-	-	300	50 - 55
Martin Callingham	Chief information officer	40 - 45	185 - 187.5	-	1100	230 - 235
Carin Charlton	Chief estates and facilities director (to december 2017)	30 - 35	35 - 37.5	-	700	65 - 70
Clare Culpin	Managing director	150 - 155	120 - 122.5	-	400	275 - 280
Mary Foulkes OBE	Chief human resources director	40 - 45	72.5 - 75	-	-	115 - 120
Paul Kingsmore	Chief estates and facilities director (from december 2017)	20 - 25	-	-	-	20 - 25
James O'Sullivan	Chief finance officer	50 - 55	32.5 - 35	-	-	85 - 90
Diane Sarkar	Chief nursing officer	45 - 50	97.5 - 100	-	-	145 - 150
Dr Celia Skinner	Chief medical officer	60 - 65	220 - 222.5	10 - 15	-	290 - 295

Notes to the salary table

***Bonus**

In accordance with the HM Treasury ARM, payments of Clinical Excellence Awards have been shown as bonuses.

****Benefits**

Benefits in kind is the taxable value of benefits provided, the values are calculated in accordance with Inland Revenue rules and relates to the salary sacrifice schemes.

Pension Related Benefits

Pension Related Benefits relate to the individuals full employment and is not limited to their paid employment with the Trust.

Paul Kingsmore

In the table above Paul Kingsmore is working in an interim capacity through an agency.

Directors' remuneration 2016/17		Salary and Fees (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Bonus* (bands of £5,000)	Benefits** (bands of £5,000)	Total (bands of £5,000)
Name and title		£000s	£000s	£000s	£000s	£000s
Chairman						
Nigel Beverley	Chairman	50-55	-	-	-	50-55
Non-executive directors						
Renata Drinkwater	Non-executive director	10-15	-	-	-	10-15
John Govett[3]	Non-executive director	15-20	-	-	-	15-20
David Hulbert	Non-executive director	10-15	-	-	-	10-15
Elaine Maxwell	Non-executive director	10-15	-	-	-	10-15
Tom Phillips[3,5]	Non-executive director (to 16th December 2016)	10-15	-	-	-	10-15
Barbara Riddell[3]	Non-executive director	15-20	-	-	-	15-20
Executive directors						
Clare Panniker	Chief executive (to January 2017) JEG chief executive (from February 2017)	95-100	52.5-55	-	0-5	150 - 155
Tom Abell	Deputy chief executive (to January 2017) JEG chief transformation officer (from February 2017)	135-140	5-7.5	-	0-5	140-145
Zoe Asensio-Sanchez	Director of environment and infrastructure (to September 2016)	55-60	12.5-15.0	-	-	65-70
Margaret Blackett[2]	Interim director of operations (November 2016 to January 2017)	65-70	-	-	0-5	70-75
Martin Callingham	JEG chief information officer (from February 2017)	-	-	-	-	-
Carin Charlton	Director of environment and infrastructure (from October 2016)	20-25	55-57.5	-	-	80-85
Clare Culpin	Managing director (from 13th March 2017)	5-10	-	-	-	5-10
Mary Foulkes OBE[4]	JEG chief human resources director (from February 2017)	-	-	-	-	-
Danny Hariram	Director of workforce and organisational development (to January 2017)	95-100	-	-	-	95-100
Nigel Kee	Chief operating officer (to 7th November 2016)	70-75	12.5-15.0	-	0-5	85-90
Steve McManus[1]	Managing director (to 16th December 2016)	50-55	-	-	-	50-55
James O'Sullivan[4]	JEG Chief finance officer (from February 2017)	-	-	-	-	-
Diane Sarkar	Director of nursing (to January 2017) JEG chief nurse (from February 2017)	125-130	62.5-65	-	-	190-195
Dr Celia Skinner	Medical director (to January 2017) JEG chief medical officer (from February 2017)	155-160	-	35-40	-	195-200
Rick Tazzini	Director of finance (to January 2017)	105-110	30-32.5	-	5-10	145-150

Notes to the Salary Table

***Bonus** In accordance with the HM Treasury ARM, payments of Clinical Excellence Awards have been shown as bonuses.

****Benefits** Benefits in kind is the taxable value of benefits provided, the values are calculated in accordance with Inland Revenue rules and relates to the salary sacrifice schemes with the exception of the item shown for Margaret Blackett which relates to travel and parking costs.

Pension Related Benefits Pension Related Benefits relate to the individual's full employment and is not limited to their paid employment with the Trust.

[1]**Steve McManus** Steve McManus joined the Trust in April 2016. The payments above relate to the period October 2016 to December 2016. The costs associated with April 2016 to September 2016 are shown in the accounts of Imperial College Healthcare NHS Trust. As this individual's costs are invoiced, information around Pension Related Benefits is not available for disclosure.

[2]**Margaret Blackett** In the table above, Margaret Blackett is working in an interim capacity. The total remuneration shown for this individual is not comparable with the other executive directors as there is no entitlement to pension, annual leave, public holiday, sick leave or any other similar entitlement for substantive staff.

[3]**Barbara Riddell, Tom Phillips and John Govett** These additional fees were payable during the year to John Govett (senior independent director), Barbara Riddell (deputy chairman for the whole year and chair of the audit committee to December 2016) and Tom Phillips (chair of the audit committee to December 2016).

[4]**JEG Executives** Martin Callingham, Mary Foulkes OBE and James O'Sullivan are shown in the above table with no costs. This is as a result of the individuals being appointed to the JEG from February but continuing to be paid via their original organisations.

[5]**Payment in lieu of notice** The value shown for Tom Phillips includes a payment in lieu of notice.

Full salary allocation 2017/18 Name and title		Total Salary and Fees (bands of £5,000) £000s	BTUHFT (bands of £5,000) £000s	MEHT (bands of £5,000) £000s	SUHFT (bands of £5,000) £000s
Executive directors					
Clare Panniker	Chief executive	230-235	75-80	75-80	75-80
Tom Abell	Chief transformation officer	150-155	50-55	50-55	50-55
Martin Callingham	Chief information officer	125-130	40-45	40-45	40-45
Carin Charlton	Chief estates and facilities director (to December 2017)	90-95	30-35	30-35	30-35
Clare Culpin	Managing director	150-155	150-155	-	-
Mary Foulkes	Chief human resources director	120-125	40-45	40-45	40-45
Paul Kingsmore	Chief estates and facilities director (from December 2017)	60-65	20 -25	20 -25	20 -25
James O'Sullivan	Chief finance officer	155-160	50-55	50-55	50-55
Diane Sarkar	Chief nursing officer	140-145	45-50	45-50	45-50
Dr Celia Skinner	Chief medical officer	220-225	70-75	70-75	70-75

Full salary allocation 2016/17 Name and title		Total Salary and Fees (bands of £5,000) £000s	BTUHFT (bands of £5,000) £000s	NHSE (bands of £5,000) £000s	MEHT (bands of £5,000) £000s	SUHFT (bands of £5,000) £000s
Executive directors						
Clare Panniker	Chief executive (to January 2017) JEG chief executive (from February 2017)	225-230	95-100	45-50	80-85	-
Tom Abell	Deputy chief executive (to January 2017)	135-140	135-140	-	-	-
Zoe Asensio-Sanchez	Director of environment and infrastructure (to September 2016)	55-60	55-60	-	-	-
Martin Callingham	JEG chief information officer (from February 2017)	100-105	-	-	100-105	-
Carin Charlton	Director of environment and infrastructure (from October 2016)	110-115	20-25	-	85-90	-
Clare Culpin	Managing director (from 13th March 2017)	5-10	5-10	-	-	-
Mary Foulkes	JEG chief human resources director (from February 2017)	100-105	-	-	-	100-105
Danny Hariram	Director of workforce and organisational development (to January 2017)	95-100	95-100	-	-	-

Full salary allocation 2016/17 Name and title		Total Salary and Fees (bands of £5,000) £000s	BTUHFT (bands of £5,000) £000s	NHSE (bands of £5,000) £000s	MEHT (bands of £5,000) £000s	SUHFT (bands of £5,000) £000s
Nigel Kee	Chief operating officer (to 7th November 2016)	70-75	70-75	-	-	-
James O'Sullivan	JEG chief finance officer (from February 2017)	135-140	-	-	-	135-140
Diane Sarkar	Director of nursing (to January 2017) JEG chief nurse (from February 2017)	130-135	125-130	0-5	-	-
Dr Celia Skinner	Medical director (to January 2017) JEG chief medical officer (from February 2017)	195-200	195-200	-	-	-
Rick Tazzini	Director of finance (to January 2017)	105 -110	105-110	-	-	-

Pensions **Name and title**		Real increase in pension at pension age (bands of £2,500) £000s	Real increase in pension lump sum at pension age (bands of £2,500) £000s	Total accrued pension at pension age at 31 March 2017 (bands of £5,000) £000s	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 31 March 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Employer's contribution to stakeholder pension £000
Clare Panniker	Chief executive	0.0-2.5	-	65-70	165-170	1,160	25	1,124	27
Tom Abell	Chief transformation officer	-	-	-	-	-	-	-	-
Carin Charlton	Chief estates and facilities director (to december 2017)	0.0-2.5	2.5-5.0	25-30	65-70	396	45	329	14
Martin Callingham	Chief information officer	7.5-10	20.0-22.5	50-55	135-140	945	202	735	18
Clare Culpin	Managing director	5.0-7.5	12.5-15.0	45-50	130-135	927	131	787	23
Mary Foulkes OBE	Chief human resources director	2.5-5.0	5.0-7.5	15-20	30-35	263	72	189	19
James O'Sullivan	Chief finance officer	2.5-5.0	-	10-15	-	157	46	110	21
Diane Sarkar	Chief nursing officer	5.0-7.5	7.5-10.0	45-50	110-115	771	122	643	21
Dr Celia Skinner	Chief medical officer	10.0-12.5	32.5-35.0	80-85	245-250	1,668	303	1,351	32

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Tom Abell has now left the NHS Pension scheme and is now a deferred member and therefore no figures are included in the table above

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 from 2004-05 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 within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. For senior managers that join the Trust during the year the opening CETV is estimated by the Trust based on the closing CETV and the movements realised from other senior managers based on length of service and age.

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, and uses common market valuation factors for the start and end of the period.

The above table provides the pension information in total for each individual regardless of employing organisation as this information can not be split.

Fair pay multiples

NHS Foundation Trusts are required to disclose the relationship between the mid-point of the banded

remuneration of the highest paid director in their organisation and the median remuneration of all staff.

The calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Where there is a sharing arrangement, it is cost to the entity of an individual that identifies them as 'highest paid' and not the total of that individual's remuneration.

Highest and median remuneration	2017/18 £000s	2016/17 £000s
Band of highest paid director's total remuneration	150-155	210-215
Median total remuneration	28.5	27.6
Ratio	5.4	7.7

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions or the cash equivalent transfer value of pensions. The median remuneration for all employees is based on employees with a permanent contract with the Trust as at 31 March 2018. Agency and bank staff working at the year-end have also been included in the median calculation, with the cost reduced by estimation for the amount of commission included in the cost.

The banding of the highest paid director is also calculated as at 31 March 2018. The highest paid director has been identified as the managing director.

As there is a sharing arrangement for all of the other members of the Joint Executive Group only one third of their annualised remuneration has been used in the calculation. The managing director is the only full time JEG director at the Trust.

This has resulted in a dramatic reduction in the banded remuneration for the highest paid director from 2016/17. Last year the CMO was identified as the highest paid director and their remuneration included their clinical excellence award and the remuneration for increased responsiblity for working across the three Trusts.

The median remuneration has marginally increased from £27,600 to £28,500.

The combination of these two factors has resulted in the ratio decreasing from 7.7 to 5.4.

Clare Panniker
Chief executive

Date: 29 May 2018

Maternity unit hosts Songs of Praise

Baby Aurelia was just 10 hours old when Katherine met her and proud first-time mum Natalie Jude

Our maternity department was the proud host of BBC's Songs of Praise in March 2018, when the unit was featured in a Mothering Sunday special.

Opera singer Katherine Jenkins came along to interview several mums and their newborn babies, plus two of our midwives, Joanne Hoare, diabetes specialist midwife and Debbie Olajugbagbe, bereavement specialist midwife.

Joanne and Debbi have 50 years' experience between them. In the programme they talk to Katherine about the privilege of sharing in some of the most precious moments of people's lives, expressing the joy of helping to bring new life into the world - as well as the heart break when things sometimes go wrong and how their strong Christian faith helps them in every situation.

Staff report

This section provides our staffing profile and describes our activities and policies to support and develop our staff and to promote diversity.

Staffing profile

Our average staffing numbers at year end are provided below:

Analysis of staff costs Staff Group	2017/18			2016/17		
	Total £000s	Permanent £000s	Temporary £000s	Total £000s	Permanent £000s	Temporary £000s
Salaries and wages	165,644	165,644	-	153,152	153,152	-
Social security costs	16,671	16,671	-	15,495	15,495	-
Apprenticeship levy	788	788	-	-	-	-
Pension cost - employer contributions to NHS pension scheme	17,967	17,967	-	17,219	17,219	-
Pension cost - other	-	-	-	-	-	-
Other post employment benefits	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-
Termination benefits	3	3	-	137	137	-
Temporary staff - external bank	15,046	-	15,046	10,567	-	10,567
Temporary staff - agency/contract staff	12,356	-	12,356	17,959	-	17,959
TOTAL GROSS STAFF COSTS	228,475	201,073	27,402	214,529	186,003	28,526
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(4,500)	(4,500)	-	(718)	(718)	-
Recoveries from other bodies in respect of staff cost netted off expenditure	(919)	(919)	-	(845)	(845)	-
TOTAL STAFF COSTS	223,056	195,654	27,402	212,966	184,440	28,526

Our average staffing numbers at year end are provided below:

Average staffing numbers Staff Group	2017/18			2016/17		
	Total (WTE)	Permanent (WTE)	Temporary (WTE)	Total (WTE)	Permanent (WTE)	Temporary (WTE)
Medical and dental	581	540	41	580	521	59
Administration and estates	1,329	1,259	70	1,278	1,245	33
Healthcare assistants and other support staff	1,128	1,022	106	1,091	969	122
Nursing, midwifery and health visiting staff	1,527	1,309	218	1,563	1,338	225
Scientific, therapeutic and technical staff	144.00	108	36	144	111	33
Healthcare science staff	51.00	51	-	52	52	-
Other	3.00	3	-	2	2	-
TOTAL	4,763	4,292	471	4,710	4,238	472

Gender analysis Staff Category	Staff numbers by headcount		
	Male	Female	Total
Directors*	3	9	12
Other senior managers	203	73	276
Employees	996	3662	4658

Grand Total	1202	3744	4946

[1]Directors includes all current site directors and all members of the Joint Working Board who are employed by the Trust

Staff exit packages

This is subject to audit

Staff exit packages 2017/18						
Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies £000s	Number of other departures agreed	Cost of other departures agreed £000s	Total number of exit packages agreed	Total cost of exit packages £000s
<£10,000	2	3	-	-	2	3
£10,000 - £25,000	-	-	-	-	-	-
£25,001 - 50,000	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total	2	3	-	-	2	3

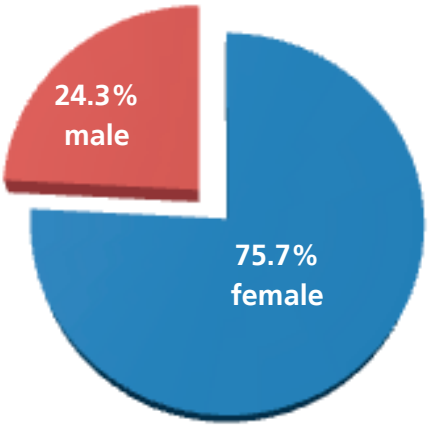
This table shows the value of exit packages agreed in each financial year. Payments may not have necessarily been made at the date of the accounts. All exit packages are agreed in line with Trust policy

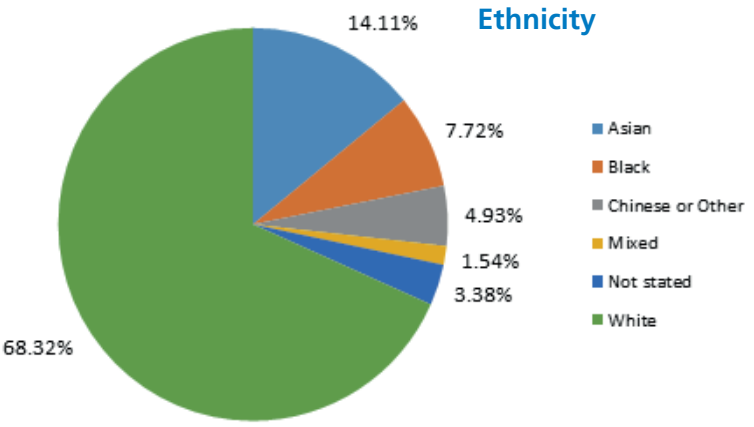
Staff exit packages 2016/17						
Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies £000s	Number of other departures agreed	Cost of other departures agreed £000s	Total number of exit packages agreed	Total cost of exit packages £000s
<£10,000	-	-	13	34	13	34
£10,000 - £25,000	1	16	3	40	4	56
£25,001 - 50,000	-	-	1	47	1	47
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total	1	16	17	121	18	137

This table shows the value of exit packages agreed in each financial year. Payments may not have necessarily been made at the date of the accounts. All exit packages are agreed in line with Trust policy

Exit Packages: Other (non-compulsory) departure payments	2017/18		2016/17	
	Payments agreed - number	Total value of agreements £000s	Payments agreed - number	Total value of agreements £000s
Mutually agreed resignations (MARS) contractual costs			1	47
Contractual payments in lieu of notice			16	74
Total			17	121

The remuneration report provides details of exit payments payable to individuals named in that report



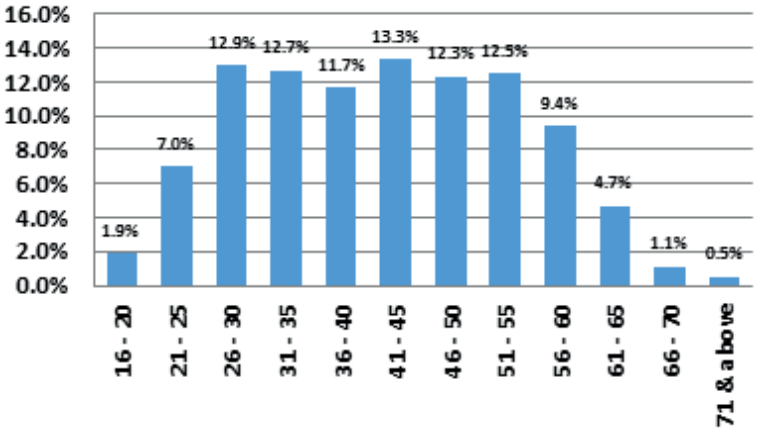


Gender

Staff category	Staff numbers by headcount		
	Male	Female	Total
Directors[1]	3	9	**12**
Other senior managers	203	73	**276**
Employees	996	3662	**4658**
Grand Total	**1202**	**3744**	**4946**

[1]Site Leadership Team and BTUH employees on JEG. Includes heads of service who are not designated as directors but are on the Site leadership team. Does not include staff performing in director capacity at MSB Group level but not on JEG.

Age



Gender Pay Gap Report

From 7 April 2017 all employers with more than 250 staff were required by law to publish figures annually on the difference between the average (mean or median) earnings of the men and women they employ.

The Trust published its Gender Pay Gap report in advance of the 31 March 2018 deadline on the Trust website and via the Government portal in line with its statutory obligations. This data relates to the financial year 2016/17 and is for those who were employed on 31 March 2017.

Gender	Mean (average) hourly rate	Median hourly rate
Male	£21.35	£16.09
Female	£15.00	£13.39
Pay gap %	29.72%	16.77%

Absence

The Trust has maintained levels of absence between 3.03% and 4.94% over the year. Sickness levels have been considerably lower compared to the previous year between the months of April and November after which there was a spike in December and January.

The Trust's approach to tackling absence is by:

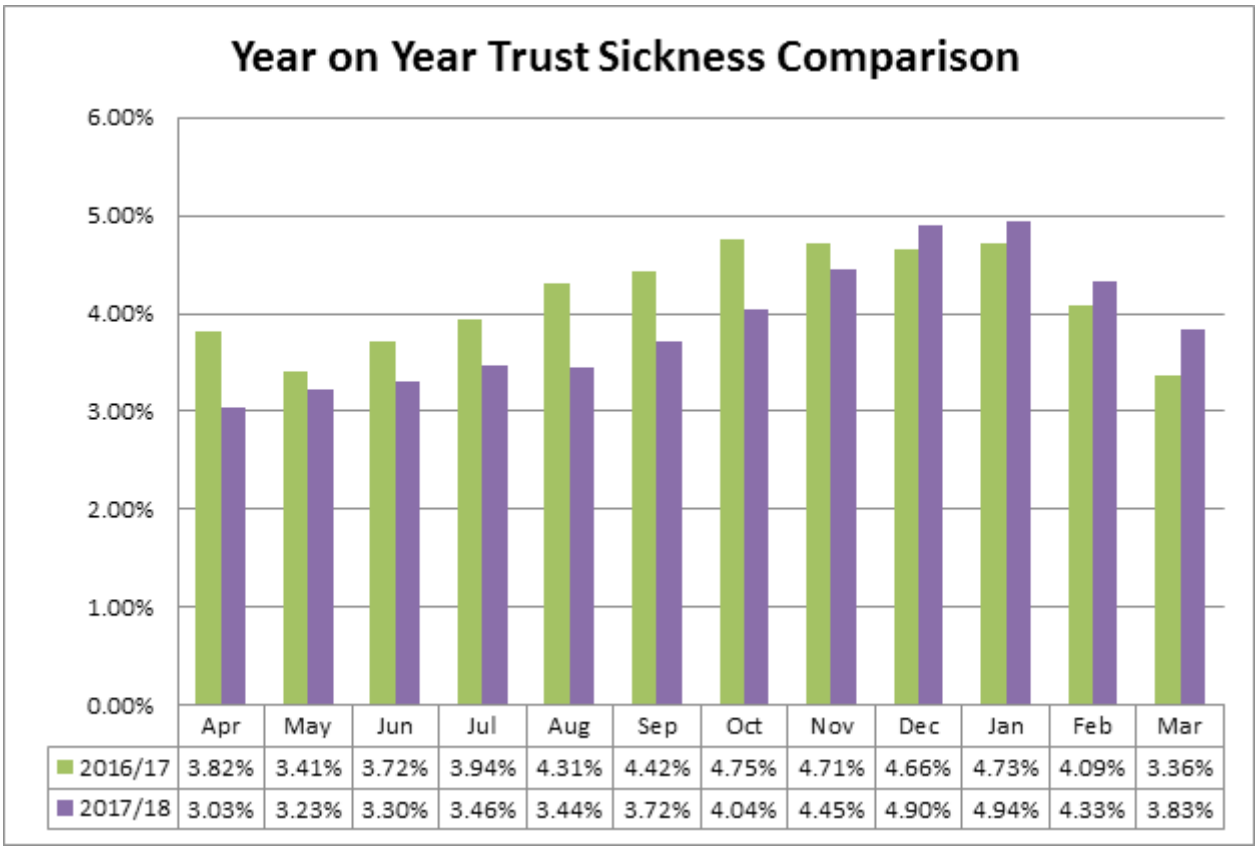
- Identifying hot spot areas and related causes specific to these areas in addition to regular meetings between HR and managers
- Having regular absence trigger meetings with managers
- Providing a resource to enable staff to access physiotherapy assessment during their working day
- Holding monthly case reviews with managers, HR and Occupational Health to address complex cases in the first instance
- Developing a clearer offer to staff to improve health and wellbeing at work

We continue to monitor sickness absence and put adequate measures in place to ensure staff are supported back into work.

Staff sickness absence	2017/18	2016/17
Total days lost	71,557	73,533

Total staff years	4311	4,208

Average working days lost (per WTE)	16.6	17.5



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	3.82%	3.41%	3.72%	3.94%	4.31%	4.42%	4.75%	4.71%	4.66%	4.73%	4.09%	3.36%
2017/18	3.03%	3.23%	3.30%	3.46%	3.44%	3.72%	4.04%	4.45%	4.90%	4.94%	4.33%	3.83%

Staff Policies

Addressing inequalities

The NHS is an equal opportunities employer and is committed to eliminating discrimination as well as dealing effectively with any proven act of discrimination towards applicants, staff and patients. Our Equality and Diversity Policy supports our commitment to treating all staff fairly with dignity and respect.

The Trust is signed up to the Department of Work and Pensions '2 tick' symbol which shows that we are 'positive about disabled people'; and shows our commitment to support the recruitment, retention, promotion and development of staff with disabilities. Reasonable adjustments are made to support applicants at interviews and should they be successful, this carries on into their employment. The Occupational Health department is also available to support staff should they become disabled during the course of their employment with us through risk assessments and providing emotional, psychological support and wellbeing advice to facilitate and support staff to remain in work or to facilitate a return to work following a disability.

We also continue to offer other forms of support including:

- Use of software packages to support staff with dyslexia
- Installation of digital hearing loops in meeting rooms
- Disabled access for wheelchair users
- Flexible working patterns in line with the Flexible Working Policy

Recruitment and Retention

The Trust is impacted by a lack of qualified staff for specific groups and many of the shortage specialties are nationwide. Our vacancies are most keenly felt in clinical areas, but there remain some corporate posts where vacancies are hard to fill.

Like other Trusts, we continue to have challenges

in attracting sufficient entry level registered general nurses which has the biggest impact in the specialties of medicine and surgery. Consultant positions can be hard to recruit to in particular specialties, but the biggest issue for us is in the middle grade doctor positions primarily in Medicine and A&E. The supply of allied health professionals is also low, both at entry level and above.

The Trust continues to recruit locally, nationally and internationally. There are recruitment events and campaigns aimed at recruiting qualified staff from universities, other employers and from overseas. In-country recruitment provides a steady number of applicants in most areas, however for nursing this has been supplemented by an ongoing overseas recruitment campaign to attract qualified nurses from across Europe. The nurses are required to pass an English language test as part of their application for registration in this country, this requirement is applicable to all professional clinical staff registering to practice here from anywhere in the world. The Trust constantly seeks to improve the advertising material used to attract more candidates, including the use of social media.

As part of a targeted plan to improve the recruitment and retention of nurses, the Trust established a Task and Finish Group during 2017/18. Successes include

- The Trust launched a successful 'More than just a Uniform' poster and Facebook campaign which raised the profile of our Registered Nurses and their valuable role within the Trust
- High conversion rates from offer to start for newly qualified nurses from Anglia Ruskin and Essex Universities by ensuring clinical areas have regular 'keeping in touch' events
- Specialist Open Days to attract newly qualified and experienced nurses for difficult to recruit areas
- Establishing new job roles and processes to support the development and progression of nurses

To retain staff the Trust has undertaken surveys and determined one of the key issues is the attainment of education, training and development opportunities.

The People and Organisation Development function provide a wide range of training and work closely with other employers and universities to provide a range of education and development opportunities for staff to access. The Trust recognises taught courses are not the only way to gain development and have created a number of rotational posts for staff to widen their sphere of experience including roles to move from one grade band to another as part of a formal step-change development programme.

Staff engagement and wellbeing are a high priority for the Trust as these contribute to the motivation of staff and their desire to remain working in the Trust. The Trust conducted its staff survey in 2017 and with the results now available, divisions will develop action plans to focus on areas for improvement. The value the Trust places on its staff can be seen in the annual awards celebrations and in the employee of the month awards in addition to the health and wellbeing activities organised by the Trust.

Communication and involvement

Ensuring that we listen to our staff and take their views on board is pivotal to providing better patient care. Significant efforts were made over the year to improve the quality and effectiveness of employee communications. Regular messages from the chief executive, chairman and managing director have ensured that employees are fully abreast of developments in the Trust and in the wider health economy of Mid and South Essex.

The monthly chief executive's/managing director's open forum meetings have continued to provide all staff with the opportunity to be directly informed by, and raise concerns with, those leading the organisation. A weekly "next week @BTUH" bulletin sent each Friday to all Trust email users informs staff what is happening in the organisation the following week. Daily "Stepping Up Now" meetings led by the directors to update staff on the "alert" status of the Trust; provide a daily opportunity for staff top raise issues regarding patient safety and the opportunity to share Trust-wide issues.

Those attending the meetings fee back to their wards and departments on the matters raised. Noticeboards are located next to the staff hand scanners which are regularly updated with information of relevance and interest to the workforce.

The Trust continues to enjoy a healthy and productive relationship with Trade Union representatives. Open and transparent communication has been instrumental in achieving and maintaining this. It is clearly recognised that the Trust management and Trade Unions share a common objectives to ensure the continued efficiency and quality of the service provided patients and their relatives, and to our staff.

The Joint Negotiating Committee (JNC), which is chaired by a non-executive director, brings together Union and Trust representatives, and continues to be well established in the routine operation of the Trust with active participation at each meeting. The Staff Council, with membership from employees and representatives from all disciplines across the Trust, continues to play an important role in representing as wide a range of staff views as possible when contributing to discussions. On a monthly basis, through the Staff Council and the JNC, staff are provided with a platform to air their views. In addition, informal but scheduled discussions take place with the Trade Union representatives on a monthly basis to ensure that all concerns are addressed promptly.

Throughout 2017/18, a joint staff-side committee was in operation. This committee brings together the staff-side representatives from the three acute trusts in Mid and South Essex to discuss relevant issues collaboratively with management. The role of this joint committee will increase during 2018/19 and beyond as the trusts continue to work more closely together.

Health and Safety Performance and Occupational Health

The Health and Safety Department address the health and safety aspects of the Trust's estate (such as waste management, fire safety and asbestos management) and those issues that affect staff directly (such as manual handling, display screen equipment usage and working at height). The Trust's health and safety activities are overseen by a dedicated health and safety management group which reports to the Directors Forum.

The Trust's Occupational Health Service works in partnership with managers and staff to safeguard and improve physical and mental health and social wellbeing at work. This includes casework to address high sickness rates in particular areas of the Trust, the provision of confidential, impartial advice to managers and staff, a confidential counselling service and complementary therapy. Occupational Health also facilitate access to a staff physiotherapy service, workshops to help individuals manage stress and anxiety and to improve their emotional resilience. The annual programme of influenza vaccinations for staff is also organised by the Occupational Health Department.

Countering fraud and corruption

The Trust has an Anti Fraud and Bribery Policy and Response Plan for raise and dealing with instances of suspected fraud and bribery. The review and implementation of this policy is overseen by the Audit Committee on behalf of the Board of Directors, with specialist input from the Local Counter Fraud Specialist (LCFS). The policy is supported by a programme of face-to-face training from the LCFS to all groups of staff. This training is provided at different times of the day and evening to ensure that coverage is as wide as possible.

Staff survey

The NHS Staff Survey provides an opportunity for the hospital to survey staff in a consistent and systematic manner. This makes it possible to build up a picture of staff experience and compare and monitor change over time to identify variations between different staff groups. Obtaining feedback from staff, and taking account of their views and priorities, is vital for driving service improvements in the NHS. This year, the national survey was completed by 2,231 employees, a response rate of 48% compared with last year's rate of 42%.

The staff engagement score is a significant indicator for hospitals and is used as a national benchmark in comparison to other Trusts. Possible scores range from 1 to 5 (1- not engaged, 5- highly engaged) and the survey asks a range of questions to calculate a score. This year we achieved a score of 3.79 which was the average for all acute trusts in England.

Key outcomes from the 2017 staff survey are provided in the following tables. The top five ranking scores have been provided against the national average for acute trusts.

Top 5 ranking scores (based on comparison to national average)	2017 score	National average (acute trusts)	2016 Score	Trust improvement
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	54%	51%	50%	Higher than national average and higher than last year score
KF10. Support from immediate managers	3.79	3.74	3.76	Higher than national average and higher than last year score
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	91%	90%	90%	Higher than national average and higher than last year score
KF29: % staff reporting errors, near misses or incidents witnessed in the last month	91%	90%	95%	Higher than national average but lower than last year score
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.96	3.91	4.01	Higher than national average but lower than last year score

Bottom 5 ranking scores (based on comparison to national average)	2017 score	National average (acute trusts)	2016 Score	Trust deterioration
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	2%	2%	Higher than national average though same as last year score
KF21: % staff believing that the organisation provides equal opportunities for career progression or promotion	81%	85%	84%	Lower than national average and lower than last year score
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	31%	28%	31%	Higher than national average though same as last year score
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	39%	36%	38%	Higher than national average and higher than last year score
KF22: % staff experiencing physical violence from patients, relatives or public in last 12 months	17%	15%	16%	Higher than national average and higher than last year score

Staff Engagement Priorities 2018/19

Based on the results, the top engagement priorities are:

- Increase the completion rate for the NHS Staff Survey and implement regular pulse checks to gather feedback throughout the year
- Create more opportunities for senior leaders to regularly engage with employees on a local level about a variety of issues
- Ensure that employees have a clear career path that is supported by their line manager
- Improve the appraisal process to help support the above actions and make people feel more valued
- Learning and organisational development

The Trust is committed to supporting every member of staff to reach their full potential through targeted learning and development opportunities. Learning and development embraces professional and personal development which includes leadership, mandatory and core skills, pre-professional education, and continuing professional development. Additional resources provided by the Trust include a virtual learning environment and a high quality library service.

Leadership training

Opportunities to develop management and leadership knowledge and skills are available to all staff. An important objective for NHS organisations is to ensure that they have highly trained people in defined leadership positions with resilience to lead sustained change.

The Trust has developed a 'leadership forum', bringing together senior leaders within the organisation on a regular basis to discuss the organisation's strategy, performance and development.

A wide range of leadership courses are available along with tailored support from the People and Organisational Development team to embed good practice. Examples of leadership development available to staff include: the in-house Core Leadership Programme and external courses delivered by the Leadership Academy.

Interventions which support leadership development have included:

- Team and individual interventions
- Coaching and mentoring
- Trait and personality questionnaires
- NHS Leadership Health Model 360° feedback
- Assessment and development centres
- Master classes inclusive of Mental Health and Wellbeing, Managing Resilience and Emotions
- Information, advice and guidance for career and personal development
- Monthly Schwartz Rounds

Core and mandatory skills

The majority of core and mandatory skills are delivered through ULearn, the Trust's online training site. The training modules and programmes are all tailored to meet the requirements of the organisation using software, voiceovers and videos to enable the e-learning to be interactive. The target completion rates vary according to the topic, between 85% and 95%.

Continuing professional development

A full range of education and training activity was commissioned from our higher education institutions in the year. Available HEE funding was fully utilised seeing the Trust achieve its target expenditure.

Pre-professional training

Pre-professional training has evolved following the introduction of the Apprenticeship Levy in April 2017, which has enabled a nursing career pathway to be developed, allowing an individual to progress from a healthcare support worker to a registered nurse.

Opportunities continue to be available in a number of sectors including administration and clerical and leadership and management which presents the opportunity to value our staff through offering vocational qualifications to improve their career and talent.

Simulation and clinical skills training

The Simulation Faculty continues to develop a varied curriculum of workshops and courses from which staff at all levels within the multi-disciplinary team can benefit. The simulation suite has expanded its capabilities with the creation of a control room which enables faculty members to observe scenarios discreetly to enable feedback to candidates.

The simulation suite has delivered a number of 'human factors' courses over the last year and successfully won a bid with three other organisations to be part of a human factors development programme working with UCLP network. This delivers a sustainable programme to deliver patient safety.

Medical education

Our medical education and training has consistently been highly regarded by the Deaneries, Colleges, GMC, trainees and other monitoring bodies. Many of our education faculty are involved in education and training at regional and national level including a past President of the Royal College of Surgeons of England and the current Head of the School of Medicine in the eastern region.

Basildon has been at the forefront of innovation, developing a number of good practice areas such as the mock Objective Structured Clinical Examinations (OSCE), history-taking sessions and twilight near-peer teaching. There have been accolades for Basildon's involvement in the Practice Assessment of Clinical Examination Skills (PACES), and Molecular Biology and Biotechnological Science examinations (MBBS) and for its innovative teaching and training methods. This year we have introduced the PACES practice revision courses to help to equip doctors with the skills they require to continue their professional development.

With the advent of a new medical school in the locality, Basildon is at the forefront helping to provide teaching, training and general groundwork support and advice.

Medical training staff have been commended by Health Education England (HEE) in quality visits, and the many school visits for their excellent support and quality of work for the trainees.

The Trust can demonstrate that all its educational supervisors have been trained to the standard required by the GMC with our HEE approved course.

Learning support

The Library and Knowledge Service (LKS) again achieved a 100% Library Quality Assurance Framework (LQAF) rating, highlighting its excellent reputation for high service standards and customer care. The library meets all standards required by HEE, the GMC and partner organisations. The library provides 24/7 access to a wide range of traditional and electronic resources via a custom external website, which provides tailored support for staff educational and professional development. The Clinical Librarian service is embedded in Paediatrics, Critical Care and The Essex Cardiothoracic Centre and provides evidence and information for safe quality care as well as supporting educational activities such as journal clubs and research initiatives. Librarians spend approximately 400 + hours per year undertaking literature search requests for clinical and managerial staff supplying information which underpins the evidence based practice of the Trust. The library also offers information skills training workshops including critical appraisal, referencing and reflective writing, created to help staff in the revalidation process.

Personal Service Contracts

This information is not subject to audit

The Trust is obliged to disclose all off-payroll engagements as set out under the HM Treasury rules. These rules have been in place since April 2012.

With effect from the 6th April 2017, HMRC determined that the tax rules for personal service companies (PSC) would change significantly. The new IR35 legislation ensures that individuals who work through their own company pay employment taxes in a similar way to employees that would be employed were it not for their PSC. This measure does not create any additional

pension obligation and statutory payments and/or other employment rights.

The Government decided that, from 6th April 2017, where a public authority makes a payment to a PSC the responsibility for deciding whether tax and national insurance should be paid and making the deductions will fall to the public sector engager (i.e. the Trust). This measure also applies to contracts entered into before 6th April 2017 which will operate after that date.

Each engagement is assessed via a HMRC employment status test and if the PSC is deemed to be within scope for IR35 tax and NI is deducted in full. Correspondence was issued prior to the change in the rules to all agencies and existing PSCs.

Arrangements were put in place with the Trust's payroll provider to enable the Trust to pay PSCs via the payroll, therefore allowing the tax and NI deductions to be made. Since the start of the 2017/18 tax all PSCs deemed to be within the scope of t he new rules have been paid via payroll.

Table: For all off payroll engagements as of 31 March 2018, for more than £245 per day and that have lasted for longer than six months

Table 1: For all off payroll engagements as of 31 March 2018, for more than £245 per day and that have lasted for longer than six months	
No. of existing engagements as of 31 Mar 2018	1
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	1
Number that have existed for four or more years at the time of reporting	0
This PSC has been reviewed and has been deemed as outside of the scope.	

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 Apr 2017 and 31 Mar 2018, greater than £245 per day and that last for longer than six months:	
The number of new engagements, or those that reached six months in duration, between April 2017 and March 2018	0
The number of new engagements that fall under the remit of IR35	1
The number of new engagements that do not fall under the remit of IR35	0
The number of those engaged directly (via PSC contracted to the entity) and are on the entity's payroll	1
The number of engagements reassessed for consistency/assurance purposes during the year	0
The number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 Apr 2017 and 31 Mar 2018	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals as at 31 March 2018 that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	15
The Chief Estates & Facilities Director was engaged via an agency on an interim basis following an initial unsuccessful recruitment process. The process to recruit a permanent replacement recommenced in April 2018.	

Trust stories | 5

New hospital appointment text reminder service launched

In September 2017, the trust introduced a new service which sends patients appointment reminders by text.

Before the text reminder was introduzced, one in 10 outpatients did not attend their hospital appointment (this is around 9,000 appointments) which was higher than at many other parts of the country. This means there were many appointment slots un-used each day which could have been reallocated to another patient.

The new appointment reminder service sends a text reminder message to outpatients seven days before their appointment. The message states the hospital, date and time of the appointment and patients will be able to reply to confirm, rebook or cancel. Unless the patient has chosen to rebook or cancel, they receive a further reminder message 48 hours before their appointment.

Patients who do not have a mobile phone have a voice message sent to the home phone. Children aged under 16 have a reminder sent to their guardian.

Since September, the number of patients not attending their outpatient appointment has dramatically reduced and we now expect to see around 7,000 more patients each year.

NHS Foundation Trust Code of Governance Disclosures

Basildon and Thurrock University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The Code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors reviews its compliance with the Code of Governance provisions annually and where it does not comply, the Board considers the risks associated with non-compliance and mitigates those risks as far as possible.

All disclosures required by the Board of Directors and its committees can be found in the Directors' Report from page 22.

All disclosures required by the Council of Governors about its activities can be found in the Council of Governors Report on page 39.

All disclosures required in relation to remuneration can be found in the Directors' Remuneration Report on page 51.

The Code of Governance was reviewed in 2014/15 and the Board reviewed its compliance against the revised Code in March 2014. Following this review, the Board agreed that the Trust complied with all of the main and supporting provisions of the Code, where they were applicable. This review has been reconfirmed by the Board in respect of 2017/18.

Single oversight framework

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and the first two quarters relating to the RAF has not been presented as the basis of accountability was difference. This is in line with NHSI's guidance for annual reports.

Segmentation

Basildon and Thurrock University Hospitals NHS Foundation Trust has remained in Segment 3 for quarters 3 and 4 of the 2017/18 year. The description of trusts falling into Segment 3 set out in the Single Oversight Framework is as follows:

'Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider of the Provider Regulation Committee has agreed to impose regulatory requirements'.

Our Trust is in Segment 3 due to the breach in our licence with NHSI for financial performance which remained in place throughout 2017/18.

This segmentation is the Trust's position as at 31 March 2018.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall

score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 Q3 score	2017/18 Q4 score
Financial sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial efficiency	I&E margin	4	4
Financial controls	Distance from financial plan	4	4
	Agency spend	2	2
Overall scoring		4	4

Improving our position

Throughout this annual report, we have explained the steps being taken to improve this Trust's financial sustainability, efficiency and financial controls during 2017/18 and beyond.

We will be maximising the benefits of working collaboratively with our partner trusts in mid and south Essex, alongside NHSI to improve our performance against the Single Oversight Framework.

Statement of Accounting Officer's Responsibility

Statement of the chief executive's responsibilities as the accounting officer of Basildon and Thurrock University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS act 2006, has given Accounts Directions which require Basildon and Thurrock University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Basildon and Thurrock University Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Prepare the financial statements on a going concern basis

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him or her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Clare Panniker
Chief Executive

Date: 29 May 2018

Statement of the Board of Directors

The Board of Directors of the NHS Foundation Trust consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and that it provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Annual Governance Statement 2017/18

Scope of responsibility

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

The purpose of the system of internal control

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

Collaborative Governance Arrangements

Whilst this Trust remains a statutory organisation governed by a Board of Directors holding the fiduciary duties required by legislation and the Trust Constitution, a collaborative governance framework (with a contractual joint venture overlay) was and continues to be in place between the three acute trusts within the Mid and South Essex Sustainability and Transformation Partnership (STP). Under this arrangement, the Boards of Directors of each trust delegated those functions that could be safely delegated in law and within the parameters of good corporate governance, to a Joint Working Board comprising a committee of each Trust meeting in common on a monthly basis. The aim of this collaborative governance was to deliver joined up clinical service planning across the three trusts.

As such, the capacity to identify and handle strategic and high level operational risks and to put in place effective controls across the three trusts has developed to complement the systems within the individual organisations and hospital sites. The key aspects of the risk and control framework across the 'group' are drawn out in the relevant sections of this Annual Governance Statement.

Further details about the collaborative governance arrangements can be found in the Directors Report (**page 24)**.

Capacity to handle risk

The Board of Directors holds ultimate responsibility for ensuring that the Trust delivers upon its statutory duties and governance requirements. As such, the Board of Directors has the authority and responsibility for the establishment, maintenance, support and evaluation of the Trust's Risk Management Strategy.

The Joint Working Board and the finance and quality committees in common provides additional capacity to handle risk across Basildon and Thurrock University Hospitals NHS Foundation Trust and our partner trusts in Mid and South Essex (Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust) as explained in the "risk and control framework" section below. Hereafter the aforementioned organisations will be referred to collectively as "the three trusts" or "the group". Any reference to "the trust" refers specifically to Basildon and Thurrock University Hospitals NHS Foundation Trust.

The Oversight Committee provides specific capacity to assess and manage the risks and governance challenges associated with the collaborative governance framework under which the three trusts are operating. Further details on the Oversight Committee and its review of the effectiveness of the collaborative governance framework can be found in the Directors Report (**page 25)**.

From January 2018, the Future Organisational Form Programme Board provides dedicated capacity to identify and handle risks associated with the proposed merger of the three trusts. The Programme Board comprises executive directors (including the Chief Executive), the Chairs of each trust and a number of non-executive directors to provide the appropriate level of scrutiny and oversight of the risks associated with a change in organisational form. It will continue to meet throughout 2018/19 and into the first year of the new organisation to provide additional assurance on the strategic and operational risks associated with the transition.

Leadership on risk management is provided by the Trust Board, through myself as Chief Executive, site and divisional directors. Clinical and corporate directors are accountable for risk management within their own directorates and divisions. The executive lead for risk management for the entirety of the 2017/18 year was the Chief Nursing Officer, who also holds executive responsibility for risk and risk management across the three trusts. As such, the Chief Nursing Officer provides additional capacity to identify risks that relate to the strategic objectives of the wider Mid and South Essex Sustainability and Transformation Partnership (STP) and to put in place system-wide as well as local controls to mitigate those risks The operational site lead for risk management was the Director of Nursing.

The roles and functions of the executive directors are formally reviewed each year to ensure that there are no gaps or overlaps in the corporate management structure of the Trust. During 2017/18 this review has also taken account of any gaps or overlap in the functions of the joint executives and their interface with the site leadership teams and cross-site services.

As the joint working between and redesign of services across the three trusts developed over the year, the decision was taken to create a number of 'group'-wide leadership roles below executive level in order to provide additional capacity to handle risk in critical and high-risk corporate support and clinical support services. These new roles included a Group Head of Information Governance, a Group Director of Procurement and a Group Chief Pharmacist. The creation of these posts provides a single point of leadership for these services and mitigates the risk of the control framework across the three trusts becoming ineffective as the organisation develops towards the proposed merger.

During 2017/18, the review of the roles and functions of the executive directors was conducted by the meetings in common of the remuneration and nominations committees (RemNoms) of the three trusts in Mid and South Essex. As a result of this review, a role of deputy chief executive was created, as an enhancement to the role of an existing joint executive. Following a process overseen by the remuneration and nominations committees, the chief transformation officer was appointed as deputy chief executive with effect from July 2017. The RemNoms approved the creation of a new post of chief commercial officer, recognising a skill and portfolio gap within the existing joint executive structure. This post was fulfilled on an interim basis up to the end of the 2017/18 year whilst recruitment to a substantive appointment took place.

The role of each director is clarified through the agreement of comprehensive job descriptions. Key priorities are determined by and aligned to the objectives documented in the Annual Plan. Training needs are identified and met through personal development plans. Performance against objectives is assessed throughout the year. Formal appraisals are undertaken of the joint executives by the chief executive. The formal appraisal of the chief executive is undertaken by the Chairs of the three trusts. The outcome of these appraisals is presented to the RemNoms in common. The structure of the

executive and site leadership teams ensures that appropriate focus is placed on managing the key risks faced by the Trust and sound management of its financial, human and property resources within a framework of good governance.

In view of the need to safeguard capacity to handle risk within the site leadership team, a decision was taken during Summer 2017 to split the portfolio of the Director of Operations role into two distinct roles : one focussing upon Urgent and Emergency Care and the other upon Planned and Scheduled Care. This action mitigated the risk that the Trust's achievement of its operational standards against both planned and unplanned care may be compromised by lack of leadership capacity within the site leadership team. For a similar reason related to capacity and resilience, a deputy managing director role as an enhancement to the role of an existing member of the site leadership team was introduced during Summer 2017. The deputy managing director role was fulfilled by the director of finance.

Whilst the composition and remuneration of the site leadership team does not fall within the traditional remit of RemNoms, the Joint Working Board agreed that it would be in line with good governance for the individual Trust RemNoms to maintain an overview and vehicle for consultation on changes within the site leadership teams. This additional control has added value during 2017/18 in relation to the appointment of a site director and the creation of a deputy managing director role as noted above.

Operational day-to-day management of the Trust is delegated to the site leadership team in partnership with the divisional clinical directors. The Directors' Forum meets on a twice-monthly basis, comprising the SLT and the divisional leadership teams. Directors' Forum meetings are chaired by the Managing Director.

Each divisional clinical director is a practicing clinician and is supported professionally and managerially by a divisional general manager and a divisional head of nursing. The Directors' Forum implements the strategies and decisions of the Board of Directors and has responsibility for operational decision-making and the management of operational risks. All divisions are sub-divided into clinical service units (CSUs); each CSU is managed by a CSU lead (a practising clinical specialist), a service unit manager and a lead nurse. This triumvirate has delegated responsibility for the professional and managerial performance of the CSU, reporting to the divisional clinical director and the divisional general manager.

Risk specialists and advisors are engaged where appropriate throughout the Trust and each maintains the relevant qualifications and experience to ensure that competent advice is available to all managers. A list of advisors is available in the risk management strategy and includes professionals in patient safety, medicines management, fire safety, security, health and safety, financial governance, clinical risk, business continuity and emergency planning. Together with clinical and non-clinical leads and advisors, these specialists support the creation, implementation and monitoring of policies, protocols and guidelines for the effective control of risk. Where responsibilities are assigned to individuals within the risk management strategy, the Trust has reviewed their training needs as part of the annual performance review process to ensure that their competence is sufficient for the discharge of their duties.

All employees have an important role to play in identifying, assessing and managing risk. To support employees in this role, the Trust provides a range of policies, strategies, procedures, protocols and guidelines together with information at all levels that are relevant to an individual's role. The Trust aims to ensure that employees have the knowledge, skills, support and access to the expert advice necessary to manage risk efficiently and effectively. Support and training are provided in line with the risk management training needs analysis, which identified the level of training appropriate for an individual's authority and duties. The Trust has a clear policy for staff completion of mandatory and core training aimed at managing risk. The

policy is clear that managers are responsible for ensuring staff completion of training. This is monitored regularly and reported to the Finance, Resources and Performance Committee (FRPC) as part of the regular workforce report to the Directors' Forum and to the Joint Working Board as part of the monthly integrated performance reports.

Learning from good practice is encouraged, as is learning from mistakes in order to continually strive for better outcomes for patients. Learning is shared internally through team, professional and divisional meetings where clinical practice changes following incidents and complaints are discussed and corporate meetings where risk recommendations from solicitors following inquests and claims are shared. The Trust has a high rate of incident reporting when benchmarked against peer organisations. This is considered by the Board and its Committees as a reflection of an open and transparent culture across the organisation.

In addition during 2017/18 the Trust has maintained a number of communication methods which have proven effective and popular with staff. These include:

The weekday "Stepping Up Now" patient safety meeting, led by a member of the site leadership team;

- Weekly safety messages displayed on computer screens and on the Trust intranet;
- Divisional patient safety briefings;
- Weekly "Next Week@BTUH" diary emails;
- Weekly email briefings from the Managing Director;
- Monthly "#PassItOn" core messages from the Directors' Forum to the wider Trust.

Learning is shared externally by reporting to organisations such as the Care Quality Commission (CQC), the National Reporting and Learning System (NRLS), the Medical and Healthcare Products Regulatory Agency (MHRA), NHS Counter Fraud Authority, the local commissioners and the Local Area Team of NHS England.

The three trusts have established a Risk and Compliance Group which co-ordinates the identification, dissemination and implementation of learning from incidents and developments in best practice across all sites. This group, comprising risk, compliance, corporate and clinical governance leads, provides additional capacity to handle risk in a co-ordinated way across all three trusts and was a key development in the collaborative governance arrangements during 2017/18.

The risk and control framework

The risk management strategy is one of the seven designated policies that must be agreed and endorsed by the Board of Directors. It details the Trust's approach to risk management and describes it as both a statutory requirement and a key element of good management. Risk management is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and care system, as a public benefit corporation and provider of health services, as a custodian of public funds and a significant employer. The risk management strategy clearly sets out accountabilities for risk management at each level in the organisation and aims to ensure a comprehensive system of internal control without stifling flexibility and innovation.

The strategy and its associated policies and procedures set out the processes for identifying, assessing, communicating, documenting, escalating, managing and review risks. The effectiveness of the risk management strategy and its implementation is monitored by the Audit Committee. In doing so, the Committee mitigates the risk of failure to comply with Foundation Trust Licence condition 4 (governance).
Risks are identified in a number of ways, including recommendations from external reports, organisational failures and incidents and more local methods of risk profiling, incidents, claims, complaints, receipt of alerts and risk assessment of work-related activities. Risks are assessed using an agreed risk assessment template and recorded on the Corporate Risk Register, which is a single repository for all the risks identified across the Trust.

Each division is responsible for managing a risk register which is reviewed by senior managers and risk leads on a regular basis. The Board of Directors receives the Board Assurance Framework (BAF) on a quarterly basis. The BAF ensures that the Board of Directors is aware of the highest risks to the achievement of the Trust's objectives and the controls necessary to ensure that the risk is maintained at an acceptable level. The appetite for risk is determined for individual circumstances or events and the Board will request additional controls where it wishes to further reduce the likelihood or impact.

The Finance, Resources and Performance Committee and the Quality and Patient Safety Committee regularly review relevant significant risks and incidents relating to their areas of responsibility. The terms of reference for the Finance, Resources and Performance Committee (formerly the Finance and Resources Committee) were amended during 2017/18 to ensure robust scrutiny of operational performance and recovery plans at board committee level. The Audit Committee independently monitors, reviews and reports to the Board of Directors on the extent to which the Trust has in place an effective system of governance, risk management and internal control. The Audit Committee has a key role in assuring the Trust of the validity of its Annual Governance Statement. This is achieved by regular review of the system of internal control and reports from auditors throughout the year and at least two examinations of the draft Annual Governance Statement prior to its submission to the Board of Directors for adoption. This committee also reviewed the BAF, which documents the risks, controls and related assurances that underpin the delivery of the Trust's objectives.

The Council of Governors is the main mechanism by which the Trust involves patient and the public in managing risks which impact upon them. Governors are encouraged to highlight risks, in particular those relating to quality, patient safety and patient experience at either the informal or the formal Council meetings. Executive and site directors regularly provide assurance at these meetings on how risks are being managed. The Trust also involves Governors in board walkabouts and environmental audits to help identify and address risks in the patient environment. A formal sub-group of the Council of Governors focusses upon patient experience.

The Joint Working Board (JWB) is a key element of the risk and control framework across the three trusts complementing the risk management processes operating within the Trust. On a quarterly basis during 2017/18, the JWB reviewed a 'Group Board Assurance Framework' on a quarterly basis, capturing those risks which could impact upon the delivery of the strategic objectives of one or more of the trusts, or of the STP as a whole. The JWB reviewed the Group Board Assurance Framework in detail, reaching decisions on the accuracy of the risk ratings and the adequacy of the controls and assurances identified. During 2018/19, the 'group'-wide risk management processes will be further refined to ensure the Group BAF becomes more strategic in nature whilst introducing a 'group'-wide corporate risk register to record and manage high level operational risks. It is anticipated that the Oversight Committee will evolve during 2018/19 into an 'audit committees in common' model, which will be an additional element of the risk and control framework across the three trusts, taking an overview of the 'group' risk management processes and providing assurance on the effectiveness of the system of internal control to the JWB.

The most highly rated risks which were recorded on the BTUH Board Assurance Framework during 2017/18 included :

- Failure to maintain financial sustainability thereby resulting in external action being taken may risk the organisation's reputation;
- Failure to meet the 4-hour A&E waiting time target due to system-wide capacity pressures may lead to poor patient experience and safety, harm to patients and additional pressures on elective care;
- Failure to consider fully the challenges faced by the Trust with regard to Referral to Treatment (RTT) times and cancer waits may lead to further scrutiny from regulatory bodies, further contract performance

notices (CPNs) being issued and poor patient experience or harm;

- Failure to achieve and maintain quality standards within the pathology joint venture may lead to patient harm and reputational damage to the organisations involved

The most highly rated risks recorded on the 'Group Board Assurance Framework' during 2017/18 were:

- Failure to manage patient flow and capacity, develop new pathways and lack of delivery by external partners against the Transformation Plan may lead to failure to deliver the standards of the NHS Constitution;
- The 'group' may fail to achieve its annual control total and return to financial balance in the required timescale;
- Failure to recruit and retain an appropriate workforce to meet the needs of the current and future patient base may lead to a deterioration in patient experience and low staff morale;
- Failure to deliver the strategic transformation plan may lead to poor patient outcome, poor patient and staff experience and financial instability, resulting in regulatory and statutory sanctions and increased reputational risk;
- Failure to achieve the internal transformation objectives of the 'group' may lead to poor patient outcome, poor patient and staff experience, inefficient use of resources and financial instability, resulting in statutory sanctions, increased reputational risk and difficulty retaining staff.

The Trust's risk profile for 2018/19 is expected to remain broadly similar to 2017/18, although it is intended that the third risk related to the pathology joint venture will be de-escalated early in 2018/19 subject to the board and its committees continuing to receive adequate assurance of sustained improvements.

The Trust has paid particular attention during 2017/18 to assessing its performance against the CQC Well Led Framework. This work was involved internal self-assessments as well as peer-led reviews undertaken by colleagues from our nearby acute trusts. Further details of our work to ensure that the Trust is Well Led can be found on page 36.

Quality Governance

The key elements of quality governance in place during 2017/18 were:

Strategy

The Trust has communicated its quality priorities and goals for the year across the organisation and designed its performance information to support the monitoring of progress against these goals.

A Trust-wide clinical strategy is in place, supported by a number of enabling strategies and plans. These have been communicated to staff across the Trust and have formed the basis of business planning activities.

Specific and challenging Trust objectives are in place for 2013/14 to 2017/18 that includes key performance indicators, milestones and trajectories. These objectives are monitored regularly through the performance report, with supporting benchmarking data (where available) and improvement trajectories.

Capability and culture

Processes are in place to ensure that the Board of Directors has the suitable skills, knowledge and capacity to deliver the Trust's objectives. In 2017/18, this information provided the basis of the preferred skill-base for a new non-executive director and influenced the process for appointing a deputy chief executive (as an enhancement to the role of the chief transformation officer), as well as several appointments to the Site Leadership Team.

A refresh of the Trust values took place during 2015/16 to ensure they remained relevant to the Trust's circumstances and fresh in the mind of all staff, regardless of their role and level in the organisation. Work has continued during 2017/18 to embed the Trust values.

Processes and structure

The internal Quality Assurance and Compliance Team (within the Directorate of Nursing) has conducted a significant number of clinical reviews, using the CQC prompts in order to determine the level of ongoing compliance with the essential standards.

The ongoing programme of unannounced clinical visits, conducted regularly with our commissioners, provides valuable intelligence on the level of compliance with essential and professional standards. During 2017/18, the Trust hosted a number of regulatory visits and inspections. These included a quality assurance visit by Public Health England of the Trust's cervical screening programme in June 2017 and of the antenatal and newborn screening programme in September 2017. There was an inspection by the Human Tissue Authority (HTA) in December 2017 of the Trust's practices and governance associated with the handling of human tissue, particularly in the hospital mortuary and a review by the Royal College of Emergency Medicine of the A&E Service in March 2018. Whilst some of these inspections identified gaps in compliance, there were no identified shortcomings that caused harm to patients. The reports and implementation of recommendations from all external inspections are overseen by the quality and patient safety committee.

Key assurance committees of the Board focus on quality and safety supported by three management groups (Patient Experience, Patient Safety and the Risk and Compliance Group) each led by the relevant director. Each group has a work programme that reflects the expectations and performance of directorates and corporate activities.

The principal committee that scrutinises quality and patient safety performance, providing assurance to the Trust Board is the Quality and Patient Safety Committee (QPSC). This committee meets on a monthly basis. Quality metrics scrutinised by the Committee include mortality, serious incidents and never events, hospital associated infections, pressure ulcers, complaints and Friends and Family Test results and compliance with CQC standards. This data is presented as part of an integrated quality report. Further detail on the structure and work of the QPSC can be found on **page 34.** The role of the Trust Board is to receive assurance from QPSC in relation to the Trust's performance against quality and patient safety metrics and compliance with statutory duties.

The role of the quality committees in common of the three trusts is to maintain a high level overview of quality and safety performance across the organisations, alongside the consideration of strategic quality issues and the development of a group-wide quality strategy. The development of this strategy commenced in 2017/18 and will be completed in the first half of 2018/19.

There is a formal process to consider and document the potential impact of cost improvement programmes and other significant decisions on the quality of patient care. Quality impact assessments are signed off by the Medical Director and Director of Nursing and are reviewed at six month intervals. Commissioners also review and challenge the Trust's quality impact assessments to provide additional assurance.

Communications have been maintained with staff through blogs and briefings from the Chief Executive, the Managing Director and the Director of Nursing, frequent executive and site leadership team "walkabouts" during the day and night, unannounced observational clinical visits, regular Board and Governor walkabout visits to clinical areas and monthly divisional performance reviews against key metrics of service quality. At each meeting of the Board of Directors, there is either a Patient Story or a "Reflections on Practice" presentation to promote a culture of "ward to board" learning and continuous improvement.

The Trust's Data Quality Policy mandates the undertaking of regular data quality audits (externally commissioned) during the year and these provide assurance on the accuracy of data within the Trust.

Measurement

A robust Clinical Audit Plan exists which reflects the processes used in financial audit. As reliance upon clinical audit for appropriate assurance has increased, the clinical audit plan has evolved to become more risk-based providing consistent coverage across the Trust's activities and using patient feedback to identify priorities for audit.

The graphical information provided within the performance reports (reported at the Board meetings in public and the Council of Governors meetings) incorporates the Trust's internal quality targets and standards and, where appropriate, benchmarking data to provide clear and transparent information on the Trust's performance. Where variances exist, narrative is provided to give assurance that remedial action is being taken to bring performance back within expected limits.

Benchmarking, wherever possible, takes place against other Trusts and through the use of national data sets, such as Dr Foster Intelligence, Summary Hospital Mortality Indicator (SHMI), Care Quality Commission, National Reporting and Learning System of the National Patient Safety Association and the Quality Observatory data.

Challenge is provided by Board members to the information presented and requests are made for more detailed underlying information in order to identify the root cause of potential issues of concern and emerging trends. Board challenge of this nature is documented in Board minutes and captured in subsequent action plans. Executives note sources of information on board and committee reports and ensure independent validation to strengthen assurance, wherever possible.

Documentation of the systems and controls used to produce data for quality and patient safety reports provides assurance about the underlying assumptions to the Board. The Board, the Quality and Patient Safety Committee and the Audit Committee are able to commission external reviews or tailored internal audit reviews should they consider additional assurance to be required.

Compliance with CQC standards

The Foundation Trust is fully compliant with the requirements of the Care Quality Commission (CQC).

NHS Pension Scheme

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

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Further details of the Trust's activities to promote equality, diversity, human rights and inclusion can be found on pages 19 and 60.

Compliance with emergency preparedness, civil contingency and sustainability requirements

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

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

The Board of Directors, the Audit Committee and the Finance, Resources and Performance Committee regularly review the financial resources and financial performance of the Trust. Quarterly returns are provided on use of resources to NHS Improvement and the CQC. Weekly and monthly financial information is provided to all budget holders. Other internal processes that ensure resources are used economically, efficiently and effectively include:

Internal audit

Utilising a risk-based approach, internal audit has reviewed selected systems and processes in place during the year and published reports detailing the required actions within specific areas to ensure that economy, efficiency and effectiveness of the use of resources is maintained. Progress with actions is reviewed at each meeting of the Audit Committee.

Financial efficiencies and cost improvement programmes

A cycle of monthly divisional performance meetings has been in place throughout the year, to increase accountability of the divisions for use of resources, delivery of cost improvement plans and effective, cost efficient service provision. This was enhanced and formalised by a Divisional Governance, Support and Accountability Framework in place from November 2017.

The approval of individual capital expenditure projects is managed by a Capital Investment Group and overseen by the Finance, Resources and Performance Committee.

The maintenance of a Clinical Effectiveness Unit

This Unit oversees the implementation of guidance from the National Institute of Health and Care Excellent (NICE) and recommendations from National Confidential Enquiries and other inspecting and authoritative bodies.

The Unit monitors the introduction of new techniques and research and development projects ensuring patient safety, clinical and cost effectiveness of new treatments as well as the appropriate training of clinicians.

It supports clinical audit across the Trust, ensuring that the Board receives assurance that key clinical risks are being audited as robustly as financial risks.

The Unit promotes evidence-based healthcare through training and education of nurses and as part of the Foundation Programme for doctors.

Good practice is shared through collaborative working with primary care, secondary care, mental health and public health providers in the south Essex area.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference

The Directors' Forum is responsible for ensuring that the clinical risks and priorities of the Trust are understood, assessed, mitigated and addressed. Issues and risks can be escalated by the Directors' Forum to the Trust Board or its committees.

Divisional Management Boards and Divisional Governance Committees are responsible for ensuring that the divisions are managed efficiently and effectively and that evidence is available to support that assessment.

The Medicines Safety Group oversees the maintenance of a local drug formulary to ensure clinically appropriate and cost effective use of medicines.

Information governance

NHS Digital (formerly the Health and Social Care Information Centre) has published guidance and a checklist for reporting information governance (IG) incidents. This checklist comprises a baseline scale dependent on the level of individual involvement (ranked from 0 to 3). Together with a sensitivity factor, it provides an overall score which details how an incident should be investigated. Only IG incidents which score at level 2 are reportable and are escalated to the Information Commissioner's Office (ICO).

During 2017/18, two information governance incidents were report, as outlined below.

Date of incident	Summary of incident	Volume	ICO informed	ICO action date	ICO action
23 Jun 2017	The communications team received a phone call from a patient's mother advising that her daughter had been given a discharge letter for another patient along with her own copy.	1	25/7/17	14/8/17	Incident closed with no further regulatory action required
24 Nov 2017	A doctor's handover sheet containing patient identifiable information was reportedly found in Basildon Town Centre by a member of the public. This was returned to the hospital for further investigation.	17	11/12/17	26/2/18	Incident closed with no further regulatory action required

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The content of the Quality Report and the selection of key quality priorities is a decision taken by the Board of Directors based on national and local priorities with input from a range of local stakeholders.

The production of the Quality Report is the responsibility of the Quality, Innovation and Patient Safety Directorate. This corporate team is drawn mainly from clinical backgrounds with experience of working in areas that affect patient safety, clinical effectiveness and patient experience. In preparing this report, the priorities agreed the previous year are reviewed. The data used within the Quality Report is extracted from the Integrated Performance Report which is scrutinised by the Quality and Patient Safety Committee, the Directors' Forum and the Board of Directors.

Additional data is gathered through the Trust's annual clinical audit programme.

The accuracy and quality of elective waiting list information received regular scrutiny throughout the year. This is because failure to record accurate data may lead to patients experiencing prolonged waits for treatment and the Trust being unable to appropriately track and manage its waiting list. To provide assurance that the systems used are robust, the Trust has a number of mechanisms to monitor this area of risk, which are both internal and external, including:

- The CCG Access Board which scrutinises the waiting list data on a monthly basis
- The Internal Patient Access Steering Group which meets weekly to review the patient tracking lists and monitor waiting times, taking action where necessary
- There is a team of validators whose role is to ensure all elective patients are on the correct clinical pathway and to validate all patient pathways

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality and Patient Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in reviewing the effectiveness of the system of internal control includes the ongoing work of and reports from:

- The Board of Directors which monitors the effectiveness of the system of internal control through clear accountability arrangements;
- The Joint Executive Group which meets formally on a weekly basis to review performance in real-time and to ensure executive oversight and approval of all service development proposals with a financial impact;
- The Audit Committee, which is a committee of the Board of Directors and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The Committee meets five times per year. The Audit Committee approves the annual audit plans and activities for internal and external audit and ensures a programme of clinical audits associated with the highest clinical risks is overseen by the Quality and Patient Safety Committee. It ensures that recommendations to improve weaknesses in the systems of control arising from audits are addressed by management. The Audit Committee reviews the Board Assurance Framework and ensures that the board committees work cohesively and efficiently;
- The Quality and Patient Safety Committee and the Finance, Resources and Performance Committee which have advised me on the arrangements for clinical governance, clinical risk management, internal clinical effectiveness and patient safety, health and safety, and financial performance respectively;
- The Head of Internal Audit who has provided me with an opinion that the organisation has an adequate and effective framework for risk management, governance and internal control. However, the work of Internal Audit during 2017/18 has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. Most particularly, these related to the areas of Medicines Management, Temporary Staffing (Doctors), Data Quality, Payroll and General Data Protection Regulation (GDPR) Readiness. The Head of Internal Audit is satisfied that significant progress has been made up to and beyond 31st March 2018 to enhance the framework of risk management, governance and internal control in relation to these particular areas.

Conclusion

Although no significant control issues have been identified, the Trust has continued to face challenges during 2017/18 as a sovereign statutory organisation and as a partner in the Mid and South Essex STP, particularly in relation to financial sustainability and the consistent achievement of access standards within the NHS Constitution. Whilst there is evidence that our systems and processes around finance have improved this year, it is clear that our system of internal control around financial management and operational delivery require continued focus and delivery in 2018/19 and beyond in order to provide the Board with assurance that the system

of internal control is robust and supports the delivery of patient outcomes in a sustainable manner.

The Trust remains compliant with the registration requirements of the CQC.

The Board has responded to (and will continue to respond to) all the reports and correspondence from regulators. The Board has developed action plans with measurable outcome and clear accountabilities and has strengthened the Board, corporate and clinical governance, site and executive leadership structures.

As noted in the "risk and control framework" section of this AGS, our risk management and governance processes will continue to evolve to address the challenges and exploit the opportunities associated with service transformation across the three trusts, not least the anticipated patient benefits of the proposed merger from April 2019.

I recognise that this is an ongoing process and believe this to be a balanced statement of the risks and controls within the Trust during 2017/18.

Clare Panniker

Chief Executive

Date: 29 May 2018

Best foot forward for hospital staff health and wellbeing

The 'baby walkers' team with Lorna Stoddart, therapy lead, health and wellbeing

Staff powered their way through more than 52 million steps during June as part of a challenge to promote health and wellbeing at work.

The month-long step challenge, organised by the occupational health and therapies teams, was open to individuals and groups of up to eight people.

The team winners were the 'baby walkers' from the maternity department, who clocked up a combined tally of 3,950,239 steps.

Chris Boatman, contracts manager, who paced herself over a total of 593,393 steps, was the individual winner.

The step challenge was part of a workout@work programme during the summer. Other events included Tai chi, teaching staff exercises they can do at their desk and mindfulness sessions.

Sue Hillman, head of occupational health and wellbeing, said: "We want to encourage people to make small changes to move around a bit more. Simple things like taking the stairs instead of the lift and doing some simple exercises during your working day can make a big difference to overall fitness, health and wellbeing.

Quality report 2017/18

Introduction

Foundation trusts are required to produce an annual quality report published within the Annual Report, providing information about the quality of services delivered and priorities for improvement. Quality accounts have become an important tool for strengthening accountability for quality within NHS trusts and for ensuring effective engagement of the Trust Board of Directors in quality improvement. By producing a quality report, we are able to demonstrate our commitment to continuous evidence-based quality improvement and to explain our progress. It shows the data we use to monitor improvement in patient safety, clinical effectiveness and patient experience.

This is the ninth quality report produced by the Trust.

The quality report is set out in three sections:

Part 1: A statement on quality

A statement from chief executive, Clare Panniker

Part 2: Priorities for improvement

In this section the Trust sets out key commitments for improving the quality of services provided. We look back at our quality aims for last year and look forward as we set out priorities for the year ahead. Included in this section are statements about the organisation which are intended to help people compare different health organisations.

Part 3: Review of quality performance

This demonstrates how the organisation has performed to date.

How we produced the quality report

As a provider of healthcare, the Trust's priority is to ensure our patients receive high quality, safe, care. The Trust is committed to ensuring continuous improvement to service delivery, setting challenging annual quality improvement goals with the aim of becoming one of the safest organisations in the NHS. In developing this year's quality report, the Trust has ensured that governors, local HealthWatch, staff and other stakeholders including the local Clinical Commissioning Groups (CCGs), have had an opportunity to comment on the quality priorities for the Trust. This report also includes the mandated content as set by the Department of Health. We welcomed the comments that were received and have reflected these in this report. The report has been overseen by our senior clinicians and managers through our senior management team, chaired by the chief executive, and the Trust's Audit Committee.

What is quality in healthcare?

High quality healthcare is defined as safe and effective care that is delivered with compassion and respect. Quality in healthcare is often described by three domains:

- **Patient Safety**
  The first principle of quality in healthcare is to try to ensure patients do not experience harm. This is supported by ensuring the environment is safe, clean and that processes and guidance support the reduction of potential harmful events, such as medication errors, falls and healthcare associated infections
- **Patient experience**
  Quality of care embraces both the quality of care delivered to the patient and the manner in which it is provided. To ensure patient experience is one of dignity, compassion and respect, as a result of high quality care delivery, all feedback from patients is analysed, and the learning identified in order to continually respond and improve care
- **Clinical Effectiveness**
  To ensure care delivery is safe and effective, the Trust is required to understand evidence of both success and failure of the treatments

offered to our patients. This knowledge is gained by measuring clinical outcomes such as mortality, survival, complications and clinical improvements. Clinical effectiveness also encompasses people's wellbeing and their ability to live an independent life

- The quality report was approved and ratified by the Trust Board of Directors on 29 May 2018.

Part 1 - Chief executive's statement on quality

This is the sixth quality report I have overseen for the Trust and I am pleased to provide a detailed picture of the quality of care provided which has continued to improve throughout 2017/18. The quality report enables us to demonstrate our commitment to providing each patient with the best possible care and treatment. It reports our progress on the priorities identified last year and sets out those identified for improvement in the coming year. The Trust's continued programmes of improvement will enable us to build on our successes to date. During the coming year, the Mid and South Essex STP and the three acute hospital trusts in mid and south Essex will cointinue to work closely to provide more co-ordinated, integrated, services, sharing best practice to continue to improve the care received by the local population.

The Trust overall was rated 'good' by the Care Quality Commission (CQC) in June 2016. Whilst there has not been an inspection of the Trust in 2017/18 we have strived to maintain standards and work to ensure sustained improvements. The Trust has had a number of visits and inspections by other regulators such as NHS Improvement as well as other stakeholders to review the services we provide. These visits provide assurance to our patients and ourselves that we are doing well and identify areas where we need to change practice and improve.

We are committed to providing safe, high quality emergency care within the national expected waiting times. During this winter despite the continued development of measures to improve urgent care flow in the hospital and community, like the rest of the NHS we came under extreme pressure with an increase in attendances. The efforts of our staff and those working for other organisations that support our hospitals were exceptional to ensure our patients received safe care.

To the best of my knowledge the information in this document is accurate.

Clare Panniker
Chief Executive

Date: 29 May 2018

Part 2 - Priorities for improvement

This section of the quality report reviews the quality goals for the last year and the plan for 2018/19, setting the quality goals for the year ahead. It also includes statements about the organisation to provide a comparison with other health care organisations.

Reflecting on 2017/18 improvement priorities

The goals identified were key to the safe and effective delivery of patient care. Some remain a priority for 2018/19 and will be supported by additional resource to ensure continued improvement. The remaining priorities are now standard measures that demonstrate how well the organisation is performing.

A summary of the Trust's performance against the 2017/18 quality goals, is detailed in the table below:

	Priority for improvement	Key Objective	Measure	Rating
Patient safety	To provide harm free and safer care, for all patients we provide services to.	To reduce patient harm events	The priorities for patient safety and clinical effectiveness are part of the Trust's quality improvement programme and will be supported by quality improvement methodologies which assess effectiveness of process and support a dynamic, timely response to the data. Data is then presented monthly to the executive leads at the Stepping up board.	Mostly achieved
Clinical effectiveness	To improve the quality and reliability of the care delivered. By implementing best practice this will support the delivery of high quality care for our patients.	To prevent patients' clinical deterioration		Achieved
Patient experience	Improving patient experience by providing our patients and their carers the best possible experience while they are using our services	To improve patient experience and satisfaction	Patient experience is monitored via a number of metrics that indicate the quality of experience. These include Friends and Family Test (FFT), responsiveness to PALS and complaints. All metrics are presented in the Integrated Quality Report and drive improvement.	Mostly achieved

Red Quality priority not achieved **Amber** Quality priority partly achieved **Green** Quality priority achieved

Source: Patient Safety Priorities 2017/18

Care that is safer

The actions undertaken to achieve the 2017/18 quality goal 'improving patient safety' are described in detail in the table below.

Quality Improvement Goal	Aim	Achieved	2015/16	2016/17	2017/18	National average	Source
Percentage of patients with harm free care	On or above national average by end of Q4		95.36%	95.75%	94.79%	95.24%	NHS Digital
Harm from injurious falls	20% reduction by end of Q4		19	27	13	N/A	Internal
Pressure ulcer incidence	0.25 per 1,000 bed days by end of Q4		0.247	0.244	0.244	N/A	Internal
Reduction in Never Events *	Zero		2	2	2	N/A	Internal
Reduction in avoidable VTE events	20% based on Q1 & 2 outturn		2	7	3	N/A	Internal

Harm Free Care

To assist in monitoring the safety of our patients, the Trust uses 'The Patient Safety Thermometer', a national benchmarking tool developed by the NHS to provide a 'temperature check' relating to harm experienced by patients during their hospital stay. Information is obtained via a monthly audit that examines the care given to inpatients and captures any harm events in the following areas

- Pressure ulcers
- Falls
- Catheter associated urine infections (UTI)
- Venous thromboembolism (VTE)

For the past two years the Trust has remained above the national average for the delivery of Harm Free Care. In 2017/18 there has been a further increase in the number of patients that attended the Trust who received harm free care, compared to the previous year.

All pressure ulcers and injurious falls are subject to root cause analysis, the outcome is peer reviewed weekly at the Trust's Harm Free Group. The group includes representatives from a cross-section of professional groups, including matrons, senior sisters and charge nurses, tissue viability nurse specialists, falls nurse specialists, clinical governance and risk managers, senior corporate nurses and Clinical Commissioning Group (CCG) representation. This process ensures a consistent methodology in the identification of the root cause, level of harm and the impact on the patient. It also facilitates shared learning across the organisation by identifying good practice, lessons learnt and any areas for improvement. This provides assurance in reliability of outcome and facilitates the rapid sharing of identified learning across the organisation.

Reducing harm from falls

Accidental falls remain one of the most commonly reported patient safety incidents in NHS hospitals. In English hospital trusts alone there are more than 200,000 falls reported each year. The actual figure is thought to be higher.

In 2014/15 falls became an integral part of the Trust's Sign up to Safety campaign. This was in response to an increase in the number of injurious falls, new recommendations from NICE to improve the management of inpatients that fall, the Royal College of Physicians (RCP) national audit on inpatient falls and the launch of the RCP's FallSafe quality initiative.

The 2015 RCP national inpatient falls audit report provided both local and national benchmarks for total inpatient falls in acute hospitals.

- **National benchmark**
  6.63 falls per 1000 bed days
- **Basildon and Thurrock University Hospitals NHS Foundation Trust benchmark**
  5.97 falls per 1000 bed days

This has been the agreed standard with our commissioners against which we monitor the effectiveness of falls risk management for 2018/19.

Whilst reducing the total number of falls is important, the level of harm experienced following a fall is a key consideration, as the impact on an individual can be life-changing. Therefore, since 2014/15 the Trust has continued to work to reduce the number of falls that may result in severe harm. The RCP audit also provided the first benchmarks nationally for falls with harm. The national standard is set at 0.19 injurious falls per 1,000 bed days and Trust's standard at 0.12 injurious falls per 1,000 bed days. Performance against this benchmark reflects 'that the total falls and falls with harm' has consistently improved against the agreed benchmarks. The annual 2017/18 performance for falls with severe harm was also improved against the Trust RCP benchmark.

The results of the second national falls audit were published in November 2017. This audit provides national benchmarks to act as a catalyst to improve falls risk management services. It is based on guidance from NICE and NHS Improvement. The Trust chose to participate in

this process with the aim to identify changes achieved since the first audit in 2015. The Trust has significantly improved in three key areas since 2015, mobility aid provision, call bell within reach, medication review. The areas to improve on in relation to falls risk management are:

- Management and identification of delirium
- Continence care plan
- Lying and standing blood pressure
- Vision assessment

Of these areas that require improvement, lying and standing blood pressure and vision assessment are areas that nationally fall below the benchmark.

Falls are measured by two factors, firstly the actual number as well as measuring them against the number of patients bed days, which enables Trusts to accurately compare the rate of falls and/or injury against that hospitals activity. It also provides a more reliable national benchmark. The annual performance for the past three years, for total falls and injurious falls with severe harm are detailed in the following table.

	Total falls with severe harm per 1000 bed days (RCP Benchmark 0.19 per 1000 bed days)	Total falls with severe harm	Total falls per 1000 bed days	Total falls
2015 - 16	0.07	19	5.12	1365
2016 - 17	0.07	21	4.24	1250
2017 - 18	0.06	14	5.17	1231

Source: Ulysses/PamsBi BTUH

The Trust's commitment to the national Sign up to Safety campaign was successful and during this reporting period the improvement plan has been completed. The focus for the next 12 months and beyond is to ensure previous improvements are sustained and to address new areas that are highlighted for improvement.

During 2017/18 there have been many improvements and initiatives introduced that support a continued reduction in falls risk and possible injury:

- High density crash mats placed at the bedside, that reduce the impact of a fall and the risk of potential injury
- FallSafe toilets in clinical areas where there are patients at a high risk of falling. These toilets have been adapted to support patients with dementia and minimise known falls risks associated with toilet areas
- A targeted care pathway has been designed, tested and introduced – The ED FallSafe care pathway has been introduced
- A Falls Strategy Group has been implemented to support the Trust's commitment to improving falls performance
- The Trust has adopted the Royal College of Physicians patient information leaflet and these are now available for patients in all clinical areas
- The FallSafe care bundle has been developed into an electronic version which will be facilitated by the E-obs (electronic observations) system. It is currently in the first of three test phases to ensure functionality and the aim is to replace the paper version of the care bundle and implement the E-obs version into clinical practice in 2018/19
- FallStop initiative is in a developmental phase, the aim to improve the supervision of high risk falls patient's reflecting a national initiative to improve care of this patient group
- Commitment to staff education and FallSafe Champions continues and is supported by an education strategy
- A monthly information poster detailing each ward's falls performance and good news stories is produced and sets a monthly improvement goal, with the overall aim to support staff learning and improved care delivery
- A new medical lead for falls has been appointed, who will lead the medical engagement strategy for falls. This role will also support the peer review of falls root cause

analysis and act as the medical representation on the Trust Harm Free Group

- Whilst the commitment to the above improvements is maintained there are further developments planned for 2018/19 improvement plan is presented as follows:
- To develop a visual assessment tool for medical staff, that supports falls risk reduction
- Design and implement strategies, risk assessments and care plans, that will reduce the associated risks for patients admitted to hospital with delirium in partnership with the Trust's Admiral nurse, the consultant leads for dementia and the falls team
- To improve compliance with the recording of lying and standing blood pressures that are undertaken by therapy staff
- To enhance the existing education strategy with the introduction of a lying and standing blood pressure education and competency assessment for all nursing staff
- To develop a collaborative network across the acute hospitals in mid and south Essex
- Implement a falls engagement strategy for medical teams
- To support the urology nurse specialist in the development of a continence care pathway and catheter passport, that will interface with the FallSafe care bundle to facilitate a continence assessment
- To work with the therapy team to facilitate 24 hour access to walking aid provision for inpatients
- To introduce an robust and timely monthly electronic assessment of compliance following the introduction of the e-FallSafe care bundle,
- The Trust will actively participate National Falls week in September 2018, providing a local focus on falls risk management and improvements

Reducing harm from avoidable pressure ulcers

It is estimated that just under half a million people in the UK will develop a pressure ulcer in any year. Pressure ulcers occur in people with health conditions who find it hard to move and can develop when a large amount of pressure is applied to an area of skin over a short time, but they can occur over longer periods when less pressure is applied.

In October 2011, NHS Midlands and East developed a set of five ambitions. One of the five ambitions was the "elimination of avoidable grade 2, 3 and 4 pressure ulcers". The Trust engaged with this project and devised a local 'Stop the Pressure' campaign and changed the process for declaring and investigating pressure ulcers. In 2017/19, NHS Improvement are re-launching the National Stop the Pressure Programme (NSTPP). The aim of NSTPP is to drive further improvement in the levels of pressure damage. In addition to this, the Trust opted to join the Sign up to Safety campaign 2015/16, which continues to date.

All patients admitted with pressure ulcers have an incident form completed which is shared with the CCGs. All hospital-acquired pressure ulcers (HAPUs - damage to skin noted after 72 hours of admission) have an incident form, a root cause analysis document completed and are discussed at the Harm Free group. The analysis is reviewed and preventability and impact are agreed.

Goals for 2018/19 will be to reduce the rate of incidence of preventable HAPUs by 20%. To achieve this we will:

- Support the ongoing work to implement the tissue viability education and competency strategy
- Continue ward tissue viability improvement project to embed best practice and reduce incidence of pressure related injury, in identified high risk areas
- Develop an improvement plan for the temporary work force, to facilitate their knowledge of local strategies and enhance the tissue viability care delivery
- Work collaboratively with our colleagues in neighbouring hospitals to align standards of best practice

- To continue in collaboration with the nutrition team, in the development of the Agents of Nutrition and Tissue Viability link nurse programme
- To roll out a health care assistant (HCA) Pressure Ulcer Champions, to support the qualified team in prevention of pressure related injuries
- Test and then roll out pressure ulcer assessments and care planning via e-obs platform-including scheduled repositioning charts with electronic prompting when repositioning times are missed

Never Events

'Never Events' are serious incidents that are preventable, as outlined by the guidance and safety recommendations published by the NHS. Each Never Event has the potential to cause the patient serious harm or may result in death, however serious harm or death is not the only requirement for an incident to be categorised as a Never Event.

Never Events include incidents such as:

- Wrong site surgery
- Retained surgical instrument following surgery
- Chemotherapy administered by the wrong route

It is essential that an organisation learns from all Never Events to reduce or remove the risk of repeated events. Therefore the Trust undertakes a root cause investigation and in partnership with the CCG ensures the patients and/or family are fully supported and informed throughout the process in line with Duty of Candour guidance.

Two Never events were declared by the Trust in 2017/18, involving dermatology patients. Neither incident resulted in the death of a patient. Both incidents have been investigated with recommendations and associated actions in place.

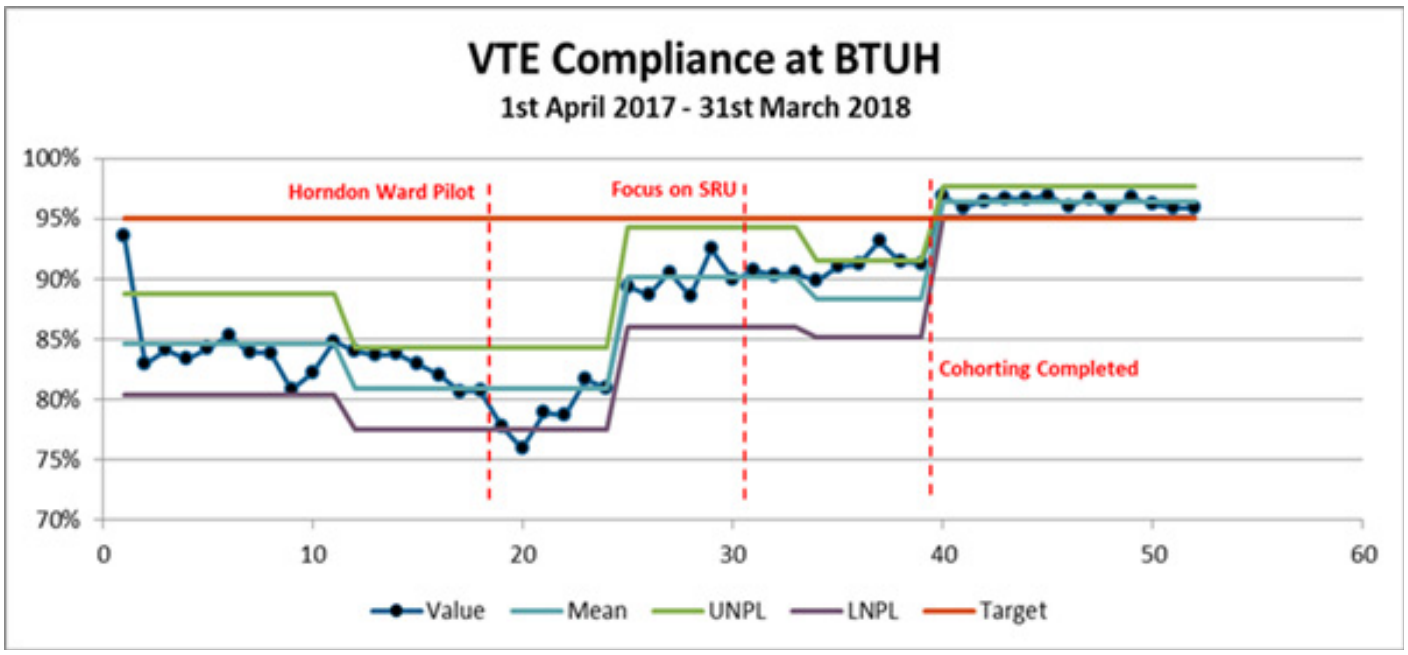
As with all serious incidents, reports are shared with individuals involved for reflective learning as well as wider with clinical teams as shared learning. Reports and action plans are presented at local clinical governance group meetings by the designated action plan lead. The nominated leads, as indicated through the action plan, are required to deliver their action(s) within the timescales agreed. Delivery of actions is monitored and recorded at the appropriate clinical governance group meeting.

Reducing harm from venous thromboembolism (VTE)

Venous thromboembolism (VTE) is a condition when blood clots develop in a vein. Most commonly this is a deep vein thrombosis (DVT), when a clot occurs in the deep veins of the leg. A possible complication of this is a more serious condition called a pulmonary embolism (PE), when the clot in the leg has become mobile, moves and blocks a vessel in the lungs.

All blood clots that occur within 90 days of a person's hospital stay are classed as hospital acquired and declared as a serious incident. This then initiates an investigation into the root cause, to establish if the VTE may have been prevented, evidence of good practice and any failings in care delivery identified.

The Thrombosis committee was reinstated in September 2017 as part of the Trust quality improvement programme. The Trust compliance with VTE risk assessments on admission had fallen to 80% at the beginning of 2017. The Department of Health Standard is 95%, the most recent data demonstrates a compliance of completion of VTE assessment of 96%.



Data source BTUH

The thrombosis committee have facilitated this improvement through:

Education

- Raising the profile of VTE
- Identifying the clinical areas which are not part of the sample for data collection
- Reviewing the information systems that capture the VTE data

The thrombosis committee have worked closely with Kings College which is a VTE exemplar site to adopt best practice in order to achieve the 95% standard of patients receiving VTE risk assessments on admission.

In October 2017 a process for capturing hospital acquired VTEs was implemented, whereby the coroner and imaging department provide monthly reports of patients with confirmed pulmonary emboli and deep vein thrombosis. Root cause analysis is undertaken for all VTEs that had a hospital admission within 90 days.

There have been three incidences of hospital acquired VTE investigated in 2017/18 compared to seven in 2016/17.

The focus on the year ahead is to

Sustain the VTE compliance for risk assessments on admission above the 95% standard

- Work with imaging to reducing waits for Dopplers for diagnosis
- Implement the NICE 2018 VTE guidance
- Introduce patient information across the Trust explaining how to reduce the risk of VTE

Reporting Period	BTUH value	National Average
April 2017	91%	95%
July 2017	90.6%	95%
October 2017	95.9%	95%
January 2018	96.7%	95%
March 2018	96.3%	95%

Data source: BTUH performance report

Clinical effectiveness priorities

Care that is effective

The actions undertaken to achieve the 2017/18 quality goal - 'Clinical Effectiveness Priority' are described in detail in the table below.

Quality Improvement Goal	Aim	Achieved	2015/16	2016/17	2017/18	National average	Source	Comments
Reduction in cardiac arrests	Median per 1000 admissions	Achieved	1.75	1.25	0.97	Not applicable	Internal	Data Source: Balanced Scorecard (Target <=1.5) Apr17 - Feb18
Crude mortality	On or below 1.9%	Achieved	1.90%	2.05%	1.59%	Not applicable	Internal	Report R178
HSMR *	Below 95	Achieved	89.66	100.74	94.31	100	HED	HED Report Apr17 - Dec17
SHMI **	< 1.0	Not achieved	0.92	1.059	1.066	1.00	NHS Digital	NHS Digital - SHMI - Oct16 - Jun17

*Hospital standardised mortality ratio **Summary Hospital-level Indicator

Reducing Cardiac Arrests

Reducing cardiac arrests studies have suggested that nationally one third of all cardiac arrests are avoidable. Since the outcome of patients who undergo cardiopulmonary resuscitation (CPR) is poor, the Trust has worked hard to reduce the number of patients that require this emergency intervention. Strategies to improve the recognition of early signs of deterioration have been implemented so that appropriate management can be instituted to avoid the need for CPR. During 2017/18, interventions included:

- Completing a peer review of all patients who have a cardiac arrest on adult inpatient wards. This includes sharing lessons learnt and areas of good practice with the ward area and more widely
- Reporting any significant deficiencies in the early recognition and escalation of a deteriorating patient as a clinical incident which are then reviewed by the executive review group to decide the level of investigation required
- Introducing electronic observations (E-obs) to The Essex Cardiothoracic Centre and paediatric department
- Introducing peer review of cardiac arrests/ medical emergencies have been introduced in the Emergency Department and Critical Care Unit
- Developing an integrated care pathway for deteriorating patients which, in the pilot stage, includes sepsis, acute kidney injury and pneumonia
- This improvement programme has succeeded in reducing the cardiac arrest rate from 1.22/1,000 admissions to 1.00/1,000 admissions during the reporting year, which has achieved the aspirations for 2017/18. The trajectory for 2018/19 is to maintain the rate of cardiac arrests at the rate of 1.00/1,000 admissions and to continue to improve care delivery to this patient group. This will be supported by analyzing all medical emergency calls for patients who have not had a cardiac arrest, but have deteriorated clinically. This will provide robust intelligence to support the continued improvement work around the management of the deteriorating patient.

The 2018/19 goals are to:

- Continue to use the learning from cardiac arrest reviews - target is to review 90% within a four week timeframe of the date of the emergency
- Support robust alerting of changing clinical condition. E-Obs together with a new patient

administration system will be introduced to the emergency department

- Activate a bleep alerting of deteriorating patients to the medical team via the e-Obs observation system
- Launch an integrated care pathway for deteriorating patients module onto the E-obs system
- Sustain the median cardiac arrest rate of 1.00/1000 admissions and gain a comprehensive knowledge of the trends and themes that contribute to the patients clinical deterioration, which in turn will prevent cardiac arrest.

Mortality

The Trust monitors mortality using a number of measures:

- Crude Mortality Rate which is calculated by the Trust
- Hospital Standardised Mortality Ratio (HSMR) which is published by Dr Foster
- Summary Level Hospital-level Mortality Indicator (SHMI), a national indicator published by NHS Digital

Crude mortality

The Trust's rolling 12 month average for crude mortality at the end of March 2018 was 1.7% of all patients admitted to hospital or attended hospital as day case.

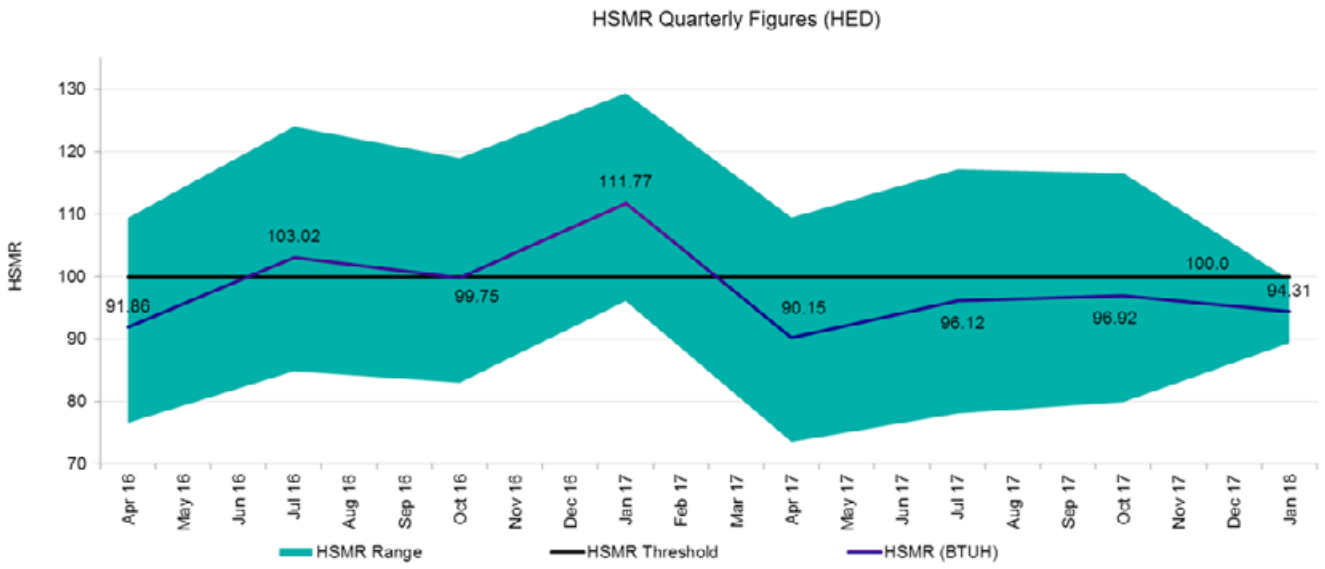
The crude mortality rate is a near real-time mortality metric that compares deaths to discharges. This metric is currently calculated differently across the hospitals in mid and south Essex and there is a need to standardise the metric to allow for cross-trust comparison. The primary difference relates to the number of discharges included in the denominator. Basildon and Mid-Essex Hospitals include day cases, but these are excluded from the calculations by Southend Hospital. It is proposed that all three trusts exclude day cases activity and deaths from the numerator and denominator.

It is also proposed that the three trusts adopt a common crude mortality threshold of 2.5%. This combined threshold will need to be reviewed periodically and it might be a requirement in the future for each trust to have their own individual threshold.

HSMR

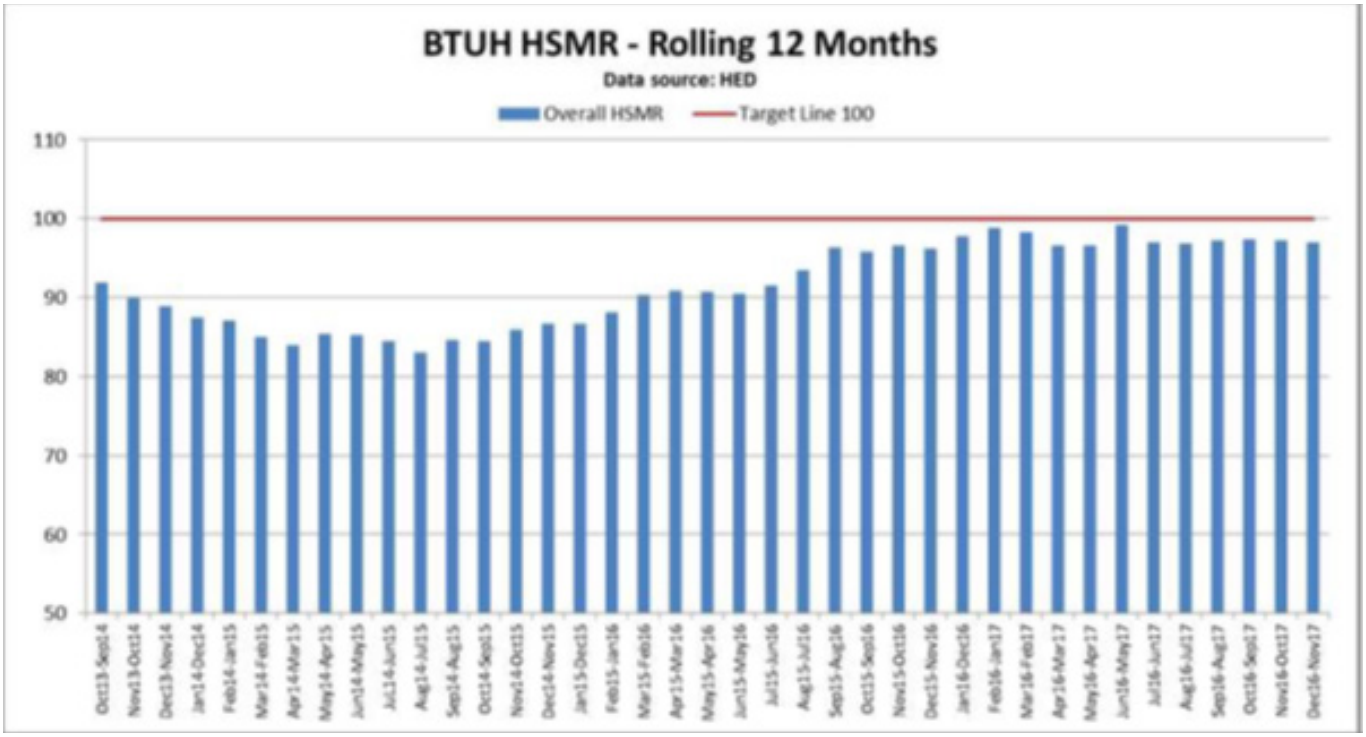
The Hospital Standardised Mortality Ratio (HSMR) is a statistical indicator of healthcare quality that demonstrates whether the mortality rate at a hospital measures if the number of people who die in hospital is higher or lower than expected. Therefore the HSMR is a ratio of observed deaths to expected deaths for 56 diagnosis groups, which represent approximately 80% of in-hospital deaths. The rate of death takes account of age, illness and additional influencing factors, such as living in a deprived geographical area of the country.

The Trust's HSMR and its variation is compared to a score of 100. A score of 100 indicates that the observed number of deaths matched the expected number. In order to identify if variation from this is significant, confidence intervals are calculated. To achieve this a statistical distribution model is used to calculate 95% and 99.9% confidence intervals and only when these intervals have been crossed is performance classed as higher or lower than expected.



Data source HED

The information provided by HSMR, acts as an indicator and allows hospitals to assess their mortality rates and if they fall above the average to instigate investigation into the cause. The Trust HSMR for the 12 month period January 2017 – December 2017 was 95.07, falling within the 'as expected' category and the twelve month rolling HSMR indicates a downward trend.



Data source BTUH

SHMI

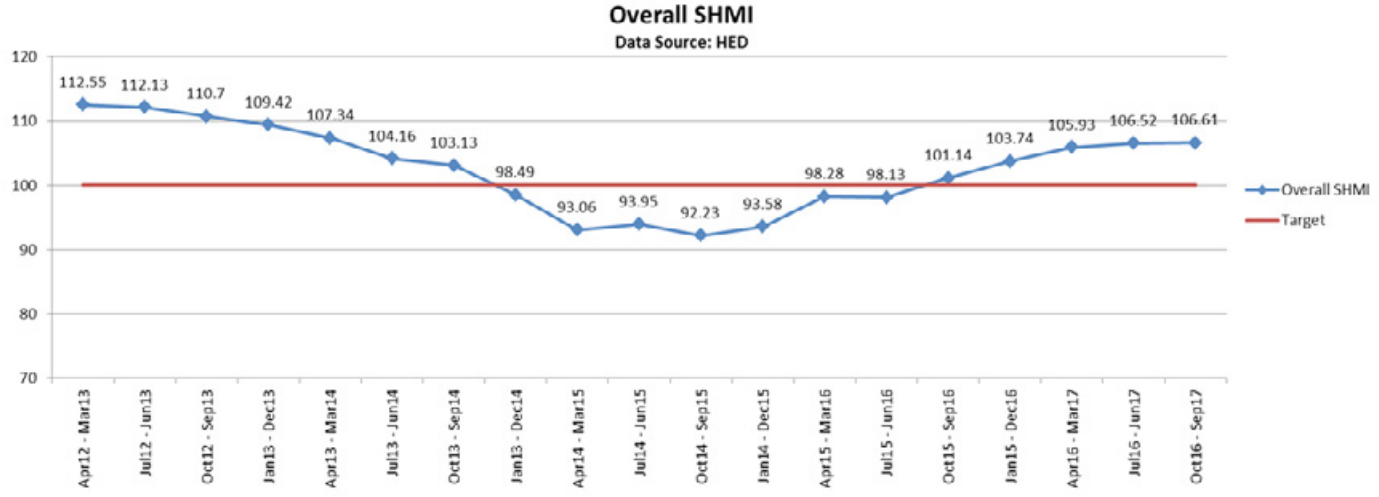
The Summary Hospital-Level Mortality Indicator (SHMI) is a high level hospital mortality indicator that follows a similar principle to the HSMR. The SHMI, like the HSMR, is a ratio of the observed number of deaths to the expected number of deaths. However there are differences which are demonstrated in the table below.

Key Differences between the HSMR and SHMI		
	HSMR	SHMI
Are all hospital deaths included?	No, approximately 80% of in-hospital deaths are included. This will vary dependent upon the services provided by each hospital.	Yes - all deaths are included
When a patient dies how many times is this counted?	If a patient is transferred between hospitals within 2 days of their death, it is then counted multiple times and included in the statistics of both hospitals.	A death is counted on one occasion, if the patient is transferred the death is attributed to the last acute hospital that cared for the patient.
Does the use of the palliative care code reduce the impact of a death on the indicator?	Yes – palliative care deaths are excluded from the data collection.	No – all deaths are counted.
Does the indicator consider where deaths occur?	This indicator only counts deaths that have happened in hospital.	This indicator counts in-hospital deaths and those deaths that happen within 30 days of discharge from that organisation.
Is this applied to all health care providers?	Yes	No - specialist hospitals are exempt from this indicator.

The SHMI indicator is only applied to non-specialist acute hospitals and the calculation is based on the total number of patient admissions to the hospital which resulted in a death either in hospital or within 30 days of discharge from acute hospitals. The indicator utilises five factors to adjust mortality rates, these are:

- The primary admitting diagnosis
- The type of admission
- A calculation of co-morbid complexity (Charlson Index of Co-morbidities)
- Age
- Gender

The SHMI shows whether the number of deaths is linked to a particular hospital is more or less than expected and demonstrates if the difference is statistically significant. NHS Digital published the latest SHMI on 22 March 2018 covering the period October 2016 to September 2017. The SHMI value was 106.61 which is within expected range. The goal for 2018/19 is to keep SHMI within the 'expected' range, with no avoidable deaths.



Data source HED

Trust Monitoring and Improvement Plan

The Trust's results have improved in the last 12 months, compared to previous 12 months in relation to crude mortality and HSMR. The results are within confidence interval for expected deaths, as measured by the SHMI indicator.

As a proactive dynamic organisation we are actively liaising with our local acute hospital partners, as well as national bodies and have implemented the medical examiner model of scrutiny of deaths. Medical examiners will ensure compliance with legal and procedural requirements of death certification, scrutinising case notes to ensure there are no care or service delivery issues. Selected cases will be highlighted for a more in depth mortality review. This supports the introduction of a joint 'Learning from deaths and mortality' review policy across acute hospitals in mid and south Essex.

Trust mortality is monitored through the Hospital Mortality Review Group (HMRG) and actions taken are scrutinised to evaluate the performance. HMRG is a senior clinical and managerial group that has strategic responsibility for mortality surveillance, reporting and corrective action. The group is chaired by the medical director with external scrutiny is provided by representation from the Clinical Commissioning Group and this group reports directly to the Quality and Patient Safety Committee to provide assurance. The HMRG brings all the divisions together to appraise current completed mortality reviews and action the learning identified.

To further strengthen this process a monthly meeting is held to scrutinise the outcomes of the HMRG, the overall mortality performance and any actions identified. The group consists of:

- Medical director
- Director of nursing
- Associate medical director for patient safety
- Deputy director of nursing
- Trust mortality lead
- Performance analyst

The learning identified has resulted in a number of improvement programmes for the Trust:

- Stepping up improvement programme, which focuses on improving patient flow from admission to discharge. 'Dr Foster' research demonstrates that trusts with higher bed occupancy have a higher HSMR, therefore the Trust ensures that capacity management has the highest priority both for clinicians and managers
- The Quality and Safety work stream builds on work to improve the management of the deteriorating patient and promote harm free care, both of which have a direct impact on reducing avoidable deaths
- Following medical examiner scrutiny, 25% of all deaths will undergo an in-depth mortality review
- In response to any disease specific mortality alerts raised by HSMR, a full and robust investigation was undertaken
- An Executive Review Group (ERG) has been established which meets three times a week to review incidents that require investigation. All serious incidents (SIs) including those associated with mortality are presented at the meeting following investigation. Recommendations and actions are approved and this ensures that the learning is shared and that care is improved
- The End of Life strategy is structured to improve services to meet the National Key Ambitions to improve end of life care
- Continuing to work with clinical coding to ensure the quality and depth of medical coding is maintained
- Learning from deaths

Number of patient deaths

During 2017/18, 1,354 patients died in Basildon Hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 312 in the first quarter
- 306 in the second quarter
- 334 in the third quarter
- 402 in the fourth quarter

Data source - PamsBi

Case reviews

Following national quality board's recommendations on review of deaths, the Trust is in the process of determining avoidability for these deaths that were investigated as serious incidents.

By 31 January 2018, 1099 case record reviews and 13 investigations have been carried out in relation to 1354 of the deaths included.

In 10 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 5 in the first quarter
- 2 in the second quarter
- 3 in the third quarter
- 0 in the fourth quarter

data source PAMSBi BTUH

Identified learning

In response to alerts from external organisations, focused speciality mortality reviews were undertaken by the multi-disciplinary team, in the following areas:

- chronic obstructive pulmonary disease
- aspiration pneumonia
- acute myocardial infarction
- poisoning
- fracture neck of femur

data source PAMSBi BTUH

Until March 2017 the Trust conducted a peer review for 25% of all deaths. This process will improve from April 2018, following the appointment of the medical examiners (ME). This role will facilitate an immediate scrutiny of the healthcare records, which will ensure timely identification of care delivery concerns. The clinicians will undertake a structured judgement review following the Structured Judgement Review guidance published by the Royal College of Physicians.

If there are any potential avoidable deaths identified by this review, the cases where concerns are identified will be presented at the Senior Executive Review Group, for peer review with the purpose of determining avoidability of mortality. In turn this will strengthen the identification and sharing of learning together with the response to improve care. For all reviews a thematic review is completed, learning and improvements are identified, then shared through the Hospital Mortality Review Group.

Previous Reporting

This data has been collected and presented prior to this reporting period. A retrospective review of available data has identified that of the 335 case record reviews, 10 serious incident investigations were completed after 1 April 2016, which related to deaths which took place before the start of the reporting period.

In March 2017 the National Quality Board directed acute trusts to produce data relating to learning from deaths and possible avoidability. Therefore the trust is not able to respond to request for this data, however for the next reporting period systems are in place to facilitate this for future reporting.

Data source - PamsBi

Deteriorating patient

Sepsis is a life-threatening condition that is the result of the body's response to infection, when it injures its own tissues and organs. Every year in the UK an estimated 100,000 people are admitted to hospital with sepsis and approximately 31,000 will die as a result of the condition each year.

The management of the deteriorating patient workstreams within the Trust have included all factors of deterioration, including Sepsis and acute kidney injury. This piece of work was undertaken following recognition of the multi-faceted clinical causes of patients decline in health. This enabled staff to initiate treatments and investigations to aid an earlier diagnosis of sepsis or other related conditions.

Improvements undertaken to drive this initiative in 2017/18 were:

- The deteriorating patient care bundle was introduced to clinical practice
- A deteriorating patient nurse was appointed to educate and evaluate care delivery
- The collection of data for national CQUINS with targeted quality improvement work streams to address care delivery issues
- There has been a reduction in sepsis-related mortality and the length of stay during 2017/18

Plans to build on this improvement for 2018/19 include the design and implement an E-obs version of the care bundle which will introduce automatic alerting.

This standard aims to ensure all patients who are emergency admissions to hospital are seen by a consultant within 14 hours of admission and where appropriate patients and families/ carers are actively involved in the shared decision making about their care. The Trust continues to develop this programme of work to ensure that patient experience is improved by early clinical review and access to radiology services.

Plans for how seven-day services will become sustainable will be included in the business planning cycle to ensure that the Trust is fully prepared for seven-day working by 2020.

Patient Experience Priorities 2017-18

Care that is personal

The outcome of actions taken to achieve the quality goal, 'Improving Patient Experience' are demonstrated in the table below:

Quality Improvement Goal	Aim	Achieved	2015/16	2016/17	2017/18	National average	Source	Comments
Patient - Friends and Family Test	Recommended on median	Achieved	97%	95%	96%	96%	NHS Friends and Family Test	Apr 17 - Feb 18
	Response rate inpatient: 40% Q4 in inpatient areas	Not achieved	31%	35%	37%	25.2%		Apr 17 - Feb 18
Staff - Friends and Family Test	Establish baseline in Q4 for proportion of staff uptake v. staff recommender score	Not achieved	67%	69%	71%	71%	National Staff Survey 2017	Q21C from Survey
Patient Reported Outcome Measures	Median or above	Data not available	Suppressed due to small numbers				NHS Digital	
Cancer survey	Median or above	Data not available	86%	91%	94%	89%	Quality Health 2016	% response to Q56: Overall the administration of the care was very good/good

Friends and Family Test – Recommender Score

The NHS Friends and Family Test (FFT) was created in 2013, to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for people to provide their feedback after receiving NHS care and treatment, focusing on inpatient care, accident and emergency, maternity and outpatient services.

The survey is completed across England and the results provide a benchmark to improve the patient experience of care delivery. The feedback

is used to help the Trust to improve the services we provide. The Trust-wide and divisional outcome data is presented to the Trust's Patient Safety and Experience Group (PSEG) for discussion and improvement actions agreed and via a divisional dashboard.

Reporting period	BTUH value	National Average	National lowest	National highest
April 2017	97%	96%	80%	100%
May 2017	97%	96%	76%	100%
June 2017	97%	96%	77%	100%
July 2017	96%	96%	80%	100%
August 2017	95%	96%	76%	100%
September 2017	96%	96%	72%	100%
October 2017	96%	96%	73%	100%
November 2017	97%	96%	73%	100%
December 2017	96%	96%	64%	100%
January 2018	95%	96%	75%	100%
February 2018	96%	96%	82%	100%

Data source: NHSE

The data for the Friends and Family Test is collected and reported nationally focusing on four areas:

- Inpatient care (including day case patients)
- Accident and Emergency care (including paediatric emergency care and ambulatory care)
- Maternity care (focusing on antenatal care at 36 weeks and postnatal community care at 10 days)
- Outpatient care
- The results are published monthly and are shared with the divisions for appropriate action.

The Trust recommender score for 2017/18 reflects the national average score of 95% for the twelve month period.

National Staff Survey 2017

The NHS Staff Survey is one of the best ways for staff to share views about their job and the NHS and the feedback given provides the Trust with important information about how to improve. The hospital had a good uptake with 2,231 people completing the survey and a response rate of 48%, compared to 42% last year, and above the average rate of 41% for acute trusts.

The staff engagement score is a significant indicator for hospitals and is used as a national benchmark in comparison to other trusts. Possible scores range from 1 to 5 (1 = not engaged, 5 = highly engaged) and the survey asks a range of questions around themes to calculate this score. With a score of 3.79 the Trust mirrors the average national rate.

The areas where staff feel the hospital excels and place the trust in the top 20% of acute hospitals are around confidence to report incidents, support given by immediate line managers and feeling that they are able to give patients quality care that really makes a difference.

Employee engagement continues to be a focus with a rolling programme of staff listening events helping to highlight and prioritise areas for action. The focus for the next year will be the continued development of clinical staff and managers, reviewing career paths to deliver exciting and diverse roles, improving the appraisal system to help all employees maximise their potential and giving all employees the opportunity to influence improvements across all areas.

The Trust is committed to recruiting talented individuals across all staff groups to ensure we continue to deliver high quality care to all those that need to access care and treatment in our hospitals.

National Patient Survey 2017

Listening to patients' views is essential to providing a patient-centred health service. The NHS introduced the patient survey programme to systematically gather the views of patients about the care they have recently received. The findings are shared with all NHS trusts, the Care Quality Commission and the public. The Trust analyses the results and identifies actions and the services provided to improve the experience of future patients. Patients' experience is sought dependent on the pathway they take, either as an inpatient, or receiving treatment from Accident and Emergency, Maternity or Children's and Young Persons' Services.

The National Patient Survey is published annually in June after surveying patients who used hospital services between September and January each year. The survey results from patients surveyed between September 2017 and January 2018 are expected to be published in June 2018 and are viewed by the Trust as rich evidence of the patient experience and will be utilised to ensure that the patient voice is audible and is the focus of all service improvements and developments. The annual results support the Trust to formulate a plan to continually improve the quality of our patients' experience.

Looking forward: priorities for improvement in 2018/19

Setting the quality agenda

The Trust aims to provide a safe environment for patients. We understand that treatments have inherent risks associated with them and the Trust continuously works towards reducing the risks of associated harm and to act on the learning when things go wrong. We promote an open and transparent culture. Trust staff are both encouraged and supported to report identified risks or when things go wrong and to openly express their concerns.

Following consultation with stakeholders, the areas listed below will form the core of our quality improvement work for 2018/19, supporting the Trust's strategic objective 'delivering high quality care 24/7'.

To achieve the key objectives for the coming year there are a number of strategies that remain fundamental to ensure that priorities are realised.

They are:

- Reduce mortality and improve end of life planning
- Safer maternity care
- Reduce avoidable harm through the BTUH Stepping up Improvement Programme
- Decrease avoidable patient deterioration
- Reduce health care associated infections
- Reduce medication related harm
- Improve patient experience and satisfaction
- Improve patient nutrition and hydration
- Improve the mental health crisis response pathway

The Trust's ambition is to achieve these within a framework of quality improvement supported and directed by external contexts such as NHS Improvement, Public Health England, Building on the Best and the Mental Health Crisis Care Concordat. All support the development of continuous learning and practice improvement with the aim to make the NHS the safest healthcare system.

	Priority for improvement	Key Objective	Measure	Rating
Patient safety	To provide harm free and safer care, for all patients we provide services to.	To reduce patient harm events	The priorities for patient safety and clinical effectiveness are part of the Trust's quality improvement programme and will be supported by quality improvement methodologies which assess effectiveness of process and support a dynamic, timely response to the data. Data is then presented monthly to the executive leads at the Stepping up board.	Mostly achieved
Clinical effectiveness	To improve the quality and reliability of the care delivered. By implementing best practice this will support the delivery of high quality care for our patients.	To prevent patients' clinical deterioration		Achieved
Patient experience	Improving patient experience by providing our patients and their carers the best possible experience while they are using our services	To improve patient experience and satisfaction	Patient experience is monitored via a number of metrics that indicate the quality of experience. These include Friends and Family Test (FFT), responsiveness to PALS and complaints. All metrics are presented in the Integrated Quality Report and drive improvement.	Mostly achieved

Red Quality priority not achieved **Amber** Quality priority partly achieved **Green** Quality priority achieved

Source: Patient Safety Priorities 2017/18

Reflections on quality improvements made in 2017/18

In this section we present a number of examples from across the Trust of high quality care initiatives that have been implemented in 2017/18 to improve the care, safety and experience of our patients. The overall aim is to increase the capability and capacity of our workforce to deliver care that is compassionate, safe and effective.

Emergency Care Services

Ambulatory Care

To improve the experience of our patients who access acute and emergency care, the teams have continued to develop previous service improvement projects. Since the introduction of the Ambulatory care Unit in July 2014, the success of the service is demonstrable by the increase in the number of patients accessing the service. In April 2015, 400 patients were seen in Ambulatory Care and more recently the service provides care for an average of 1000 patients each month.

Falls Risk Management in acute medical units

In response to learning identified from previous falls related incidents, the Acute Medical Unit (AMU) teams have reviewed the care of patients with an associated high risk of falls and injury. To further develop the scope, sustainability and quality of the service, the following initiatives have been implemented:

- For high risk falls patients, the team have introduced high risk falls bays, supported by dedicated increased nursing supervision of the patients at all times
- Promoted the use of yellow non-slip falls socks to make patients safer when mobilising
- Implemented staff training in relation to falls risk management
- Improved the utilisation of the falls alert alarms to support patient safety
- The AMU FallSafe Champions support the Trust's programme of improvement and undertake monthly falls audits, which inform local improvement needs
- Patient falls has now been adopted as a standing agenda item at the monthly clinical governance meeting
- Falls risk is documented on the division's risk register, recognising that the AMU is the patients first point of entry to the hospital and for many patients often the falls risk is higher during the acute phase of their clinical condition
- Success has been proven by a consistent reduction in falls on AMU in recent months with February and March 2018 demonstrating

the lowest number of patient falls over the last 6 months. In 2016 the falls rate in the AMU averaged 15 per month and during 2017/18 this has reduced to between 0 – 2 each month, demonstrating a shift change in falls risk management culture within the unit.

Timely clinical review

During 2017/18 a 'Rapid Assessment Triage Tool' was designed and implemented, with patients assessed by a senior clinician on presentation to emergency care. The objective is to make the patients' pathway more effective and streamlined. A senior clinician patient assessment results in earlier treatment, investigation, onward referral to a clinical specialist and therefore earlier discharge from emergency care or admission to the hospital's inpatient services. In turn this promotes improved patient access and flow through the hospital pathways of care.

Dignity

Improvements have been made to further respect the dignity of female patients. It has been identified that women with gynaecological and obstetric concerns who require sanitary products are at times compromised by the manner in which such products are presented to them. The emergency care housekeepers have worked to ensure that all sanitary products are now given to women in a discrete package, which in turn ensures that the confidentiality and dignity of the patient is fully respected.

Maternity services

Birth Afterthoughts

Maternity services continue to introduce new services that enhance Midwifery care. The past year has seen the introduction of Birth Afterthoughts, which is available to support all women following the delivery of their baby. If they have any unanswered questions relating to their experience they can ask these questions of the Birth Afterthoughts Midwife, via email.

Birthing Options

A programme of support called Birthing Options is now available, this service supports women to make an informed choice regarding their birth plan and is facilitated by the midwives at the maternity unit. This initiative is aimed at expectant mothers who may fall outside the clinical criteria to allow them to proceed with their birth plan of choice i.e. a home birth.

Maternity lifestyle clinics

Lifestyle clinics have also been established to assess and support maternal health in pregnancy, focusing on health factors such as weight and smoking.

Maternity Direct PLus

During 2017/18 the team in maternity have further developed the maternity direct services, introducing Maternity Direct Plus. Maternity Direct Plus allows expectant mothers to contact a midwife via a Facebook page, the midwife will then be available to respond to non-urgent questions. Useful information is also shared in daily posts, including topics such as:

- Pregnancy related health
- Articles published in the press
- How partners can help
- Pre-pregnancy advice
- Pregnancy and post pregnancy advice etc

As Maternity Direct is led by experienced midwives, women are assured that they will be provided with sound, evidence-based advice and support. Facebook is the primary social media outlet for Maternity Direct but the service also has a Twitter feed and regularly tweets current topics of interest.

The project has been such a success it has received national recognition, receiving the British Journal of Midwifery (BJM) 2018 Practice Awards for 'use of technology in midwifery'.

Maternal Diabetes

The maternal gestational diabetes team have responded to patient feedback. They have introduced EGGS (**E**ducating **G**estational diabetic, **G**roup **S**ession), to empower women in monitoring and managing this condition.

The team aims to facilitate a clinical review of women within seven days of a first positive glucose tolerance test. The EGGS project won a Health Enterprise East Innovation Award in 2017.

Early Notification Scheme

In April 2017 NHS Resolution launched the Early Notification Scheme (ENS). This is a requirement for trusts to report all maternity incidents occurring on after 1 April 2017 which are likely to result in severe brain injury. The Trust has been compliant in notifying the ENS Scheme of all babies delivered which meet the criteria.

A robust process has been set up between the division, patient safety and legal services so that all babies are reported via the incident reporting system. All babies meeting this criteria are declared as a serious incident (SI) via the Executive Review Group process. The SI is investigated by a trained investigating officer and a root cause analysis report is generated into the incident. This is shared with the individuals involved in the incident, within the division and with the family following the completion of the report.

Digital technology improvements

Electronic Observations and Assessments

This system has now been in place for two years and is available in all clinical areas with the exception of maternity and emergency care, both of which are in development with the aim to bring them on line in 2018/19.

This system facilitates a more cohesive pathway of care, directly linking patients' observations, assessments and care pathways.

The following have been developed and implemented into clinical practice during 2017/18:

- Stool assessment and chart
- Nutrition assessment / MUST / Food charts
- Weight
- VTE
- Neurological Observations
- Fluid and Hydration charts

The Trust plans to implement the following during 2018/19:

- Infection Control
- Falls
- Tissue Viability
- Elimination
- Mobility

These assessments and pathways are subject to co-design and testing with the Nurse Specialist teams, together with the Deteriorating Patient Group, to ensure the detail required is included.

Ordercomms

Hospital radiology requests are now live via Electronic Patient Records (EPR) across inpatient services and the majority of outpatient services. Maternity services are in the process of implementation and a pilot in pathology is also scheduled in 2018/19.

GP Ordercomms, have successfully piloted radiology at three sites and requests are being received by the x-ray department. A phased implementation programme is planned for 2018/19.

Electronic Patient Records (Medway System C)

Electronic patient records will be introduced to emergency care in 2018/19. A new bespoke module is in design to meet the specific requirements of emergency care, with the aim that it will enable an effective and efficient movement of patient information within the system.

TeleTracking

This is an electronic patient flow system that facilitates oversight and coordination of hospital activity and will incorporate information from other hospital information systems. Work towards implementation is currently in the design phase across the three of the hospitals in mid and south Essex, with the aim that the Southend Hospital will be the first adopter in the autumn of 2018.

Additional improvements implemented in 2017/18

Work during 2017/18 has facilitated the following improvements:

- A standardised handover template and electronic system has been designed and implemented. This will support nursing staff to communicate patient care issues effectively within wards and also between wards following patient transfer. It reduces the need for duplication of information and removes the need for paper handover documents as it is located on the E-obs mobile tablet.
- The digital team have developed a portal to access a web-based programme that supports the accurate record keeping of staffing and skill mix within the organisation. This is maintained daily and provides the capacity to forward plan, which will contribute to improving care delivery, patient safety and staff experience
- To promote clinical staff engagement with the digital development teams, a clinically focussed working group has been established, the Informatics Clinical Advisory Group (iCAG). The aim is to encourage clinical staff to interact with the digital teams and bring new ideas for development. iCAG will also explore new projects and prioritise them for development based on clinical, resource and financial aspects
- Dementia Care

Admiral Nurse

In 2107, the Trust was the first acute care organisation in Essex to be fortunate to obtain sponsorship from Dementia UK. This led to the appointment of the first Admiral Nurse in an Essex acute hospital setting. The Trust now works in partnership with Dementia UK to ensure patients and their families with dementia have access to specialist support.

Using the Admiral Nurse Service as a catalyst, Dementia UK provides specialist dementia support for patients and families, particularly when they face new challenges. This service was launched in October 2017 following the appointment of the Trust's Dementia Lead Nurse into the role of Admiral Nurse. This appointment has resulted in a cultural shift in the Trust's focus on dementia care and builds on the strategic work previously undertaken. The nurse works in partnership with the patient with dementia and their families, providing one-to-one support, expert guidance and practical solutions. Their knowledge of the challenges that dementia presents to patients in hospital can result in shorter hospital stays and ensure a more coordinated approach to the care for people with dementia in hospital and following discharge.

Improvements in dementia care

During 2017/18 the following improvements were introduced to support the care of patients with dementia.

- The Trust's Dementia Strategy Group continues to act as driver for change, adopting the Staff **P**artnership **A**ssessment **C**are **E**nvironment (SPACE) acronym, identified by people with dementia and presented as optimum standards of care
- The Trust dementia charity, The Butterfly Dementia Appeal has in 2017/18 been the nominated charity of a number of large local organisations and events. This has contributed a considerable sum of monies that will allow the Trust to enhance care during 2018/19
- A review of all Trust policies relating to the care of people with dementia, to ensure they provided accurate guidance
- Quarterly carers support workshops for dementia, were hosted by the Trust and delivered by a local care agency

- A professional network was established with the local hospice and The Alzheimer's Society. The aim of this network is to promote the trusts dementia care approach, education, identify opportunities that will enhance the care and support of people with dementia and their families
- Previously two of the three older people's wards had their dayrooms refurbished into a reminiscence room. 2017/18 saw the final older peoples ward day room refurbished completing this project
- Marks & Spencer Charitable Works supported the refurbishment of a dayroom on the orthopaedic rehabilitation ward. This created a dementia friendly environment, with a tea room theme that supports the ongoing therapy assessments prior to discharge
- Round 3 of the National Dementia Audit (NDA) was completed, facilitated by the Royal College of Psychiatrists. This information drove a number of improvements:
- Introduced a buffet meal option across all patient areas.
    - Improvements to the Carers Survey which added a professional point of contact for carers with concerns they wished to explore further.
    - The trust supported the appointment of the Admiral nurse.
    - The trust participated in the 'Spotlight audit', the results of which are not yet published, to improve care of patients with delirium
    - The care of patients with delirium - this is now a standing agenda item on the Trust's dementia strategy group.
    - The dementia strategy for staff education will be re-examined.

Aspirations for 2018/19

2018/19 will focus on improving the experience of this patient group and some of the improvements planned to support this are:

- Participate in round 4 of the National Dementia Audit, facilitated by the Royal College of Psychiatrists
- In line with NHS England guidance, investigate and introduce Advance Care Planning for people with dementia
- The introduction of buffet meals for patients with dementia to all patient clinical areas, this will be evaluated to drive further service improvement
- Increase the targeted resources to support care, such as the **R**eminiscence **I**nteractive **T**herapy and **A**ctivities (RITA), dementia resource trolleys
- Review all clinical care related policies within the Trust to ensure inclusion of dementia and delirium care
- Develop and implement a formal education strategy for clinical staff
- Publish a robust policy for care of people and families with dementia
- Act in response to the results of the Spotlight Audit, which will drive the development of a robust pathway of care for patients with delirium

Safeguarding adults, maternity and children

Safeguarding has remained a key priority for the Trust and the Corporate Safeguarding Team, that has been easily accessible to all offering their expert knowledge and skills to safeguard all patients within the Hospital.

Marked improvements to the Safeguarding service were achieved in 2017/18 by the joint and collaborative work of the Corporate Safeguarding Team. Listed below are areas of success:

Policies

The team were able to embed changes from legislation, statutory guidelines, learning from serious case reviews and domestic homicides to reflect in our policies. The Mental Capacity Act, female genital mutilation (FGM), chaperone and safeguarding supervision policies have been revamped to reflect changes. These policies were also recreated to reflect the corporate safeguarding team functions - children and

young people, vulnerable adults and maternity safeguarding.

Key performance Indicators

Training has been a key priority for the Corporate Safeguarding Team, working efficiently and effectively with divisional leads to ensure the Trust is compliant. It is with great pleasure that in the last two quarters compliance had been obtained on all levels of training for children and adults.

The aim is to ensure that the Trust steadily maintains compliance and has a workforce that is not just trained but also has good knowledge and skills to safeguard all patients.

The Trust has been able to demonstrate to the Local Safeguarding Boards (LSBs - Thurrock and Essex) its commitment to ensuring efficient, effective and safe service delivery to children, young people and vulnerable adults at risk of abuse. This has been reflected in the Section 11 audits carried out annually for Essex and Thurrock LSBs. The Safeguarding Corporate team has successfully maintained their participation and gave health expertise contribution to the LSB Group meetings. LSB representation by the Trust has been anchored by transparency, an open culture and peer review recognising the LSB's regulatory oversight and critical appraisal duties with regards the quality of our services.

The Corporate Safeguarding Team maintained harmonious relationships with all key stakeholders over the year. The external relationships with the CCG have seen two quality visits and ratification of all new policies. The teams have worked closely with social care attending and participating in joint forums and hosting Social Monthly for Children Psychosocial meetings.

The Safeguarding Board meetings held quarterly have strengthened internal relationships and facilitated a platform for disseminating information to all divisions and ensuring a seamless service within the Trust. The Safeguarding Board continues to demonstrate to the Trust Board as follows:

- Assurance that safeguarding practice is person-centred and outcome-focused
- The Trust is working collaboratively to prevent abuse and neglect where possible
- Timely and proportionate responses when abuse or neglect have occurred
- Assurance that safeguarding practice is continuously improving and enhancing the quality of life of vulnerable children and adults within the local area
- A member of the Safeguarding Team attends the Executive Review Group where all incidents are discussed and reported accordingly. In addition they attend the Harm Free group which reviews all incidents in relation to pressure ulcers and falls highlighting themes arising and learning that can be shared with other services.

The team has successfully launched the Child Protection Information System; a national database used to identify children known to social care and are at risk of harm. This means that health and social care staff have a more complete picture of a child's interactions with health and social care services. This enables them to provide better care and earlier interventions for children who are considered vulnerable and at risk. The first phase has been to unscheduled care such as emergency department and the Paediatric Assessment Unit.

The Essex Domestic Abuse Partnership Project (EDAPP) supports all people suffering domestic abuse. The service is based on the Basildon hospital site and is able to respond promptly to all safeguarding domestic abuse concerns raised. The project also supports the Trust by training any member of staff in the awareness of domestic abuse.

The key aims in 2018/19 are:

- To embed the Safeguarding Champions role within all wards and departments
- Implement the Child Protection - Information Sharing Project (CPIS) to the Maternity Service
- To achieve and remain compliant with training targets
- To work closely with Mental Health Providers

Emotional Health and Wellbeing (EWMHS) and Raid to ensure safeguarding is embedded within their service delivery

- To respond to new legislation and statutory guidelines ensuring these are reflected in Trust policies
- To increase the number of NSPCC trained safeguarding supervision supervisors

Learning Disabilities

The last year has seen the Learning Disability liaison service develop and broaden its scope. The service has continued to support the hospital, wards and staff to implement reasonable adjustments for people with learning disabilities. This has enabled sometimes profoundly disabled individuals to receive investigations and treatment they would struggle to get on a general pathway due to their level of need. The Trust is in the final stages of developing and implementing a scanning pathway which will ensure that all patients with a learning disability are supported to access scans. This was developed after it was identified that people with learning disabilities were experiencing delays and failures to proceed with scans, resulting in delays in diagnosis and/or treatment.

The service has continued to increase its training and awareness initiatives, departments are now able to request training via a form found on the Trust intranet. The learning disability liaison service has also commenced teaching to junior doctors, therapy departments, imaging, pathology and hospital social care teams. In order to build upon partnership working and provide people with learning disabilities the best care in the community it has been agreed that outside agencies will be able to access the training supplied by the Trust learning disability service.

Recognising the increasing pressures on social care the Learning Disability service has developed strong links with social care hospital teams. This has facilitated closer collaborative working and a social worker to support learning disability cases. This has been driven by the need to ensure effective discharges for people with learning disabilities whilst ensuring that individual needs are assessed and packages adjusted where needed.

In 2017 the Learning Disabilities Mortality Review (LEDER) programme, run by Bristol University was started.

Moving forward, the service is looking to work closer with community providers, and work with paediatrics to implement an effective transition pathway that supports children with learning disabilities.

Clinical support services

Mortuary and Pathology Services

There has been an annual increase in the demand on mortuary and pathology services, which has impacted on the care and experience of bereaved families. In response to this demand a multiprofessional working group has been established, the Bereavement and Mortuary Operational Group. The membership is comprised of all stakeholders in the mortuary pathway:

- Coroner's office
- Funeral directors
- Bereavement team
- Chaplaincy team
- Mortuary team
- Head of professions and quality for the division
- Service unit manager
- Matron
- Emergency planning liaison officer

The optimum aim of the group is to promote the service, learn from previous concerns, review activity, to share and implement best practice.

Joint pathology governance

The Joint Venture Pathology Integrated Governance Group was established in 2017, to promote good governance, transparency and openness within the joint pathology venture, between the Trust, Southend University Hospitals Foundation Trust (SUHFT) and Integrated Pathology Partnership (IPP). This is a multi-professional forum that includes representation

from all organisations involved in the joint venture:

- Quality team at IPP
- Hospital governance teams
- Patient safety teams
- Service management

The aim of this forum is to establish robust pathways to facilitate the sharing of data, where possible standardise processes across all sites and to provide comparators and visibility of results.

Haematology Day Unit

In September 2017, the adult chemotherapy unit installed an end of treatment bell. It was the 115th bell to be installed as part of a Facebook campaign and was provided by private sponsorship. For patients with cancer and their healthcare teams, the ringing of the bell is a significant moment, a point in time that signals the end of active treatment and the beginning of a life after treatment.

To enhance their patients experience, the team has also designed and commissioned a quiet space room that provides their patients the opportunity to receive complementary therapies, such as massage and counselling.

Appointment reminders service

Historically there is an average of 12.3% missed appointments per week when patients have not notified the Trust. To support the efficient use of outpatient appointments, which in turn will have a positive impact on outpatient waiting times and subsequent access to treatment. The Trust commissioned a text outpatient appointment reminder service.

The text reminder service has significantly reduced the number of patients who did not attend since its launch in September 2017.

Harm review

Harm Review Process for suspected cancer patients waiting longer than 62 days for diagnosis or treatment

In 2016/17 NHS England agreed that local commissioners would monitor individual Trusts against a CQUIN (Commissioning for Quality and Innovation goal). The goal ensures all patients waiting longer than 104 days for diagnosis or treatment of cancer undergo a root-cause analysis (RCA) and a clinical review to determine if any harm had been caused due to delay. The rationale for this goal was to ensure that efficient investigation, diagnosis and treatment of cancer occurred as it was essential to ensuring a positive patient experience and improving cancer outcomes.

In January 2017 the Trust developed a standard operating procedure (SOP) which covers the oversight and management of a process for undertaking a root cause analysis and clinical harm review for any suspected cancer patients waiting 104 days or over. The aim is to provide assurance that all avoidable patient pathway delays are reviewed and actions implemented to reduce the risk of any future patient harm. This was revised in June 2017 to include all patients waiting longer than 62 days for diagnosis or treatment this includes the 62 day standard, consultant upgrade and screening breaches.

A harm review panel is held weekly in order for each RCA and clinical harm review to be presented. Where harm has been identified the case is escalated to the Trust Executive Review Group (ERG). Themes and trends identified are reported to the Cancer Board.

Stepping up programme

The Trust Stepping up programme consists of five priorities, each priority represents a targeted area where we want to increase our effectiveness and improve quality. Each priority is led by a member of the site leadership director team. The five priorities and the key areas of focus are

Harm free care

- VTE
- Pressure ulcers
- Medicine Management
- Infection Prevention
- Adult and paediatric deteriorating patient, incorporating avoidable mortality
- Seven day working is also a key work area

Patient flow

- Shorten length of stay
- Redesign patient pathways
- Speed up treatment and discharges

Planned care

- Cut waiting times for elective patients
- Raise productivity in theatres
- Enhance outpatient experience

Smart working

- Deliver cost improvements, make best use of resources, have confidence in our abilities through focusing on
- Cost Improvement Programme (CIPs)
- Job planning

Valued staff

- Meet agency spend targets
- Manage our rosters
- Recruit and retain staff

The Essex Cardiothoracic Centre

Minimally invasive heart valve replacements for CTC patients

A procedure to replace damaged heart valves, which does not involve major surgery, was introduced during 2017 for patients at The Essex Cardiothoracic Centre (CTC). Narrowing of the aortic valve, known as stenosis, leads to obstruction of blood flow out of the heart. It is the most common form of heart disease and occurs in 2-4% of adults over the age of 65 years. People suffering from this common form of heart valve disease no longer have to travel to London for the minimally invasive treatmentwhich is a safer option than open heart surgery, with a lower risk of infection and a faster recovery time.

Transcatheter aortic valve implantation (TAVI) is a cardiology procedure that can be done under sedation rather than a general anaesthetic. A catheter (hollow tube) with a balloon at its tip is inserted into an artery, usually in the groin. The catheter is passed into the heart and positioned in the opening of the aortic valve. The balloon is gently inflated and the new aortic valve is placed in position, inside the damaged valve.

Resuscitation service

Innovation in cardiopulmonary resuscitation training

Cardiopulmonary resuscitation (CPR) is an emergency procedure using chest compressions and rescue breaths that can prevent death or brain damage, for a person whose heart has stopped. It's an important skill for clinical staff, but some professional groups of staff, do not regularly deal with emergencies and therefore do not frequently utilise resuscitation skills. Research shows that the quality of CPR skills deteriorates if not used regularly. To address this problem, a new training programme has been designed for clinical staff who have limited exposure to clinical emergencies, this delivers the training at frequent intervals of three months rather than the current annual programme.

The Resuscitation Quality Improvement system (RQI) uses adult and infant manikins to practice CPR skills. The manikins are linked to a computer system that gives live visual and spoken feedback, informing the practitioner how effective the resuscitation is and also provides guidance on how to improve.

Basildon was the first hospital to introduce this innovation in training for the hospital therapy team. Physiotherapists, occupational therapists, together with speech and language therapists do not often encounter medical emergencies in their daily clinical practice. However, they work with patients of all ages and a range of clinical conditions and therefore it is important that they have competent skills that enable them to respond to a cardiac arrest.

RQI is used in conjunction with face-to-face training by the resuscitation service. Supervised by the resuscitation service, therapists take part in varied, short training sessions every three months. In one session they may carry out CPR on the adult manikin and in another rescue breaths on the baby manikin. Practising these skills at

regular intervals, supports the confidence of the therapist to provide CPR.

Paediatric care

Patient experience in paediatrics

During 2017 the oncology suite on Wagtail ward was refurbished and now includes a wet room, fitted kitchen, dining area, parents' bed and integrated sensory toys / equipment. The play room on the unit has also been refurbished and painted, with fitted cupboards and a sensory room installed.

The End of Treatment Bell for children to ring when they have completed chemotherapy or radiotherapy continues to be a success. Where possible for the younger children, staff combine the ringing of the bell with a visit from a favourite princess or super hero.

Patient experience on the unit continues to be enhanced by the work of a number of charities. Polly Parrot, The Karis May Darling foundation and POD children's charity are all actively engaging in the work of the unit. Monthly visits from Mr Skittles a children entertainer are supported by POD and the Karis May Darling foundation funded the annual Christmas party for the long term patients on the children's ward.

Division of medicine

Endoscopy

The endoscopy department has received a prestigious accreditation for the quality of its work. Staff were praised by inspectors for "the high standard of achievement and for their hard work during the accreditation process". The team was then awarded Joint Advisory Group of the Royal College of Physicians for gastrointestinal and endoscopy accreditation for one year. The unit was praised for many aspects of the service, including high quality, safe endoscopy for all patients, excellent all-round leadership and the compassionate attitude of the staff.

Respiratory Care

The respiratory team at Basildon Hospital received an accolade from the Royal College of Physicians (RCP) for the care and treatment they provide.

All hospital respiratory teams are now required to submit regular audit data evidencing the treatment of patients with chronic obstructive pulmonary disease (COPD). The first results for this new national audit show that the Trust is one of the best performing in London and the south east of England. The results demonstrate the team's ability to meet the standards set by the RCP. These include patients being seen by a specialist within 24 hours of admission and for patients to be assessed for an exercise and education pulmonary rehabilitation programme. The lead respiratory nurse specialist was then invited to present at a professional workshop at the RCP in London, to share the team's achievements. This award is a reflection of the team's commitment to maintaining and improving upon their high standards of care delivery.

Surgery

Development of Surgical Ambulatory Care Unit (SACU)

During 2017/18 SACU has evolved and improved the quality of surgical services for our patients. The aim of the service is to reduce the number of patients attending emergency care, as they can be directly referred to the unit and to contribute to reducing the potential for admission. The number of patients seen by the service has increased with an average of 400 patients per month, with less than 10% requiring admission. The unit is now a seven day service and sees all patients irrespective of age. This success has led to investment in the infrastructure and refurbishment of the unit, which now includes a dedicated ultrasound room to allow the investigation to be completed on the day of attendance.

End of life care

Building on the Best

'Building on the best' is a partnership between the National Council for Palliative Care and Macmillan Cancer Support, the aim of which is

to enhance existing care in hospital settings, by embedding compassion and choice for everybody at the end of life. This is facilitated by support, knowledge and leadership, so that all hospital patients receive high quality care, that reflects the wishes and needs that they have identified and those of their family, as they approach the end of their life.

The Trust is one of ten sites that have participated in this project and the team had three key aims:

- To increase the use of an Individualised Care Plan (ICP) to support patient care in the last few days of life and ensure patients receive optimal end of life care
- To commence Advance Care Planning (ACP) at the right time, in the appropriate care setting and to minimise repeated, difficult conversations with numerous health care professionals
- To improve the bereavement experience of our relatives and carers

To achieve these aims the following programs of improvement have been implemented throughout 2017/18:

- The appointment of a Bereavement Clinical Nurse Specialist in July 2017
- A bereavement survey for all expected deaths was introduced and in March 2018 the scope of the survey was widened to survey bereaved families and carers involved in both expected and unexpected deaths within the Trust
- A nurse-led DNACPR and Treatment Escalation Plan (TEP) initiative has attracted Macmillan grant funding to support the education of nurses to widen the implementation and impact of this initiative
- A nurse-led ACP and Holistic Wellbeing outpatient clinic has been implemented, that focuses on non-malignant disease, in particular motor neurone and respiratory disease
- Training and education led by Macmillan Link Nurses to establish end of life care competencies for all nursing staff
- The development and implementation of an electronic core training module for all staff to complete, that develops knowledge of end of life care
- Nurse Led initiation of ICP outside of hours for patients with a completed DNACPR and TEP form
- In response to an audit of the use of the ICP, the Bereavement CNS has targeted improvements in areas identified by the audit as poor implementers of the ICP
- To improve communication with partners in community care, established an electronic register of end of life care pathways established for patients ie ACP
- The dandelion symbol was launched to promote dignity in death throughout the Trust, alongside this bereavement support Resource boxes were presented to all inpatient wards
- The Trust is now able to offer lasting memories keepsakes to the bereaved families and carers. They are finger print key rings and hair locks keepsakes
- The publication of Hospital centered Bereavement Counselling Leaflet
- In July 2017, participated in research led by Healthwatch Essex, which focused on the communication of Advance Care Planning and the experience of patients and carers from different specialities and care settings within the acute hospital, renal outpatients, medical cancer ward and the palliative care clinic
- Developed and implemented a local audit structured on the NICE quality standards for end of life care, published in May 2017
- In February 2018 the Medical Examiners role was introduced to bereavement services

Reporting against core indicators

i) Summary Hospital-Level Mortality Indicator (SHMI)

A SHMI of greater than 1 implies more deaths occurred than predicted by the measure.

The tables below show the values for SHMI for the Trust for the reporting period.

a) Our latest SHMI result for the period to September 2017 is 1.066.

Publication Date	Reporting Period	BTUH value	BTUH SHMI Banding	National Lowest	National Highest
Jun 2017	January 16 - December 16	1.036	1.003	0.691	1.173
Sep 2017	April 16 - March 17	1.059	1.005	0.708	1.178
Dec 2017	July 16 - June 17	1.065	1.005	0.726	1.171
Mar 2018	October 16 - September 17	1.066	1.005	0.727	1.164

b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust is 30.3% for the period to September 2017

Publication Date	Reporting Period	BTUH value	National Lowest	National Highest
Jun 2017	January 16 - December 16	27.1%	7.3%	55.9%
Sep 2017	April 16 - March 17	29.2%	11.1%	56.9%
Dec 2017	July 16 - June 17	29.5%	11.2%	58.6%
Mar 2018	October 16 - September 17	30.3%	11.5%	59.8%

The Trust considers that this data is as described for the following reasons: the data is reported and monitored externally to the Trust and is based on data published by the Health and Social Care Information Centre. The Trust also uses a proxy measure to calculate hospital mortality which helps assess the validity of all mortality data.

The trust is committed to improve all factors relating to mortality and this is discussed in the mortality section (page 94)

ii) Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. They measure a patient's health status or health-related quality of life at a single point in time, and the information is collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

A higher response number indicates a more positive patient response.

Hip replacement surgery (primary)						
Publication date	**Reporting period**		**BTUH value**	**National average**	**National lowest**	**National highest**
August 2015	April 2014 - March 2015	EQ-5D Index	0.436	0.436	0.331	0.524
		EQ VAS	12.529	12.000	6.441	17.310
		Oxford Hip Score	21.876	21.400	16.291	24.651
August 2016	April 2015 - March 2016	EQ-5D Index	0.492	0.438	0.320	0.512
		EQ VAS	12.400	12.404	4.962	18.720
		Oxford Hip Score	22.723	21.607	16.884	24.755
May 2017	April 2016 - March 2017 (provisional)	EQ-5D Index	0.439	0.445	0.310	0.537
		EQ VAS	11.844	13.433	8.523	20.150
		Oxford Hip Score	22.354	21.799	16.427	25.068
February 2017	April 2016 - December 2016 (provisional)	EQ-5D Index	Suppressed due to small number of questionnaires returned			
		EQ VAS				
		Oxford Hip Score				

Source: NHS Digital

Knee replacement surgery (primary)						
Publication date	**Reporting period**		**BTUH value**	**National average**	**National lowest**	**National highest**
Aug 2016	April 2014 - March 2015	EQ-5D Index	0.293	0.315	0.204	0.418
		EQ VAS	3.519	5.800	1.133	15.405
		Oxford Knee Score	15.301	16.100	11.430	19.581
Aug 2017	April 2015 - March 2016	EQ-5D Index	0.339	320.000	0.198	0.398
		EQ VAS	6.693	6.222	1.631	12.628
		Oxford Knee Score	16.609	16.365	11.955	19.970
Feb 2018	April 2016 - March 2017 (provisional)	EQ-5D Index	22.354	21.799	16.427	25.068
		EQ VAS	6.232	6.977	1.008	14.502
		Oxford Knee Score	17.448	16.547	12.508	19.876
February 2017	April 2016 - December 2016 (provisional)	EQ-5D Index	Suppressed due to small number of questionnaires returned			
		EQ VAS				
		Oxford Knee Score				

Source: NHS Digital

Groin hernia						
Publication date	**Reporting period**		**BTUH value**	**National average**	**National lowest**	**National highest**
Aug 2016	April 2013 - March 2014	EQ-5D Index	0.079	0.084	0.000	0.154
		EQ VAS	-0.710	-0.500	-4.694	4.550
Aug 2017	April 2014 - March 2015	EQ-5D Index	0.093	0.088	0.021	0.157
		EQ VAS	-4.290	-0.817	-4.644	4.966
Feb 2018	April 2015 - March 2016 (provisional)	EQ-5D Index	0.087	0.086	0.006	0.135
		EQ VAS	1.041	-0.241	-6.507	3.273
Feb 2018	April 2016 - December 2016 (provisional)	EQ-5D Index	Suppressed due to small number of questionnaires returned	0.089	0.000	0.140
				-0.132	-5.017	3.556

Source: NHS Digital

Varicose vein surgery (primary)						
Publication date	Reporting period		BTUH value	National average	National lowest	National highest
Aug 2016	April 2014 - March 2015	EQ-5D Index	Suppressed due to small number of questionnaires returned	0.094	-0.009	0.155
		EQ VAS		-0.500	-5.792	3.937
		Aberdeen questionnaire		-8.200	-14.452	5.700
Aug 2017	April 2015 - March 2016	EQ-5D Index	Suppressed due to small number of questionnaires returned	0.096	0.018	0.150
		EQ VAS		-0.430	-7.794	4.864
		Aberdeen questionnaire		-8.626	-18.056	2.980
Feb 2018	April 2016 - March 2017	EQ-5D Index	Suppressed due to small number of questionnaires returned	0.092	0.010	0.155
		EQ VAS		0.081	-4.904	6.272
		Aberdeen questionnaire		-8.248	-18.076	2.117
Feb 2018	April 2017 - September 2017 (provisional)	EQ-5D Index	Suppressed due to small number of questionnaires returned	0.096	0.000	0.134
		EQ VAS		-0.418	0.000	2.963
		Aberdeen questionnaire		-8.894	-3.468	0.000

Source: NHS Digital

The Trust considers that this data is as described for the following reasons:

- The data is collected and analysed independently of the Trust by an approved provider. It is the latest available published by the Health and Social Care Information Centre
- Some data is recorded as 'not applicable', due to insufficient responses received, resulting in a sample size that is too small to analyse

The Trust is committed to improving participation in the survey, in order to obtain robust data, which will reliably inform service improvement and improved quality of the services delivery.

iii) Emergency readmissions to hospital within 28 days

The emergency readmission indicator measures the percentage of admissions of people who returned to hospital as an emergency within 28 days of their last discharge from hospital, when readmission is not part of an individual's plan of care. Therefore admissions for cancer and obstetrics are excluded from the measurement. The purpose of the indicator is to measure the effectiveness of the NHS in helping people to recover effectively from illness or injury. If a person does not recover well, it is more likely that they will require hospital treatment again within the 28 days of their discharge home from hospital.

Thus, readmissions are widely used as an indicator of the success of healthcare in helping people to recover. To improve care delivery nationwide and prevent avoidable readmissions, the analysis of the data supports learning and improvements from those organisations that have a low rate of readmission. The national highest and lowest figures are for comparable medium acute trusts as defined in the report, while the national average is across all trusts.

Emergency readmissions (0-15yrs.)					
Publication Date	Reporting period	BTUH value	National average	National lowest	National highest
Dec-13	March 2010 to April 2011	8.61	10.01%	4.04%	16.05%
Dec-13	March 2011 to April 2012	7.25	10.01%	3.75%	14.94%

Source: NHS Digital Indicator Portal

Emergency readmissions (16 yrs. and above)					
Publication Date	Reporting period	BTUH value	National average	National lowest	National highest
Dec-13	March 2010 to April 2011	9.18%	11.43%	4.88%	17.15%
Dec-13	March 2011 to April 2012	9.05%	11.45%	6.67%	17.10%

Source: NHS Digital Indicator Portal

This data has not been published nationally since 2013, however it is a requirement within the Quality Account reporting guidelines. In the absence of current national data, the Trust monitors the numbers of readmissions within the 28 days at monthly intervals at the divisional performance meetings and has not seen any spikes in this internal data set. To provide further assurance it monitors both non-elective and elective readmissions monthly to ensure that as an organisation we do pass the trajectory of 10% and 3%.

BTUH Readmissions within 28 days April 2016 – March 2017												
	April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Percentage of non-elective readmissions within 28 days	8.84%	9.03%	10.17%	9.85%	8.59%	9.05%	8.00%	8.99%	9.54%	9.70%	9.64%	9.69%
Percentage of elective readmissions within 28 days	3.34%	3.59%	3.34%	3.13%	3.44%	3.21%	3.09%	3.35%	3.47%	3.63%	3.33%	3.65%

Data source: Balanced scorecard

iv) Trust responsiveness to patient needs

Patient experience is a key measure of the quality of care and as an organisation the NHS continually strives to be more responsive to the needs of those using its services. Focusing on the patients need for privacy, information and to be involved in decisions about their care.

Improving hospitals' responsiveness to personal needs is a key indication of the quality of patient experience. This score is based on the average of answers to five questions from the National Inpatient Survey.

a) Q33: Were you involved as much as you wanted to be in decisions about your care and treatment?

Publication Date	Reporting Period	BTUH value	National average	National lowest	National highest
May 2015	September 2014 - January 2015	7.2	N/A	6.1	9.2
May 2016	September 2015 - January 2016	7.8	N/A	6.6	8.9
May 2017	September 2016 - January 2017	7.5	N/A	6.3	8.8

b) Q36: Did you find someone on the hospital staff to talk to about your worries and fears?

Publication Date	Reporting period	BTUH value	National average	National lowest	National highest
May 2015	September 2014 - January 2015	5.4	N/A	4.3	8.2

Publication Date	Reporting period	BTUH value	National average	National lowest	National highest
May 2016	September 2015 - January 2016	6.2	N/A	4.4	7.8
May 2017	September 2016 - January 2017	5.8	N/A	4.5	8.0

c) Q38: Were you given enough privacy when discussing your condition or treatment?

Publication Date	Reporting period	BTUH value	National average	National lowest	National highest
May 2015	September 2014 - January 2015	8.5	N/A	7.5	9.4
May 2016	September 2015 - January 2016	8.9	N/A	7.9	9.4
May 2017	September 2016 - January 2017	8.7	N/A	7.9	9.4

d) Q61: Did a member of staff tell you about medication side effects to watch for when you went home?

Publication date	Reporting period	BTUH value	National average	National lowest	National highest
May 2015	September 2014 - January 2015	4.2	N/A	3.7	7.6
May 2016	September 2015 - January 2016	4.8	N/A	3.6	7.8
May 2017	September 2016 - January 2017	4.4	N/A	3.5	7.7

e) Q67: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Publication Date	Reporting Period	BTUH value	National average	National lowest	National highest
May 2015	September 2014 - January 2015	7.7	N/A	6.4	9.7
May 2016	September 2015 - January 2016	8	N/A	6.4	9.7
May 2017	September 2016 - January 2017	7.9	N/A	6.4	9.7

Source: Care Quality Commission

The Trust considers that this data is as described for the following reasons: it is collected independently from patients who access services provided by the Trust and published by the Care Quality Commission.

In response to these results, the Trust has identified an improvement programme which includes workstreams that will support improvement of our patients' experience and enhance the quality of service delivery. This will be underpinned by a robust patient experience strategy that supports improved patient involvement and working in partnership with our patients to improve and redesign services.

The publication of the 2017 inpatient survey results are expected in early June 2018, the outcome of which will be shared throughout the organisation and will contribute to the dynamic improvement programme."

v) Staff recommender score

In April 2014, NHS England introduced the Staff Friends and Family Test (FFT) in all NHS trusts providing acute, community, ambulance and mental health services in England.

NHS England's vision for Staff FFT is that all staff should have the opportunity to feed back their views on their organisation at least once each year. It is hoped that Staff FFT will help to promote a big cultural shift in the NHS, where staff have further opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon.

The data below is taken from the National Staff Survey carried out in 2017. It shows that the recommender score has improved on 2014 and has met the national average for acute trusts in 2017.

Publication Date	Reporting Period	BTUH value	National Average	National Lowest	National Highest
Feb 2015	Sep 14	3.65	3.66	3.00	4.20
Feb 2016	Sep 15	3.74	3.75	3.30	4.10
Feb 2017	Sep 16	3.78	3.76	3.33	4.10
Feb 2018	Sep 17	3.75	3.75	3.34	4.12

Top Five ranking scores based on comparison to national average	2017 Score	National average for acute trusts	2016 Score	Trust improvement
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	54%	51%	51%	3%
KF10. Support from immediate managers	3.79	3.74	3.77	2%
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	91%	90%	91%	0%
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	90%	94%	-3%
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.96	3.91	4.01	-5%

Bottom Five ranking scores based on comparison to national average	2017 Score	National average for acute trusts	2016 Score	Trust deterioration
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	2%	2%	1%
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	81%	85%	84%	-3%
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	31%	28%	29%	2%
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	39%	36%	39%	0%
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	17%	15%	17%	0%

Source: National NHS Staff Survey 2017 – acute trusts Health and Social Care Information Centre

The Trust considers that this data is as described for the following reason; it is collected and analysed independently of the Trust.

This year, the Trust will focus on improving key findings around appraisals and support for development, health and wellbeing, job satisfaction, managers, patient experience and issues relating to violence, bullying and harassment. A corporate plan is being put together to identify the issues and formulate a number of initiatives to improve awareness, understanding and reporting of issues.

vi) Rate per 100,000 bed days Clostridium difficile

Publication Date	Reporting Period	BTUH value	National Average	National Lowest	National Highest
Jul-15	April 2014 - March 2015	16.1	15.0	0.0	62.6
Jul-16	April 2015 - March 2016	16.9	14.9	0.0	67.2
Jul-17	April 2016 - March 2017	14.2	13.2	0.0	82.7

Source: Public Health England

Upon laboratory notification, all cases of Clostridium difficile (C.diff) are reported to a

national Public Health England data capture system. Each case identified 72 hours or more after admission is incident reported and investigated using root cause analysis (RCA). The RCA is scrutinised by a multi-disciplinary team, which includes representation from the CCG. Outcomes of RCA investigations are reported through relevant divisions and where improvement is required to raise standards action is taken and the learning is shared.

The total number of cases of C. diff attributed to the Trust from April 2017 to March 2018 is 28 against a trajectory of 31. This is a reduction of 6 cases of the total number of cases in 2016/17 which was 34. The trajectory set for 2018/19 is 30.

vii) Rate of patient safety incidents

Publication date	Reporting period		BTUH value	National average	National lowest	National highest
Sep-16	October 2015 - March 2016	Number of Patient safety incidents	5477	4817	1499	11998
		% resulting in severe harm or death	0.20%	0.40%	0%	2.00%
		Number resulting in severe harm or death	11	19	0	91
Mar-17	April 2016 - September 2016	Number of Patient safety incidents	5079	4955	1485	13485
		% resulting in severe harm or death	0.60%	0.50%	0%	1.70%
		Number resulting in severe harm or death	31	19	1	98
Sep-17	October 2016 - March 2017	Number of Patient safety incidents	5168	5122	1301	14506
		% resulting in severe harm or death	0.58%	0.37%	0.0%	0.46%
		Number resulting in severe harm or death	30	19	1	92
Mar-18	April 2017 - September 2017	Number of Patient safety incidents	6228	5226	1133	15228
		% resulting in severe harm or death	0.63%	0.34%	0.00%	0.79%
		Number resulting in severe harm or death	39	18	0	121

Source: National Reporting and Learning Service

Trust staff are supported and encouraged to report incidents and near misses as part of a culture that places a high priority on patient safety. Some incidents that occur in the NHS are defined as serious incidents (SIs). Serious incidents in healthcare are uncommon but when they occur NHS trusts have a responsibility to ensure these are thoroughly investigated so that action can be taken to improve, and lessons learned to mitigate the risk of similar incidents occurring in the future.

In the event of a serious incident, the Trust appoints a trained investigating officer to ensure that the circumstances surrounding the incident are investigated in order to promote best practice, utilising root cause analysis. Then recommendations are made and implemented, and evidence is required to demonstrate actions have been undertaken. This process is scrutinized and supported by the corporate clinical governance and risk department, with the final scrutiny process overseen by the executive directors. Details of all serious incidents are shared with the Clinical Commissioning Group (CCG), who review all serious incident investigations to provide an external independent assurance function.

The Trust promotes a 'fair and just' culture, which encourages staff to be confident to report any concerns. The purpose of investigation is to encourage openness, learning is shared widely and quality improvement is positively endorsed, so that care provided to patients is continually improved. In addition, continuous analysis of incidents and serious incidents is undertaken and shared widely across the organisation. Where areas of concern are identified, specific actions are taken to undertake a deeper level of investigation, so that potential risks are mitigated. The executive team has also held a number of scrutiny panels holding the divisions to account for the actions being taken to prevent further recurrence.

The Trust has ensured that incident reporting and risk assessment has become mandatory training for all staff (clinical and non-clinical). The progress and monitoring of staff training is discussed and monitored at the risk and

compliance group. Further bespoke training sessions are provided for staff that have the responsibility of investigating incidents, and managing risk in their areas.

The number of patient safety incidents has increased in 2017/18 compared to 2016/17. This is an indicator of being open and transparent as well as an organisation that has adopted a culture that recognises the importance of incident reporting.

Duty of Candour

Duty of Candour Regulation 20 CQC is to ensure that providers are open and transparent with people who use their services and other relevant persons in general for care and treatment. The guidance sets out specific requirements when things go wrong with care and treatment including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The Trust is compliant with the Duty of Candour standard and any delays are discussed and agreed with the CCG.

Review of Services

The income generated by the relevant health services in 2017/18 represents 91.6% of the total income generated from the provision of relevant services by the Trust in this period.

Research and Development

The Trust has a long history of being research active, with particular strengths in cardiovascular, pain management, hepatology and rheumatology. The research activity is a mixture of studies that are commercially funded, non-commercial studies for which the Trust acts as a participating site, original studies gained through external funding via grants and studies that support development of staff through higher degrees.

Participation in Clinical Audits

National Clinical Audits

The National Clinical Audits and National Confidential Enquires that Basildon and Thurrock University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

During 2016/17 the Trust was eligible to participate in 43 National Clinical Audits that are relevant to the trust and four National Confidential Enquiries into patient outcome and death. It participated in 100% of both programmes of enquiry.

National Clinical Audit (participated in 43/43)	Cases submitted (% expected of eligible)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	100%
Bowel Cancer (NBOCAP)	100%
Cardiac Rhythm Management (CRM)	100%
Case Mix Programme (CMP)	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	100%
Elective Surgery (National PROMs Programme)	70%
Endocrine and Thyroid National Audit	100%
Fracture Neck of Femur (care in emergency departments)	100%
Inflammatory Bowel Disease (IBD) Programme	100%
Learning Disability Mortality Review Programme (LeDeR)	100%
Major Trauma Audit (TARN)	70%
*Maternal, Newborn and Infant Clinical Outcome Review Programme (*this programme consists of 4 workstreams)	100%
National Adult Cardiac Surgery	100%
National Audit of Breast Cancer in Older Patients (NABCOP)	100%
National Audit of Dementia: Delirium Spotlight Audit	100%
National Cardiac Arrest Audit (NCAA)	80%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	100%
National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	100%
National Diabetes Footcare Audit	60%
National Diabetes Inpatient Audit (NaDIA)	100%
National Emergency Laparotomy Audit (NELA)	60%
National Heart Failure Audit	100%
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	90%
Falls and Fragility Fractures Audit programme (FFFAP): Inpatient Falls	100%
National Joint Registry (NJR)	100%
National Lung Cancer Audit (NLCA)	100%
National Maternity and Perinatal Audit (NMPA)	100%
National Neonatal Audit Programme (NNAP): Neonatal Intensive and Special Care	100%
National Paediatric Diabetes Audit (NPDA)	100%
National Pregnancy in Diabetes Audit	100%
National Prostate Cancer Audit	100%
National Vascular Registry	100%
Nephrectomy Audit (BAUS Urology Audit)	100%
Oesophago-Gastric Cancer Audit (NAOGC)	100%
Pain in Children (care in emergency departments)	**100%**
Percutaneous Nephrolithotomy (PCNL - BAUS Urology Audit)	**70%**
Procedural Sedation in Adults (care in emergency departments)	**100%**
Red cell and platelet transfusion in adult haematology patients - reaudit 2017	**100%**
Renal Replacement Therapy (Renal Registry)	**100%**
Sentinel Stroke National Audit programme (SSNAP)	**100%**
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	**100%**
Female Stress Urinary Incontinence Audit (BAUS Urology Audit)	**100%**
***UK Parkinson's Audit (*applicability limited to inpatients with PD)**	**100%**

National Confidential Enquiries (participated in 4/5)	Cases included	Clinical questionnaire returned	Case notes returned	Organisational questionnaire returned
Cancer in Children, Teens and Young Adults	1*			1
Young People's Mental Health	1			
Acute Heart Failure	8	7	7	1
Perioperative Diabetes	10**	17	8	

*NCEPOD selected one case for inclusion which the Basildon University Hospital consultant on reviewing the case notes found the inclusion to be inappropriate. This has been communicated to NCEPOD.

**NCEPOD initially selected 10 cases for inclusion with 2 questionnaires to be completed per case (one by the surgeon and the other by the anaesthetist).

In 2017/18 the Trust also submitted data to 10 other national clinical audit projects:

1 Thoracic Surgery Data Submission (Society of Cardiothoracic Surgery) 2017/18

2 British Heart Foundation Audit on Cardiac Rehabilitation (NACR) 2017/18

3 Transcatheter Aortic Valve Implantation (TAVI) Audit (UK TAVI Registry)

4 Association of Cardiothoracic Anaesthetists and Critical Care (ACTACC) Audit on Resternotomy

5 Surgical Site Infection Surveillance Service (SSISS) - Large Bowel Surgery, Breast Surgery and Orthopaedic Surgery

6 National Audit of Psoriasis (re-audit) 2017 (British Association of Dermatologists)

7 National Audit of Small Bowel Obstruction (NASBO) 2017

8 The Right Iliac Fossa Pain Treatment (RIFT) Audit 2017

9 Ileus Management International (IMAGINE)

10 Each Baby COUNTS

Published national clinical audit and confidential enquiry reports during 2017/18

The reports of 27 national clinical audits and 1 confidential enquiry were reviewed by the provider in 2017/18 and Basildon and Thurrock University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Acute Medicine

Severe Sepsis and Septic Shock - care in emergency departments

The report was reviewed at the Acute Medicine departmental meeting. A deteriorating patient bundle incorporating the sepsis care bundle is being piloted Trust-wide. Action has been taken to initiate urine output measurement and fluid balance chart within four hours of arrival by including the charts with the blood culture packs. Weekly audits are carried out to ensure improvement.

Consultant sign off

All staff are aware of the need for consultant review prior to discharge of the four high risk groups included in this audit. Updating the IT system to flag up these patients will assist in optimal care at all times and this is being considered. This will also enable better data capture for future audits.

Major Trauma Audit (Trauma Audit and Research Network - TARN)

Reports are peer reviewed by the North East London and Essex Trauma Network. Data entry has improved the performance on data accreditation and completeness. The latest data show that more patients are surviving based on the severity of their injury. The local team are planning to recruit a lead nurse for trauma to further improve the performance.

General Medicine

Adult Asthma Audit Report

A daily asthma round is to be introduced to ensure all asthma patients are seen promptly by a respiratory specialist. Review of medications prior to discharge is planned and the team are looking to establish a weekly asthma MDT meeting. In compliance with NICE guidance, a business case to acquire a fractional exhaled nitric oxide (FeNo) machine is being finalised.

National Diabetes Inpatient Audit 2016

Medication errors, early recognition of hypoglycaemia and appropriate foot risk assessments were identified as priority areas for improvement. Quality improvement projects to address these have been included in the divisional priority programme and are currently in progress.

National Audit of Dementia Care in General Hospitals 2016-2017

Improvement in delirium screening and management is required and a quality improvement project is planned. The ongoing carers' survey provides feedback on how carers feel about the level of input they have been asked to deliver and the information they have been provided.

National Audit of Inpatient Falls 2017

Avoiding falls is the responsibility of all staff and strong foundations have been laid within the Trust. The introduction of the FallSafe care bundle has prompted collaborative working and significant improvement is evident in the Three key areas of medication review, availability of mobility aids and within reach call bell. Assessing patients for the presence of delirium is highlighted as requiring improvement and this will be addressed by the dementia action plan.

Inflammatory Bowel Disease (IBD) Programme

The Trust now subscribes to the IBD Registry and data upload has commenced. This will ensure continuous monitoring of the appropriate use of biological therapies.

The National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme

This commenced in February 2017 with a continuous data collection approach.

As monitored through this Programme, the Trust has consistently met the best practice tariff and has been identified as one of only 32 Trusts to have achieved this nationally during the first quarter of 2017/18. The COPD team were invited to present their quality improvement initiatives at a regional workshop in London.

Oesophago-gastric Cancer (NAOGC)

The report was discussed at the MDT meeting. An action plan is not required at present but will be formulated if required following further discussions.

Sentinel Stroke National Audit programme (SSNAP)

Quarterly reports are reviewed by the Stroke Team and actioned if necessary. No further action is required at present and the team will continue to monitor performance.

Surgical Services

National Emergency Laparotomy Audit (NELA)

The Year 3 report has now been published and reviewed. A quality improvement project is in progress to improve risk assessment and documentation to ensure early recognition of high risk patients.

National Audit of Breast Cancer in Older Patients

Patients and carers will continue to be invited to MDT meeting discussions to ensure they are involved adequately in decision making and receive sufficient information on treatment options.

Elective Surgery: National PROMs Programme

Patient reported outcome measures (PROMs) assess quality from the patient perspective, and seek to calculate the health gain experienced by patients. The participation rate and the Trust's results are comparable to nationally reported data.

National Vascular Registry

Comparable practice with similar units noted and further action is not required at present. The team will continue to monitor the performance.

Intensive Care National Audit and Research Centre (ICNARC)

The quarterly reports are reviewed at the Critical Care departmental meetings. Comparable practice with similar units noted. A Critical Care Delivery Board, chaired by the medical director has been set up to further improve the service and a business plan for 14 level 3 beds has been submitted to the CCG.

National Prostate Cancer Audit Annual Report 2017

Monitoring of local data completeness will continue, ensuring that data quality issues are identified and addressed as early as possible.

National Hip Fracture Database Report 2017

A project team has been established to address improvement of key performance indicators including timing to surgery. This is being monitored through Stepping Up Board as a Trust priority.

Women and Children Services

National paediatric diabetes audit report 2012-2015 (published 2017)

The increased risk of admission with diabetic ketoacidosis amongst children and young people with Type 1 diabetes on insulin pump therapy has been noted. Local audit and surveillance to ascertain reason for this is planned. Recurring themes, if identified, will be addressed.

National neonatal audit programme 2016 annual report

Action plan includes infant feeding specialist midwives implementing ward rounds on NICU to improve the percentage of babies receiving their own mother's milk at discharge to home from a neonatal unit. The two-year follow up clinic has been re-instated to ensure that all babies born preterm will receive a two-year check. A database will be maintained to ensure babies receive their appointment.

National pregnancy in diabetes audit

To ensure improved access to specialist support in early pregnancy, clear pathways have been created and published in every locally appropriate setting. A quality improvement project relating to timing of first contact in pregnancy is in progress.

National maternity and perinatal audit

Electronic maternity information systems to capture the antenatal, intrapartum and postnatal summary is recommended. Women's health care records are currently hand held and are kept with the woman. The maternity IT manager is currently reviewing electronic medical records systems to address this recommendation.

Maternal, newborn and infant clinical outcome review programme - perinatal confidential enquiry - term, singleton, intrapartum stillbirth and intrapartum-related neonatal death (MBRRACE-UK)

Monthly review is undertaken of all undiagnosed small for gestational age foetuses. Results demonstrate good compliance with fetal monitoring (GROW) guidance. Audit of management of reduced fetal movements is being considered for the 2018/19 priority programme.

Perinatal Mortality Surveillance Report - UK Perinatal Deaths for Births from January to December 2015 (MBRRACE-UK)

Implementation of serial growth scans for all smokers is being discussed with the imaging services.

As per the national recommendations, with the aim of identifying any themes and trends, a multidisciplinary review of all neonatal deaths for 2016 and 2017 will be completed.

Saving Lives, Improving Mothers' Care (MBRRACE-UK Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15)

Obstetric anaesthetists have been made aware of the recommended size of the endotracheal tube tubes to be no larger than 7.0mm proceeding to smaller tube selections if needed. A standard management pathway for women with multiple and complex problems is being considered. At present these patients are managed individually.

The Essex Cardiothoracic Centre

National Audit of Cardiac Rhythm Management

The findings for 2015/16 are comparable to other similar units. No further action is required at present.

National Heart Failure Audit

The report for 2015/16 was published in August 2017. An action plan to improve specialist review of patients who are admitted with heart failure is in place and this will include implementation of the acute heart failure pathway. Availability of a specialist nurse to triage and scan these patients is being considered.

National Confidential Enquiries into Patient Outcome and Death (NCEPOD)

The reports of the following National Confidential Enquiries (NCEPOD) were reviewed by the Trust.

Inspiring Change: Acute Non-Invasive Ventilation

The report was reviewed by the clinical lead and the self-assessment checklist completed. The current practice at the Trust is mostly compliant with the key recommendations. Ongoing local audit is planned to maintain a high quality service.

Local clinical audits

The reports of 14 projects included in the corporate clinical audit and quality improvement programme were reviewed in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Goal 1: Care that is safer

To reduce the avoidable harm to patients from pressure ulcers, injurious falls, in-hospital cardiac arrests and administration incidents. We monitor these through the following audits, groups and governance frameworks. All of the below are reported through the Trust governance groups – patient safety and experience group; risk and compliance group.

Pressure Ulcer Documentation (SSKIN bundle)

Compliance with the pressure ulcer risk assessment (Waterlow assessment) and SSKIN care bundle had been previously audited within the Nursing Care Plan audit. The current plan is to add these assessments to E-Observations.

The Trust-wide pressure ulcer quality improvement programme has made the following improvements: (1) Mattress selection guide has been revised to make the exclusion and inclusion criteria explicit for each individual mattress category. This has been disseminated to the all wards via patient safety 'Hotspot' bulletins, link nurses and all face to face teaching opportunities; (2) MEMS is exploring

an alternative mattress supplier that will provide mattresses on an ad hoc basis, within four hours from the request being raised; and (3) the Fractured Neck of Femur Nurses will ensure that every patient with a fractured neck of femur has the appropriate mattress *in situ.*

Nutrition and Hydration audit

Nutrition and hydration was once audited within the Nursing Care Plan. However, with the advancement of E-Observations and the ever growing range of facilities on offer, the hydration assessment and fluid balance is now recorded electronically. This audit is supplemented by the MUST (malnutrition universal screening tool) annual compliance and accuracy audit which is executed by the Therapy Services. From May 2018, MUST will be recorded on E-Observations.

Falls Prevention Pathway (FallSafe)

In response to the number of injurious falls in 2014/15, and changes in NICE recommendations for the management of inpatient falls, the Trust opted to include this in Sign-up to Safety campaign proposal and subsequently secured support for this work. This is building on the existing work commenced in the same period with the introduction of the Royal College of Physicians FallSafe quality initiative.

In February 2017 the FallSafe care bundle was successfully rolled out across all inpatient ward areas. Compliance with the FallSafe care Bundle is monitored at a ward level and facilitated by the ward champions, performance is shared with matrons and heads of nursing. Improvement plans are developed with ward managers if compliance consistently falls below the agreed target. To date activity versus falls demonstrates that the Trust consistently performs well against the national standard of 6.63 falls/1000 bed days set in the RCP audit of Inpatient falls and against its own performance in the same audit of 5.97 falls per 1000 bed days.

VTE Prevention - appropriate prophylaxis

The administration of VTE (venous thromboembolism) prophylaxis is audited monthly carried out in The Essex Cardiothoracic Centre, General Surgery and Urology, Maternity, Medicine and Trauma and Orthopaedics. During the year the results identified good compliance with inpatients having a documented VTE risk assessment on admission to hospital who receive appropriate prophylaxis based on national guidance. However, between September 2017 and February 2018 there was a resourcing challenge, with medical auditors needed to perform the audit across the Trust and an internal review of the methodology surrounding the audit with the CCG asking for a uniformed MSB methodological approach. This has now been resolved.

WHO Surgical Checklist

The theatre observational checklist (World Health Organisation (WHO) checklist) is carried out quarterly in main theatres, The Essex Cardiothoracic Centre (CTC) surgery, CTC cardiology, endoscopy, colposcopy, radiology, and dermatology. This audit was initially carried out in CTC and main theatres and extended over the past several years to cover the other areas mentioned above. Improvements were made to the availability and use of surgical checklists in these areas and quarterly audits are continuing to improve/maintain compliance.

Saving Lives

Overall compliance has been maintained. However, performance on 'antimicrobial care bundle' has consistently failed to reach the required level of assurance. This is a Trust-wide issue of which all divisions are aware. It is discussed at the divisional governance meetings, as well as reported at the infection control committee.

Goal 2: Care that is reliable

Reducing the risk of patients deteriorating while in hospital is a key driver for the organisation. The Trust SHMI has reduced however further work can be completed to reduce the numbers of cardiac arrests by identifying signs of deterioration and better use of the sepsis/AKI care bundle.

Management of sepsis

The Deteriorating Patient Group (DPG) monitors sepsis performance and reports this to the Sign up to Safety Steering Group and to the Stepping Up Board. Data from this quality improvement project is reviewed regularly by the Sepsis Board (SB) to determine areas for further improvement. During 1207/18 the DPG and SB became one group. There were key actions for Paediatrics and Maternity to develop tailored data collection tools for use in their own departments. The 2017/18 CQUIN looked at screening for sepsis in A&E and for inpatients, the administration of the antibiotic within one hour of diagnosis and a review of the antibiotic by an appropriate member of staff within 72 hours of prescribing.

Antimicrobial stewardship: Reduction in antibiotic consumption per 1,000 admissions

Linked to the above CQUIN the Government has set a target to reduce inappropriate prescribing of antimicrobials by 50% by the year 2020. The aim of this quality improvement project is to improve the review of IV antibiotic prescribing with a view to reducing consumption to support antimicrobial stewardship.

Treatment Escalation Plans (TEP)

Compliance with the completion of treatment escalation plans is monitored monthly (initially within the deteriorating patient audit). During 2017 against a back-drop of resourcing issues and a period of reviewing the methodology, data collection was temporarily halted. With an innovative approach to data collection including the promotion of the quality improvement methodology the TEP's data collection re-continued in March 2018.

Audit of clinical observations

Clinical observations was once audited within the Nursing monthly audit. However, with the inception of E-Observations, clinical observations (like several other monthly manual audits) has become an electronic audit.

Do not attempt cardiopulmonary resuscitation (DNACPR)

The DNACPR audit is conducted to ensure that records are completed and discussion with patients, family/carers are documented. The outcome of the audits is reviewed by the resuscitation group and divisions, and remedial actions are developed to address any gaps. The methodology surrounding this monthly audit has been reviewed resulting with the development of an innovative approach to data collection with the promotion of the quality improvement methodology.

Acute Kidney Injury

A quality improvement project to reduce mortality and complications from acute kidney injury (AKI) is in progress. During 2017 the deteriorating patient pathway was rolled out which included the management of AKI. The AKI quality improvement programme initially focussed on redesigning AKI resources on the Trust intranet and peer to peer education regarding the bundle.

Goal 3: Care that is personal

Providing our patients and their carers with the best possible experience.

Dementia (assessment and onward referral) and carers survey

Results from the dementia audit and carers' survey continue to be reviewed monthly by the dementia lead nurse and discussed at the dementia strategy group meeting bi-monthly.

The 'number of patients aged 75 yrs and above who scored positively (< or =8) on

the abbreviated mental test score, in whom dementia was suspected and who were then referred for further advice/follow up' is a Trust key performance indicator (KPI). Over the past 12 months performance against this indicator has consistently exceeded 90%.

Several improvements have been accomplished during 2017 with the introduction of a new Admiral nurse role (supported by Dementia UK). This role has been crucial in developing the care and support for patient, family and carer; reviewing Trust policies link to patients with Dementia; and networking with external specialist organisations.

The Trust also participated in the National Dementia Audit (Care in General Hospital) 2016/17 with the resulted presented at the November 2017 Clinical Governance Symposium.

Friends and Family Test (FFT)

The results from the FFT are published monthly and available to view on PAMSbi.

Data is collected and reported nationally for 4 areas: Inpatients including day cases; Accident and emergency (includes paediatrics and ambulatory care); Maternity (includes antenatal at 36 weeks and 10 days postnatal community; Outpatients. The results are fed through to the divisional dashboards for appropriate action.

Over the past six months Maternity and A&E have both achieved over the response rate target with consistently high recommended scores. The inpatients response rates have fallen short of the required response rate; however recommended scores have been consistently high.

Participation in clinical research

Aspiring to the highest standards of excellence and professionalism is a core value of the NHS Constitution[1] and this is underpinned by the promotion and conduct of research to improve the current and future health and care of the population. Developing a research-active culture can bring a host of benefits for patients, clinicians and the NHS, driving innovation, giving rise to better and more cost-effective treatments, and creating opportunities for staff development. Growing evidence supports this:

- Research-active Trusts appear to do better in overall performance2
- Academic output correlates with better mortality rates[3]
- Treatment of patients on clinical trials is associated with considerable cost savings[4]

Basildon and Thurrock University Hospital NHS Foundation Trust is committed to an environment where patients, service users, staff and visitors are given the opportunity to participate in high quality health research.

The Trust is a partner in the National Institute for Health Research (NIHR) Clinical Research Network: North Thames, and works closely with the core team to maximise funding to support the delivery of high quality research.

The Trust was involved in 70 active research studies during 2017/18 and the number of patients receiving relevant health services provided or sub-contracted by the Trust in 2017/18 that were recruited to participate in research approved by a NHS research ethics committee was 2,410. 2,278 recruits were to NIHR portfolio adopted studies with the remaining 132 to studies that have not been adopted. Of the newly recruited patients, 1,155 (48%) were enrolled to interventional clinical trials; these are complex and time-consuming studies. There were nine studies that have yet to recruit. This activity took place across all divisions.

During 2017/18, 73 events were reported; 35 were adverse events and 38 were serious adverse events. 15 of the serious adverse events were death; none of these were related to the study. Of the 73 events, three (4%) were deemed to be directly related to the research study; all were resolved.

The Research and Development Department continues to support educational research and provide training and advice to staff requiring support for academic qualifications and to external students.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and

active participation in research leads to successful patient outcomes.

References:

1 NHS Constitution

2 Ozdemir BA, Karthikesalingam A, Sinha S, Poloniecki JD, Hinchliffe RJ, Thompson MM, et al. Research Activity and the Association with Mortality. PLoS ONE 10(2).

3 W.O. Bennett, J.H. Bird, S.A. Burrows, P.R. Counter, V.M. Reddy http://www.ncbi.nlm.nih.gov/pubmed/22795835 Does academic output correlate with better mortality rates in NHS trusts in England? Public Health 126 (2012) S40 eS43.

4 Liniker E, Harrison M, Weaver JM, Agrawal N, Chhabra A, Kingshott V, Bailey S, Eisen TG, Corrie PG. Treatment costs associated with interventional cancer clinical trials conducted at a single UK institution over 2 years (2009-2010). Br J Cancer. 2013 Oct 15;109(8):2051-7.

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

The CQUIN payment framework was introduced with the aim of making care quality the core value of NHS providers. The framework makes a proportion of provider income conditional on locally agreed quality and innovation goals. A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The CQUIN value for 2017/18 was £5,977,576 compared to £5,733,000 in 2016/17. The CQUIN schemes agreed with the Trust's main commissioner for 2017/18 are shown in the following table.

Commissioner	Ref	Indicator name
CCG	**1a**	**Improvement of health and wellbeing of NHS staff**
CCG	**1b**	**Healthy food for NHS staff, visitors and patients**
CCG	**1c**	**Improving the uptake of flu vaccinations for frontline clinical staff**
CCG	2a	Timely identification of patients with sepsis in emergency departments and acute inpatient settings
CCG	**2b**	**Timely treatment of sepsis in emergency departments and acute inpatient settings**
CCG	**2c**	**Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.**
CCG	2d	Reduction in antibiotic consumption per 1,000 admissions
CCG	**4**	**Improving services for people with mental health needs who present to A&E**
CCG	**6**	**Advice and Guidance**
CCG	7	E-referrals
CCG	**8a**	**Supporting proactive and safe discharge**
CCG	9a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening
CCG	**9b**	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice**
CCG	9c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication
CCG	**9d**	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening**
CCG	**9e**	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral**
NHS E	**GE3**	**Medicines optimisation (2 year scheme)**
NHS E	CA2	Dose banding
NHS E	**GE1**	**Clinical utilisation review - yr3**
NHS E	GE5	Shared decision making (PCI/CABG/Medical
NHS E	**IM4**	**Complex device optimisation**
NHS E	**CA3**	**Optimising palliative chemotherapy decision making**

What the regulators said about the Trust

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England and protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act. The CQC ensure that health and social care services provided are safe, effective, and compassionate with high-quality care by monitoring, inspecting and regulating services to ensure they meet the fundamental standards of quality and safety.

The Trust is required to register with the CQC and has no conditions on registration. We are currently registered with the CQC to carry out the following legally regulated services.

At Basildon University Hospital

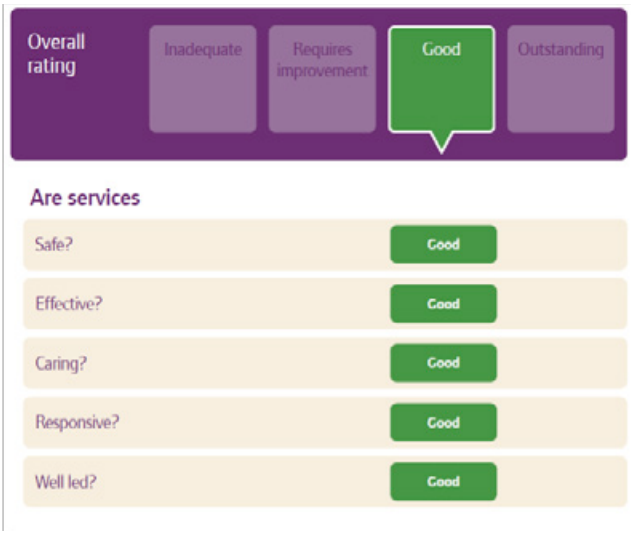
Maternity and midwifery services; termination of pregnancies; treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures; management of supply of blood and blood derived products; assessment or medical treatment for persons detained under the Mental Health Act 1983; and family planning.

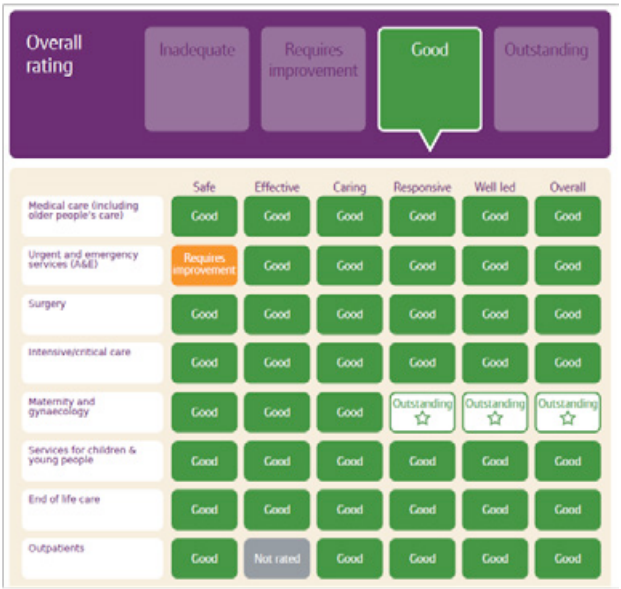
At Orsett Hospital

Termination of pregnancies; treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures; and family planning.

Basildon and Thurrock University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period. The CQC has not taken enforcement action against the Trust during this reporting period. For further information about the CQC's acute hospital regulatory model and inspection framework please visit: www.cqc.org.uk

The current CQC ratings for services by the Trust are:





Data Quality

Clinicians and managers are dependent on good quality data from clinical systems to ensure that they are delivering appropriate services to patients. This data must be accurate and accessible when needed to ensure it effectively supports the delivery of patient services.

Information Governance Toolkit

Information governance guidance and legislation will change in 2018/19 and replace the current Information Governance Toolkit and compliance standards. The Trust's overall compliance for the current toolkit, is 74%. This does not fall within the satisfactory parameters, as the Trust did not achieve the compliance threshold of 95% for Information Governance Training, as stipulated in Standard 112 in the toolkit. To improve on the training standards, there is an improvement plan for 2018/19 which will support engagement of all staff groups in the training programme.

Clinical Coding Error Rate

During 2017/18, there was no request for a payment by results national coding audit. The Trust participated in the national Information Governance audit, which is an audit of clinical coding, based on national standards. This has been undertaken by a Clinical Classifications Service, approved clinical coding auditor within the last 12 months. The aim of the audit is to check that clinical coding processes are in place and to ensure the inputted data complies with national clinical coding standards.

Clinical Coding Category	Level of Attainment			
	Level 2 target	Level 2 BTUH performance	Level 3 target	Level 3 BTUH performance
Primary Diagnosis	>=90%	90.00%	>=95%	
Secondary Diagnosis	>=80%	Level 3 attained	>=90%	93.94%
Primary Procedure	>=90%	94.94%	>=95%	
Secondary Procedure	>=80%	88.24%	>=90%	

Data source: National Information Governance Audit 2017/18

This acts as an indicator of coding quality and Trusts must meet or exceed the required percentage across all four areas in order to meet the attainment level. Therefore based on the results presented in the Trust has achieved in all four required areas. The Trust does not rely on an annual assessment of accuracy and has a rolling programme of audit to support continued quality.

Secondary Uses Service (SUS) Submissions

The Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SUS Submissions (Data Source: NHS Digital)	2014/15	2015/16	2016/17	2017/18
Which included the patient's valid NHS number was:				
% for admitted patient care	99.7%	99.7%	98.9%	99.1%
% for outpatient care	99.8%	99.7%	99.4%	99.4%
% for accident and emergency care	98.7%	99.7%	98.7%	98.8%
Which included the patient's valid General Medical Practice Code was:				
% for admitted patient care	100.0%	99.9%	99.8%	99.8%
% for outpatient care	100.0%	99.9%	99.9%	99.9%
% for accident and emergency care	99.9%	99.3%	99.5%	99.4%

Data Source: SUS+ DQ Dashboards - M10 submission

Part 3 - Review of quality performance

The Trust uses a wide range of information to monitor performance and the quality of services. The Trust Board has reviewed the indicators required for the quality strategy and as a result a number of indicators are no longer referenced in the quality report.

Each of the three indicators for patient safety, clinical effectiveness and patient experience monitored in 2016/17 has been discussed in detail historical and benchmarked data in Section 2.

The table shows a summary of indicators, with a comparison of performance over the past four quarters and the arithmetic average as part of the NHS Improvement Risk Assessment Framework (RAF). Further information is included in Appendix 3 including locally defined measures and targets.

Indicator	Target YTD	Q1	Q2	Q3	Q4	2017/18 average
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	65.3%	67.0%	66.4%	69.6%	67.1%
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	85.8%	84.7%	84.1%	85.5%	85.0%
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	84.1%	82.7%	83.3%	81.7%	82.9%
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	91.1%	90.7%	86.5%	82.7%	87.7%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	65.1%	72.0%	74.4%	67.8%	69.8%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	77.8%	68.1%	39.7%	50.0%	58.9%
Cancer 31 day wait for second or subsequent treatment - surgery	94%	84.0%	96.0%	97.6%	87.9%	91.4%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100.0%	100.0%	100.0%	92.9%	98.2%
Cancer 31 day wait from diagnosis to first treatment	96%	94.8%	95.1%	96.1%	94.8%	95.2%
Cancer 2 week (all cancers)	93%	87.8%	87.8%	94.7%	93.0%	90.8%
Cancer 2 week (breast symptoms)	93%	88.0%	86.0%	96.0%	93.9%	91.0%
Diagnostic - 6 week wait	99%	98.9%	98.4%	99.0%	97.6%	98.5%
Cumulative total C.diff (including: cases deemed not to be due to lapse in care and cases under review)	**31**	**8**	**12**	**19**	**28**	**17**

Cumulative total C.diff (including: cases deemed not to be due to lapse in care and cases under review)

Appendix 1 – Statement from Directors

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangement that the NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including: Board minutes and papers for the period April 2017 to May 2018

Papers relating to quality reported to the board over the period April 2017 to May 2018

- Feedback from commissioners dated May 2018
- Feedback from governors dated May 2018
- Feedback from local Healthwatch organisations dated May 2018
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, integral to the CLIC annual report - May 2018
- The (latest) national patient survey dated May 2017
- The (latest) national staff survey dated March 2018
- The head of internal audit's annual opinion of the trusts control environment dated May 2018
- CQC inspection report dated 15 July 2016
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account Regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

Nigel Beverley
Chairman

Date: 29 May 2018

Clare Panniker
Chief executive

Date: 29 May 2018

Appendix 2 – Statements from Stakeholders

Response to Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) Quality Account 2017-18 from Healthwatch Essex

Healthwatch Essex is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by BTUH. In this case, we have received quality of feedback about services provided by the acute hospital, and so offer only the following comments on the BTUH Quality Account.

- What's has been very encouraging has been the way the hospital has remained focused on its delivery of high quality care and improvement, whilst also being part of the biggest transformation consultation ever to take place in Essex.
- HWE is very encouraged by the approach to patient complaints and compliments, its patient engagement both internally and externally and its positive attitude to working with external agencies such as the CQC, HWE, CCG, NHS and ECC.
- The commitment to safe care and a positive approach to patient harm is very encouraging.
- HWE is reassured that BTUH has recognised its current under performance and has set in place future measures around ensuring quality.
- HWE is impressed by the way BTUH is continually looking to recruit, train and retain its workforce through support and care.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the encouraging work of BTUH.

Dr David Sollis
Chief Executive Officer, Healthwatch Essex
May 2018

Mid and South Essex Joint Commissioning Team response to Basildon and Thurrock University Hospitals NHS Foundation Trust Quality Report 2017/2018

Since January 2018, Mid and South Essex Joint Commissioning Team (the JCT) have devolved authority from mid and south Essex CCGs to commission "in hospital" services on their behalf. Therefore, as the lead commissioner of services provided by Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) the JCT welcomes the opportunity to comment on this quality report.

To the best of the JCT's knowledge, the information contained within this report is generally accurate and is representative of the quality of services delivered. Any queries will have been fed back to BTUH prior to publication for consideration of inclusion, along with all missing data in the final report.

Additional requirements for insertion within 2017/2018 Quality Reports are:-

- Disclosures in relation to "Learning from Deaths" which are included within the report and
- Seven day hospital services.

Both of which are included within the report.

When looking to see if priorities for 2017/18 have been met, it is worth noting that this has been another challenging year with increasing demand for services and a number of key targets remain unmet, such as 4 hours in Accident & Emergency, Referral to Treatment and some cancer waits.

When looking at Healthcare Associated Infections, the 2017/18 trajectory of 31 for Clostridium difficile was not breached with 28 cases attributed to BTUH, in addition, six cases of MRSA bacteraemia were assigned against a zero tolerance level.

It was interesting to see that technological developments have been introduced, particularly those relating to maternity with a change in communications using social media and greater interaction with patients.

The roll out of the FallSafe care bundle looks to have shown a positive spotlight on falls reduction focusing attention on what works and making it everyone's responsibility.

Quality Improvement priorities for 2018/19 seem appropriate with many following on from 2017/18.

A comprehensive description of your participation in and learning from clinical audit and research is produced. Plus a summary of findings and learning from all clinical audits undertaken.

In conclusion the JCT considers Basildon and Thurrock University Hospitals NHS Foundation Trust Quality Report for 2017/2018 as providing an accurate and balanced picture of the reporting period. The JCT will continue to seek assurance on performance and delivery of care by regular monitoring through its agreed contract; via quality assurance visits and triangulation of local intelligence.

Carol Anderson
Chief nursing officer
Mid and South Essex STP Joint Committee

May 2018

Appendix 3 - Supplementary Performance Information

In addition to the information provided in the main part of the report with regard to quality improvement and performance delivery, this section describes other quality measures that the Trust seeks to achieve.

Infection prevention and control

Sustainable reduction in healthcare associated infection (HCAI) requires a culture of 'zero tolerance' of avoidable infections that is embedded across the organisation from board to ward. In the Trust it is recognised that a strategic approach to healthcare associated infection prevention and control is fundamental to the delivery of the organisational objectives to provide safe, caring and excellent care and improve patient experience. Sustainable reductions in HCAIs such as MRSA and Clostridium difficile require the proactive involvement of every member of staff across all disciplines in the Trust.

The Trust has an Infection Prevention and Control (IP&C) structure which is able to support frontline staff in the delivery of safe care, promotes robust IP&C practices and monitors that practice is of sufficiently high standard and to challenge where there are lapses in order to protect patients, visitors and staff.

It is a requirement to report every episode of MRSA bacteraemia. The national guidance on the reporting and monitoring and post infection review (PIR) process for MRSA bloodstream infections (BSI) was implemented in April 2013 as part of a strategy for achieving a zero tolerance to HCAI. Following laboratory identification, each case of MRSA BSI is reported immediately to a national Public Health England data capture system, and a multi-disciplinary post infection review, which includes a representative from the local clinical commissioning group (CCG), is instigated. This review identifies contributory factors, non-optimal practice and lessons learned from the case to improve future practice. It also identifies the organisation best placed to ensure these lessons are acted upon and the organisation to which the case is assigned.

The Trust has been involved in the investigation of eleven Post Infection Reviews during 2017/18, with six cases being attributed to the Trust. The MRSA threshold will remain as zero for 2018/19.

Complaints

The number of complaints received in 2017/18 has reduced compared to 2016/17.

Complaints received	2014/15	2015/16	2016/17	2017/18
Total Complaints	700	658	732	658

Source: Ulysses Safeguard

The key themes and trends are extrapolated and reported in the Performance Report to the Trust board. This information is then utilised by the clinical divisions to support their improvement plans.

Top three complaints trends 2014-2018				
	2014/15	2015/16	2016/17	2017/18
1	Medical care/ treatment (170)	Medical care/ treatment (181)	Medical care/ treatment (160)	Medical care/ treatment (200)
2	Communication (103)	Communication (99)	Clinical Delay/Waiting Time (100)	Medical Judgement/ diagnosis (96)
3	Medical Judgement/ diagnosis (84)	Medical Judgement/ diagnosis (87)	Medical Judgement/ diagnosis (99)	Communication (81)

Source: Ulysses Safeguard

Complaints and their themes are reviewed at the Trust's Patient Safety and Experience group, the divisions discuss the learning and outcomes from complaints, together with any actions for improvement. This allows the divisions to share the data and learning across the organisation.

Patient Advice and Liaison Service (PALS)

The PALS service is a point of contact for patients, their families and carers to receive advice, support and information about health related matters. The total number of PALS concerns received in 2017/18 have increased by 0.8% compared to 2016/17.

PALS concerns	2015/16	2016/17	2017/18
Total PALS concerns received and closed	3120	3015	3040

Source: Ulysses safeguard

Top 3 PALS trends 2014-2018				
	2014/15	2015/16	2016/17	2017/18
1	Appointment Delay/Cancellation Outpatients (611)	Appointment Delay/Cancellation Outpatients (860)	Appointment Delay/Cancellation Outpatients (1315)	Appointment Delay/Cancellation Outpatients (1231)
2	Communication (381)	Communication (479)	Communication (447)	Communication (623)
3	Access to appointments (309)	Clinical treatment (361)	Clinical treatment (306)	Clinical treatment (397)

*category included contact types which are now attributed to more specific categories. Source: Ulysses safeguard

The key themes and trends are extrapolated and reported in the Performance Report to the Trust board. This information is then utilised by the clinical divisions to support their improvement plans.

PALS concerns	2015/16	2016/17	2017/18
Percentage of PALS concerns closed within 5 working days	82% (2551)	82% (2470)	84.5% (2568)

Source: Ulysses safeguard

In order to ensure a timely response to all concerns raised the Trust has set a time bound standard, which acts as a quality indicator of service provision. The aim is to respond to 90% of all concerns raised within five working days of the initial contact.

Polly Parrot charity appeal exceeds £250,000 fundraising target

Young patients are benefitting from more child-friendly surroundings in hospital thanks to the Polly Parrot Appeal.

By July 2017, the appeal has raised a grand total of £284,674.57, due to the fantastic efforts of hundreds of local people who have abseiled, skydived, baked, walked, hiked, run, crafted, danced and swung golf clubs, in the name of charity.

The money raised helped to create a child-friendly welcoming environment and fund additional equipment for children's A&E and the paediatric assessment unit, refurbish the children's outpatient department and create a teen room on Puffin Ward, equipped with comfy sofas, computer consoles and DVDs.

It also funds the ongoing running and maintenance of Polly's Pad, a self-contained, three bedroomed house with its own communal area and self-catering kitchen, for families of sick children and the parents of babies in our neonatal intensive care unit (NICU) to stay in while their child is in hospital.

Independent auditor's report to the Council of Governors of Basildon and Thurrock University Hospitals NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Basildon and Thurrock University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Basildon and Thurrock University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 ("the Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

We refer to these national priority indicators collectively as "the indicators".

Directors' responsibilities

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibilities

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Requirements for External Assurance for Quality Reports 2017/18 issued by NHS Improvement in February 2018 ("the Guidance"); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners, dated May 2018;
- feedback from local Healthwatch organisations, dated May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018;
- the latest national patient survey, dated May 2017;
- the latest national staff survey, dated March 2018;
- Care Quality Commission inspection, dated July 2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment for 2017/18.

We consider the implications for our report if we become aware of any apparent misstatements

or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Basildon and Thurrock University Hospitals NHS Foundation Trust as a body, in reporting Basildon and Thurrock university Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Basildon and Thurrock University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Basildon and Thurrock University Hospitals NHS Foundation Trust.

Basis for qualified conclusion

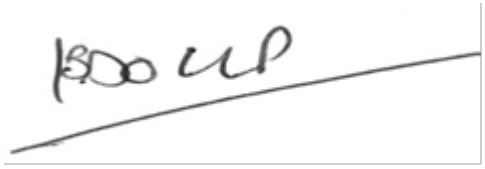
Our testing completed over the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator has identified errors in relation to the accuracy of the data

recorded that lead us to conclude that the indicator has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for External Assurance for Quality Reports 2017/18 issued by NHS Improvement in February 2018; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.



BDO LLP
Chartered Accountants
Ipswich, UK

25 May 2018

Background information

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

Accounting policies

The accounting policies for the Trust are shown on page 157 and include policies on pensions and other retirement benefits. Details of senior employees' remuneration are set out in the Remuneration Report on page 48.

Internal auditors

The internal audit function was provided throughout the year by RSM Risk Assurance Services LLP, an independent business assurance provider. Internal audit reports to the Audit Committee and a workplan of audits is agreed by the committee each year.

RSM Risk Assurance Services LLP are contracted to provide internal audit services for a period of three years from 1 April 2016.

External auditors

The Trust's external auditors for 2017/18 were BDO LLP. This firm are contracted to provide external audit service for three years from 1 April 2016, with two possible 12-month extensions.

Details of their remuneration and fees are set out in **note** 5.1 of the accounts.

Fixed assets

In line wit**h note 1.8 o**f the accounts professional valuations are undertaken for land, buildings and dwellings every three and five years. The 2016/17 accounts reflect the five year valuation.

The valuations are primarily carried out on the basis of modern equivalent assets for specialised operational property and existing use value for non- specialised operational property. The current valuation has been carried out on the basis of an alternative site as it has been assumed that the modern equivalent re-provision of the existing services provided from Basildon Hospital and Orsett Hospital could be from a single combined/amalgamated site. This has been done for valuation purposes only.

There has been a significant increase in prices for land, buildings and dwellings during 2017/18. To reflect this an index has been applied as determined by the Trust's valuer.

There are no property, plant and equipment assets where, in the directors' opinion, the market values are significantly different from the values shown in the accounts.

Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information Guidance.

Post balance sheet events

Details of any post balance sheet events are provided on page **21** of the accounts.

Financial instruments

The Trust does not have any significant exposure to interest rate or exchange rate risks and therefore does not hold any complicated financial instruments to hedge against such risks. Details of the Trust's financial instruments are shown in **note** 25 to the accounts.

Pension and retirement benefits

The accounting policies for pensions and other benefits are set out in **note** 27 to the accounts and details of the senior employees' remuneration can be found on page 54 as part of the Remuneration Report.

Trust stories | 8

Improved recruitment and retention leads to improved quality and safety

Three years ago the Acute Medical Unit (AMU) at Basildon Hospital had serious challenges with recruitment and was heavily reliant on temporary staff, which was predominantly filled by external agencies.

Now, this has been turned-around, AMU has not used any external agency staff to fill shifts for over a year and staff turnover is at a record low. There are multiple strong applicants for vacant posts on AMU, and the unit has become a firm favourite for newly qualified nurses to begin their careers.

Anthony Schirn, head of nursing acute and urgent care, explains: "First we carried out a skill-mix review to ensure the staffing establishment met the needs of the patient group, then we put in the support needed for newly qualified nurses to develop their skills and for existing staff to encourage their career progression.

"Not only has this helped with our recruitment and retention, but we have seen quality and safety improve too. Serious Incidents are at a record low, inpatient falls have reduced and AMU is now one of the most highly rated clinical areas on internal quality reviews. This is because our staff work together consistently and understand the protocols, practices and escalation procedures on the ward.

"But none of this would be possible without the close joint working of doctors and nurses, and creating a positive 'can do' culture. If a member of staff has an idea for how to improve what we do on AMU, or a new way of working, we work out what we need to do to make it happen, with all staff groups and professions involved."

Annual Accounts

Foreword to the accounts

BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Basildon and Thurrock University Hospitals NHS Foundation Trust ("the Trust") is required to "keep accounts in such form as NHSI may with the approval of Treasury direct" (paragraph 24(1), Schedule 7 of the National Health Services Act 2006 ("the 2006 Act")). The Trust is required to "prepare in respect of each financial year annual accounts in such form as NHSI may with the approval of Treasury direct" paragraph 25(1), Schedule 7 to the 2006 Act). In preparing their annual accounts, the Trust must comply with any directions given by NHSI, with the approval of Treasury, as to the methods and principles according to which the accounts are to be prepared and the information to be given in the accounts (paragraph 25(2), Schedule 7 to the 2006 Act).

In determining the form and the content of the annual accounts NHSI must aim to ensure that the accounts present a true and fair view (paragraph 25(3), Schedule 7 to the 2006 Act).

Clare Panniker

Chief executive

Date: 29 May 2018

Independent auditor's report to the Council of Governors of Basildon and Thurrock University Hospital NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of Basildon and Thurrock University Hospitals NHS Foundation Trust (the Trust) for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and as interpreted and adapted by the 2017-18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18, and the NHS Foundation Trust Annual Reporting Manual 2017-18 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainties related to going concern

We draw attention to the Note 1.2 in the financial statements which sets out the Directors' assessment of the financial position of the Trust in the context of the National Health Service framework in which it operates and their conclusion that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Our opinion is not qualified in respect of this matter.

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

In addition to the matters described in the Material uncertainties related to gong concern section of our report, we have determined the following to be the key audit matters:

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Matter	How we addressed the matter in the audit
Revenue recognition For Trusts, the risks can be identified as affecting the existence and accuracy of Non-NHS income. Revenue recognition is a critical area when considering financial performance, which impacts on the achievement of control totals and the eligibility for Sustainability and Transformation Funding.	We reviewed a sample of contracts with NHS commissioners, and compared amounts billed under these contracts to underlying supporting data. We reviewed correspondence between the Trust and commissioners, together with the minutes from contract challenge meetings, to obtain further evidence to corroborate or challenge the Trust's position. We reviewed the year-end NHS Agreement of Balances process, and mismatches report provided by the Department of Health, with a particular focus on income and receivables amounts which are subject to adjustments or disputes by the counter-party, or where significant mismatches with counter-party returns are identified. We carried out focussed substantive testing on a sample of non-NHS income transactions during the year and after the year-end, to conclude upon whether income has been recognised appropriately in the correct accounting period.

Matter	How we addressed the matter in the audit
Fair value of property, plant and equipment (PPE) PPE is the most significant balance on the Statement of Financial Position and there is a high degree of estimation involved in the value of these assets. There is a risk over the valuation of land and buildings where valuations are based on assumptions or where updated valuations have not been provided for a class of assets at year-end.	We assessed management's review of the alternative site basis to determine whether this remained a valid judgement within the financial statements during 2017/18. We reviewed indices of price movements for similar classes of assets to determine whether there might be a material difference between the carrying value and a fair value at the balance sheet date and therefore whether any updated valuation was required. We revisited the impact on depreciation charges calculated using the Trust's weighted average useful economic lives (UEL) basis compared to using componentised significant assets.

Matter	How we addressed the matter in the audit
Provisions The Trust has provisions in place in relation to a number of potential liabilities as at 31 March 2018. This includes a provision in relation to an ongoing employment tribunal. The estimates required in calculating the required provisions are complex	We assessed management's review of the alternative site basis to determine whether this remained a valid judgement within the financial statements during 2017/18. We reviewed indices of price movements for similar classes of assets to determine whether there might be a material difference between the carrying value and a fair value at the balance sheet date and therefore whether any updated valuation was required. We revisited the impact on depreciation charges calculated using the Trust's weighted average useful economic lives (UEL) basis compared to using componentised significant assets.

Matter	How we addressed the matter in the audit
Accounting for recharges As part of collaborative working arrangement between the Trust and Mid Essex Hospital Services NHS Trust and Southend University Hospitals NHS FT (three trusts within the Mid and South Essex STP) there are some cost sharing arrangements, under which costs initially paid by one trust are recharged to other two trusts. This is sensitive both in terms of the potential for manipulation of expenditure apportionment but also in terms of disclosures within the Remuneration Report.	We reviewed the Trust's procedures for identifying and accurately accounting for recharges to ensure that the procedures in place were robust. We considered the appropriateness of the approach agreed among the trusts and performed detailed substantive testing over recharges to determine whether these had been correctly accounted for. We reviewed remuneration tables to determine whether appropriate shares of costs had been disclosed where senior managers are shared between the three trusts.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements. We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonable users that are taken on the basis of the financial statements.

Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the financial statements as a whole was set at £6 million (2017 £5.8 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.75%) (2017 – 1.75%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £290,000 (2017- £250,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

The Trust operates as a single entity with no significant subsidiary bodies or other controlled undertakings. Accordingly our audit was conducted as a full scope audit of the Trust.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes ;
- the tables of exit packages and related notes;
- the analysis of staff numbers and related notes; and
- the table of pay multiples and related narrative notes.

In our opinion the parts of the Remuneration Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual reporting Manual 2017-18.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion on use of resources

The Trust achieved a deficit of £29.4m (£26.3m post Sustainability and Transformation Funding [STF]) against a control total deficit of £23.3m (£12.6m post STF). The Trust met its CIP target of £16.3m for the year. The non-achievement of the control total was mainly due to staffing costs overspends in particular pay groups.

The Trust's financial plan for 2018/19 shows a £26.8m deficit against a proposed control total deficit of £17m (£1.9m post STF) from NHSI, but with no current agreement on control total. The Trust does not yet have plans to secure a return to a breakeven position in the foreseeable future, whether as a standalone trust or through the proposed merger within the Mid and South Essex Sustainability and Transformation Partnership.

These matters are evidence of significant weaknesses in arrangements to ensure that the Trust deployed its resources to achieve sustainable outcomes for taxpayers and local people.

Qualified conclusion

Except for the matters discussed above in the Basis for qualified conclusion on use of resources section, we have been able to satisfy ourselves that Basildon and Thurrock University Hospitals NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit; or
- the Quality Report has been prepared in accordance with the detailed guidance issued by NHS Improvement.

We also report to you if we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibility, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

The Accounting Officer is also responsible for ensuring that the resources of the Trust are used economically, efficiently and effectively,

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under section 21(3)(c) 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.

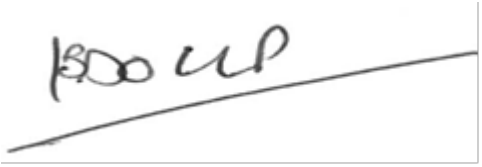
We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Basildon and Thurrock University Hospitals Trust in accordance with the Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Council of Governors of Basildon and Thurrock NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of Basildon and Thurrock NHS Foundation Trust those matters we are required to state to it 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 NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.



David Eagles

for and on behalf of
BDO LLP
Registered auditor
Ipswich, UK

25 May 2018

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017/18 £000	2017/18 £000	2016/17 £000	2016/17 £000
Continuing Operations					
Operating income from activities	3		**294,066**		286,778
Other operating income	4		**26,827**		36,667
Operating expenses					
General	5-6	**(342,160)**		(331,387)	
Impairments	9	**749**		(3,212)	
			(341,411)		(334,599)
OPERATING (DEFICIT)/ SURPLUS			**(20,518)**		(11,154)
Interest receivable		**45**		40	
Interest payable	8	**(1,776)**		(1,566)	
PDC Dividends payable	10	**(3,285)**		(4,250)	
Other finance costs - unwinding of discount		**(138)**		(12)	
NET FINANCE COSTS			**(5,154)**		(5,788)
Gains/(losses) on disposal of assets			(1)		(73)
Share of profit/(loss) of Joint ventures accounted for using the equity method	28		**-**		-
(LOSS)/PROFIT BEFORE INCOME TAX			**(25,672)**		(17,015)
Income Tax expense			**-**		-
(DEFICIT)/SURPLUS FOR THE YEAR			**(25,672)**		(17,015)
Other Comprehensive Income (will not be reclassified to income and expenditure)					
Revaluation on property, plant and equipment			**17,898**		-
Impairment losses on property, plant and equipment	9		**-**		(17,448)
TOTAL OTHER COMPREHENSIVE (EXPENDITURE)/ INCOME FOR THE YEAR			**17,898**		(17,448)
Prior Period Adjustments			**-**		-
TOTAL COMPREHENSIVE (EXPENDITURE)/INCOME FOR THE YEAR			**(7,775)**		(34,463)

The notes on pages 157 to 182 are an integral part of these accounts.

STATEMENT OF FINANCIAL POSITION
AS AT 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
NON-CURRENT ASSETS			
Intangible assets	12	**7,455**	7,532
Property, plant and equipment	13	**226,043**	204,394
Trade and other receivables	15	**2,022**	2,302
Total non-current assets		**235,520**	214,228
CURRENT ASSETS			
Inventories	14	**6,276**	6,979
Trade and other receivables	15	**18,937**	17,948
Cash and cash equivalents	16	**13,786**	7,059
Total Current Assets		**38,999**	31,986
CURRENT LIABILITIES			
Trade and other payables	17	**(41,898)**	(30,647)
Borrowings	18	**(38,536)**	(38,536)
Provisions	19	**(5,012)**	(6,402)
Total Current Liabilities		**(85,446)**	(75,585)
TOTAL ASSETS LESS CURRENT LIABILITIES		**189,073**	**170,629**
NON-CURRENT LIABILITIES			
Borrowings	18	**(65,080)**	(39,701)
Provisions	19	**(1,047)**	(1,069)
Total Non-Current Liabilities		**(66,126)**	(40,770)
TOTAL ASSETS EMPLOYED		**122,947**	**129,859**
TAXPAYERS' EQUITY			
Public Dividend Capital		**113,239**	112,376
Revaluation Reserve		**75,546**	58,127
Income and Expenditure Reserve		**(65,837)**	(40,644)
TOTAL TAXPAYERS' EQUITY		**122,947**	129,859

Clare Panniker

Clare Panniker
Chief executive

Date: 29 May 2018

The notes on pages 157 to 182 are an integral part of these accounts

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

FOR THE YEAR ENDED 31 MARCH 2018

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2016 - as previously stated	**164,322**	**112,376**	**76,121**	**(24,175)**
Surplus/(deficit) for the year	**(17,015)**	-	-	(17,015)
Transfers between reserves	**-**	-	(546)	546
Impairments	**(17,448)**	-	(17,448)	-
Taxpayers' Equity at 31 March 2017	**129,859**	**112,376**	**58,127**	**(40,644)**
Taxpayers' Equity at 1 April 2017	**129,859**	112,376	58,127	(40,644)
Surplus/(deficit) for the year	**(25,672)**	-	-	(25,672)
Transfers between reserves	**-**	-	(479)	479
Revaluation gains/(losses) - property, plant and equipment	**17,898**	-	17,898	-
Public dividend capital received	**863**	863	-	-
Taxpayers' Equity at 31 March 2018	**122,947**	**113,239**	**75,546**	**(65,837)**

The notes on pages 157 to 182 are an integral part of these accounts.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017/18 £000	2016/17 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash generated from operations	22	**(7,566)**	(11,851)
Net cash generated from operating activities		**(7,566)**	(11,851)
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		**47**	40
Purchase of intangible assets		**(1,393)**	(467)
Purchase of property, plant and equipment and Investment Property		**(6,081)**	(8,559)
Net cash used in investing activities		**(7,427)**	(8,986)
CASH FLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		**863**	-
Movement in loans from the Department of Health and Social Care		**25,379**	27,986
Interest paid		**(1,754)**	(1,554)
PDC Dividend paid		**(2,768)**	(5,147)
Net cash used in financing activities		**21,720**	21,285
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**6,727**	448
Cash and cash equivalents as at beginning of year		7,059	6,611
CASH AND CASH EQUIVALENTS AS AT END OF YEAR		**13,786**	7,059

The notes on pages 157 to 182 are an integral part of these accounts.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular

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 Going Concern

The Trust will incur a sizeable financial deficit in delivering its services in 2017/18 and it anticipates that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors has carefully considered the principle of “Going Concern” and the Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

Nevertheless, the going concern basis remains appropriate. This is because the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health and Social Care (NHS Act 2006, s42a) to continue to deliver the full range of mandatory services for the foreseeable future.

The assessment accords with the statutory guidance contained in the Department of Health and Social Care Group Accounting Manual.

1.3 Critical Judgements and Estimation Uncertainty

The preparation of financial statements, in conformity with IFRS, requires the use of certain critical accounting estimates and the exercise of management judgement in applying accounting policies. 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.

The following are the key areas of critical accounting estimates:

Useful Economic Life

The useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is used in assessing the useful economic lives of assets. See note 1.8 for further details.

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. See note 1.14 for further details.

Fair Value of Land and Buildings

Valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. See note 1.8 for further details.

1.4 Expenditure on Other Goods and Services

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

1.5 Revenue Recognition

The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the year in which services are provided, where these services are partially completed during the year an appropriate proportion of the total income due for that service is accrued. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred for example, maternity partially completed spells.

1.6 Losses and Special Payments

Losses and special payments are included on a cash basis when they arise. Details for the payments made are included in note 11 in these accounts. Guidance on the definitions of losses and special payments can be found in HM Treasury's *Managing Public Money*.

1.7 Intangible Assets

Capitalisation

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably and is at least £5,000 or form a group of assets which individually have a cost of more the £250 and collectively have a cost of at least £5,000 and where the assets are functionally interdependent.

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. As no active market exists, intangible assets are valued at amortised cost. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. This is normally assumed to be 5 to 10 years.

1.8 Property, Plant and Equipment

Capitalisation

Property, plant and equipment are capitalised where the item:

- is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

In addition, the cost of each asset must meet the following criteria:

- individually has a cost of at least £5,000; or,
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, 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,
- form part of the initial setting-up cost of a new building, or refurbishment of a 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 e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.8 Property, Plant and Equipment (cont.)

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed assets are not capitalised but are charged to the income and expenditure account in the year to which they relate.

IAS 16 requires valuations to be undertaken with sufficient frequency that the book value isn't materially different to the fair value. All land and buildings are restated to current value using professional valuations every five years. In the intervening years a valuation is requested if land and property prices are known to have significantly fluctuated. The valuation was carried out in March 2017 and valued as at 31 March 2017.

Due to a signification increase in market prices during 2017/18 land, buildings and dwellings were revalued using indices provided by the Trust's valuer, This was not a formal revaluation but the accounts have been adjusted to reflect these increases.

The valuations are carried out primarily using the depreciated replacement cost approach. This approach assumes that the assets would be replaced with a modern equivalent for specialised operational property and existing use value for non-specialised operational property. It has been assumed that the modern equivalent re-provision of existing services would be from a single combined/amalgamated site and the alternative site approach for this valuation has been applied.

Additional alternative open market figures will only be supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are included at cost to date and are valued by professional values when they are brought into use.

Plant and equipment is valued at depreciated purchase cost.

Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset’s carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

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

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuers.

Revaluation Gains and Losses

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

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

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

Impairments

1.8 Property, Plant and Equipment (cont.)

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

Useful Economic Lives

The following table details the useful economic lives for the main classes of property, plant and equipment and, where applicable, sub-categories, within each class.

Main Asset Class	Sub-Category	Useful Economic Life (Years)
Buildings (including Dwellings)	Structural	**90 (max)**
	Engineering	**25**
Plant and Machinery	Short Term	**5**
	Medium Term	**6-10**
	Long Term	**11-15**
Information Technology		**5**
Furniture and Fittings		**10**
Transport Equipment		**10**

The above lives are used prior to the professional valuers' assessment. Following assessment by the professional valuer, the useful economic lives are adjusted on an asset-by-asset basis.

De-recognition

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

1.9 Donated, Government Grant and Other Grant Funded Assets

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

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

1.10 Revenue Government and Other Grants

Government grants are grants from Government bodies other than income from clinical commissioning groups, NHS England and NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure in line with any given conditions.

1.11 Inventories

Inventories are valued at current cost which, whilst not consistent with IAS2, is considered to be a close approximation to the lower of cost or net realisable value and will not lead to a materially mis-stated amount for the value of inventories.

1.12 Cash, Bank and Overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank accounts belonging to patients (see note 26). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within current liabilities. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as 'operating expenditure' in the periods to which they relate.

1.13 Research and Development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;
  - it results in a product or service which will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, the Trust will disclose the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.14 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 0.1% in real terms.

1.15 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to it, which, in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 19.1 but is not recognised in the Trust's accounts.

1.16 Non-Clinical Risk Pooling

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

1.17 Pension 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. They are not designed in a way that woudl enable NHS bodies to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

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

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

Further information can be found in Note 27.

1.18 Value Added Tax

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

1.19 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury *Financial Reporting Manual*.

1.20 Leases

Operating Leases

Leases for equipment and vehicles are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.21 Public Dividend Capital (PDC) and PDC Dividend

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,

(iii) any PDC dividend balance receivable or payable.

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 the audit of the annual accounts.

1.22 Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular purchases or sales are recognised and de-recognised, as applicable, using the trade date - the date on which the trust commits to purchase or sell the asset.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as loans and receivables. Financial liabilities are classified as 'Other Financial liabilities'.

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts estimate future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other Financial Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts estimate future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1.22 Financial Assets and Financial Liabilities (cont)

Impairment of Financial Assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 cashflows 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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.23 Corporation Tax

The activities of the Trust are limited to healthcare or the provision of services associated with healthcare and therefore the Trust has determined that it has no liability to corporation tax.

1.24 Prior year adjustment

There have been a number of adjustments made to the comparative information shown for 2016/17. These are alternative categorisation of information rather than amendments to the accounts.

1.25 Accounting Standards and Amendments Issued But Not Yet Adopted

The following standards and interpretations issued by the International Accounting Standards Board have not yet been adopted. The Trust has yet to assess the impact of these standards.

IFRS 14	Regulatory Deferral Accounts
IFRS 16	Leases
IFRS 17	Insurance Contracts
IFRIC 22	Foreign Currency Transactions and Advance Consideration
IFRIC 23	Uncertainty over Income Tax Treatments

2. Segmental Analysis

The Trust reports its performance to the Board on a monthly basis. The main source of income for the Trust is from commissioners in respect of healthcare services from Clinical Commissioning Groups and NHS England who are under common control and classified as a single customer. Net assets are not reported to the Board so therefore have been excluded for the purpose of this note.

The Trust report's to the Board by directorate down to an Operating Contribution. All further costs are shown on a corporate level so have been excluded in the analysis.

2.1 Operating Segments

	Surgical Services	Women's and Children's Services	Cardio-thoracic Centre	Clincial Support Services	Acute Medicine	General Medicine	Corporate	Total
	£000	£000	£000	£000	£000	£000	£000	£000
2017/18								
Income	58,248	42,598	52,274	37,261	21,426	79,531	29,518	**320,856**
Expenditure	(55,566)	(28,118)	(42,591)	(58,622)	(21,265)	(62,649)	(73,350)	**(342,161)**
Contribution	2,682	14,480	9,683	(21,361)	161	16,882	(43,832)	**(21,305)**
2016/17								
Income	61,442	41,793	49,608	33,049	18,356	82,599	36,600	**323,447**
Expenditure	(56,881)	(26,683)	(39,537)	(50,929)	(19,938)	(67,773)	(72,860)	**(334,601)**
Contribution	4,561	15,110	10,071	(17,880)	(1,582)	14,826	(36,260)	**(11,154)**

3. Income from Activities	2017/18 £000	2016/17 £000
3.1.1 Provision of Healthcare Services		
Elective income	**44,463**	46,109
Non-elective income	**97,307**	87,884
First outpatient income	**32,050**	34,362
Follow up outpatient income	**15,279**	18,544
Other types of activity income	**70,270**	68,894
A&E income	**16,720**	14,917
High cost drugs income from commissioners	**13,467**	13,657
Income from protected activities	**289,555**	284,367
Private patient income	**2,962**	479
Other clinical income	**1,549**	1,932
Total income from activities	**294,066**	286,778
3.1.2 Commissioner Requested Services		
Commissioner Requested Services	**289,555**	284,367
Non-Commissioner Requested Services	**4,511**	2,411
	294,066	286,778

The main source of income is from CCGs, £227,785k in 2017/18 (£283,615k in 2016/17). Further information can be found in Note 24.

4. Other Operating Income	2017/18 £000	2016/17 £000
Research and development	**1,278**	1,327
Education and training	**7,149**	6,526
Charitable and other contributions to expenditure	**37**	140
Non-patient care services to other bodies	**5,060**	3,788
Support from DHSC for mergers	**-**	-
Sustainability and Transformation Fund income	**3,117**	12,473
Car parking	**2,608**	2,394
Pharmacy sales	**37**	54
Accommodation charges	**892**	875
Staff contributions to employee benefit schemes	**778**	807
Catering	**1,625**	1,461
Commercial property rentals, supplies and services	**1,741**	1,559
Non-patient care services to private healthcare providers	**1,330**	2,499
Other	**1,174**	2,764
	26,827	36,667

4a. Overseas visitors	2017/18 £000	2016/17 £000
Income recognised this year	738	313
Cash payments received in year	391	91
Amounts added to provision for impairment of receivables	474	138
Amounts written off in year	36	101

5. Operating Expenses	2017/18 £000	2016/17 Restated £000
5.1 Operating Expenses Comprise:		
5.1.1 General		
Purchase of healthcare from NHS and DHSC bodies	5,469	4,174
Purchase of healthcare from non-NHS bodies	13,492	17,534
Staff and executive directors costs	222,279	211,827
Non-executive directors	127	145
Drug costs	19,752	19,376
Supplies and services		
- Clinical (excluding drug costs)	33,523	32,684
- General	4,038	4,608
Establishment	2,348	2,240
Transport (including patient travel)	576	796
Premises	10,513	11,181
Bad debts	1,249	913
Inventories written down	216	189
Depreciation and amortisation	9,408	9,545
Audit fees		
- statutory audit	50	50
- Internal audit and counter fraud services	122	158
- other assurance services	-	-
Consultancy	2,105	1,139
Clinical negligence	11,905	10,844
Other	4,985	3,984
	342,160	331,387
5.1.2 Impairments		
Impairment losses due to revaluation of property	(749)	3,212
	(749)	3,212
	341,411	334,599

5.2 Operating Leases	2017/18 £000	2016/17 £000
5.2.1 Operating Expenses Include the following cost in respect of operating leases:		
Minimum lease payments	647	673
	647	673

5.2.2 Annual Commitments Under Operating Leases are:

The Trust has some plant and equipment under operating leases. Some of these leases are cancellable and all are based on an original period not exceeding three years.

The future aggregate minimum lease payments under the operating leases are:

No later than 1 year	538	671
Later than 1 year and no later than 5 years	566	506
	1,104	1,177

5.3 Limitation on Auditor's Liability

The auditor limits liability in respect of the audit of these financial statements to £1m.

6. Staff Costs and Numbers

	2017/18 £000	2016/17 £000

Staff costs and numbers includes all staff employed by the Trust and agency staff. It specifically excludes non-executive directors and staff charges in relation to services from other trusts unless it is not a simple recharge or sharing of costs.

6.1 Staff Costs

Executive Directors		
Salaries and wages	594	1,038
Social Security Costs	76	124
Employer contributions to NHS Pensions Authority	74	102
	744	1,264
Other Staff		
Salaries and wages	159,631	150,544
Social Security Costs	16,595	15,371
Apprenticeship levy	788	-
Employer contributions to NHS Pensions Authority	17,893	17,117
Research & development	-	7
Termination costs	3	137
Temporary Staff - Agency/Contract	12,356	17,959
Temporary Staff - External Bank	15,046	10,567
	222,312	211,702

The above table includes £774k 2017/18 (£995k 2016/17) of staff costs that have been charged to the capital programme. These cost are not included in operating expenses, note 5.1.1.

Past and present employees are covered by the provisions of the two NHS Pension Schemes and details of these can be found in Note 27.

6.2 Employee Benefits

The total taxable value of benefits for the year is £1,258,552 (2016/17: £988,591) and relates to Salary Sacrifice schemes. The value of benefits is based on the taxable value of the benefit less any contribution made by the employee. There were no payments made for staff benefits that were linked to an incentive scheme and exceeded £100,000 in the year.

6.3 Retirements Due to Ill-Health

During 2017/18 there were 2 (2016/17 - 2) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £23,287 (2016/17 - £232,932). The cost of these ill-health retirement will be borne by the NHS Pensions Agency.

7. The Late Payment of Commercial Debts (Interest) Act 1998

	2017/18 £000	2016/17 £000

There were no payments included within interest payable (note 8) that arose from claims made by small businesses under this legislation.

8. Finance Costs

	2017/18 £000	2016/17 £000
Finance Income		
Interest on bank accounts	45	40
	45	40
Finance Costs		
Capital loans from the Department of Health	(923)	(987)
Working capital loans from the Department of Health	(853)	(579)
	(1,776)	(1,566)

9. Impairment of assets

	2017/18 £000	2016/17 £000
Changes in asset value charged to revaluation reserve	-	17,448
Changes in asset value charged to operating expenses	(749)	3,212
	(749)	20,660

Land, buildings and dwellings were revalued as at 31 March 2017. As part of this process the Trust has adopted the alternative site valuation methodology resulting in a significant reduction in value relating to land of £16.960m.

10. Public Dividend Capital Dividends	2017/18 £000	2016/17 £000
Opening Net Relevant Assets	**126,576**	163,243
Closing Net Relevant Assets	**100,187**	126,529
Average Net Relevant Assets	**113,381**	144,886
Daily Average Cash Balance	**19,522**	23,456
Adjusted Average Net Relevant Assets	**93,859**	121,430
Dividend Charge	**3,285**	4,250
Dividend Rate	**3.5%**	3.5%

Note 1.21 of the Accounting Policies gives information on how this is calculated. For 2016/17 the incentive elements of Sustainability and Transformation Funding has been excluded from the calculation in line with NHSI instructions.

11. Losses and Special Payments	Number	£000
2017/18		
Bad debts and claims abandoned	470	709
Damage to buildings, property including stores losses	6	216
Compensation under legal obligation	-	-
Ex gratia payments	34	364
Total Losses and Special Payments	**510**	**1,290**

There was one case in 2017/18 that exceeded £300k and related to a legionella claim. The total costs were shared with NHSLA.

2016/17		
Bad debts and claims abandoned	560	844
Damage to buildings, property including stores losses	9	189
Ex gratia payments	32	10
Total Losses and Special Payments	**601**	**1,043**

12. Intangible Assets Software Licences	2017/18 Total £000	2016/17 Total £000
Gross cost at 1 April	16,321	15,629
Reclassifications	717	413
Additions purchased	1,324	536
Disposals	-	(273)
Gross cost at 31 March	**18,362**	**16,321**
Amortisation at 1 April	8,789	6,839
Provided during the year	2,118	2,071
Reclassifications	-	147
Disposals	-	(268)
Amortisation at 31 March	**10,907**	**8,789**
Net book value		
- Purchased at 1 April 2017	7,516	8,788
- Donated at 1 April 2017	16	2
- Total at 1 April 2017	**7,532**	**8,790**
- Purchased at 31 March 2018	7,455	7,516
- Donated at 31 March 2018	-	16
- Total at 31 March 2018	**7,455**	**7,532**

The Trust has no trademarks or patents.

13. Property, Plant and Equipment

Property, Plant and Equipment at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction *	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	25,925	157,438	3,795	1,926	39,556	186	9,423	4,250	**242,499**
Additions - purchased	-	1,955	-	3,661	3,420	-	1,601	336	**10,973**
Additions - donated	-	-	-	-	37	-	-	-	**37**
Reversal of impairments	-	749	-	-	-	-	-	-	**749**
Reclassifications	-	19	-	(767)	-	-	31	-	**(717)**
Revaluations	3,235	14,643	366	-	-	-	-	-	**18,244**
Disposals	-	-	-	-	(1,550)	-	(2)	-	**(1,552)**
At 31 March 2018	**29,160**	**174,804**	**4,161**	**4,820**	**41,463**	**186**	**11,053**	**4,586**	**270,234**
Depreciation at 1 April 2017	-	520	-	-	28,582	158	6,277	2,568	**38,105**
Provided during the year	-	2,996	79	-	2,719	10	1,117	369	**7,290**
Revaluations	-	339	8	-	-	-	-	-	**347**
Disposals	-	-	-	-	(1,550)	-	(1)	-	**(1,551)**
Depreciation at 31 March 2018	**-**	**3,855**	**87**	**-**	**29,751**	**168**	**7,393**	**2,937**	**44,191**
Net book value									
- Purchased at 31 March 2017	25,925	156,238	3,795	1,926	10,587	28	3,134	1,648	**203,281**
- Donated at 31 March 2017	-	680	-	-	387	-	12	34	**1,113**
Total at 31 March 2017	**25,925**	**156,918**	**3,795**	**1,926**	**10,974**	**28**	**3,146**	**1,682**	**204,394**
- Purchased at 31 March 2018	29,160	170,279	4,075	4,820	11,435	18	3,650	1,621	**225,059**
- Donated at 31 March 2018	-	670	-	-	277	-	10	28	**984**
Total at 31 March 2018	**29,160**	**170,949**	**4,075**	**4,820**	**11,712**	**18**	**3,660**	**1,649**	**226,043**

* Assets under construction and payments on account

All assets are used in provision of commissioner requested services.

The last full revaluation of property and land was carried out in 2016-17. Due to a significant increase in market prices during 2017/18, land, buildings and dwellings were revalued using the BCIS All-in TPI Index supplied by Cushman and Wakefield, RICS qualified.

13. Property, Plant and Equipment

Property, Plant and Equipment at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction *	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	42,885	162,629	5,622	2,066	37,544	186	9,164	4,209	**264,305**
Prior period adjustment	-	-	-	18	-	-	-	-	**18**
Additions - purchased	-	2,873	2	649	3,091	-	1,056	130	**7,801**
Additions - donated	-	-	-	-	107	-	12	5	**124**
Impairments	(16,960)	(8,473)	(1,829)	-	-	-	-	-	**(27,262)**
Reclassifications	-	409	-	(807)	374	-	(389)	-	**(413)**
Disposals	-	-	-	-	(1,560)	-	(420)	(94)	**(2,074)**
At 31 March 2017	**25,925**	**157,438**	**3,795**	**1,926**	**39,556**	**186**	**9,423**	**4,250**	**242,499**
Depreciation at 1 April 2016	-	3,624	127	-	27,384	145	5,814	2,292	**39,386**
Provided during the year	-	3,294	127	-	2,666	13	1,005	369	**7,474**
Impairments charged to operating expenses	-	3,433	-	-	-	-	-	-	**3,433**
Impairments charged to the revaluation reserve		(9,560)	(254)	-	-	-	-	-	**(9,814)**
Reversal of impairments	-	(221)	-	-	-	-	-	-	**(221)**
Reclassifications	-	(50)	-	-	50	-	(147)	-	**(147)**
Disposals	-	-	-	-	(1,518)	-	(395)	(93)	**(2,006)**
Depreciation at 31 March 2017	**-**	**520**	**-**	**-**	**28,582**	**158**	**6,277**	**2,568**	**38,105**
Net book value									
- Purchased at 31 March 2016	42,885	158,396	5,495	2,084	9,726	41	3,350	1,882	**223,859**
- Donated at 31 March 2016	-	609	-	-	434	-	-	35	**1,078**
Total at 31 March 2016	**42,885**	**159,005**	**5,495**	**2,066**	**10,160**	**41**	**3,350**	**1,917**	**224,919**
- Purchased at 31 March 2017	25,925	156,238	3,795	1,926	10,587	28	3,134	1,648	**203,281**
- Donated at 31 March 2017	-	680	-	-	387	-	12	34	**1,113**
Total at 31 March 2017	**25,925**	**156,918**	**3,795**	**1,926**	**10,974**	**28**	**3,146**	**1,682**	**204,394**

* Assets under construction and payments on account

All assets are used in provision of commissioner requested services.

14 Inventories	31 March 2018 £000	31 March 2017 £000
Raw materials and consumables	**6,276**	6,979
TOTAL	**6,276**	6,979

The cost of inventories recognised as an expense and included in operating expenses was £52,608k (2016/17: £51,104k)

No inventories were written down at the year end. Certain inventories were written off during the year due to normal breakages or expiry of shelf life. The amount of write-off during the year was £189k (2015/16: £218k) and is included in operating expenses.

15 Trade and Other Receivables	31 March 2018 £000	31 March 2017 £000 Restated
15.1 Current		
Trade Receivables	**16,867**	11,525
Provision for doubtful debts	**(1,501)**	(871)
Other prepayments and accrued income	**2,462**	2,642
Interest Receivable	**-**	2
VAT Receivable	**442**	1,074
PDC Receivable	**415**	932
Other Receivables	**253**	2,644
Sub Total	**18,937**	17,948
15.2 Non-Current		
Trade and Other Receivables	**2,201**	2,502
Provision for doubtful debts	**(179)**	(200)
Sub Total	**2,022**	2,302
TOTAL	**20,959**	20,250
Of which receivables from NHS and DHSC group bodies:		
Current	**12,951**	12,286
Non-current	**-**	-

Most of the income for the Trust arises from income generated from government agencies and no credit scoring is carried out for these customers. For other income from activities, income is obtained in advance where possible or is secured by service level agreements or contracts. Other operating income comes from various sources, including Government agencies. Before accepting new customers, other than Government agencies, for other operating income the Trust uses an external scoring system to assess the potential customer's credit quality and defines credit limits by customer.

The restatement reflected above is detailed in note 1.24.

15 Trade and Other Receivables (continued)

15.3 Movement in Provision for Impaired Trade and Other Receivables

	31 March 2018 £000	31 March 2017 £000
Opening Balance	**1,071**	988
Impairment losses recognised	**2,320**	1,941
Amounts written off as uncollectable	**(641)**	(830)
Impairment losses reversed	**(1,071)**	(1,028)
Closing Balance	**1,679**	1,071

The Trust provides for impairment of trade receivables based on past payment experience of various debtor types and also takes into account any change in payment practices by individual or groups of customers. Provision is made in full for outstanding amounts for each class of debt, the gross amount outstanding by each debtor is shown in the table below.

	31 March 2018 £000	31 March 2017 £000
Up to 30 days	**213**	55
30 to 60 days	**41**	67
60 to 90 days	**93**	23
90 to 180 days	**218**	144
Over 180 days	**1,114**	782
	1,679	1,071

There were no investments and other financial assets to disclose in this note.

15.4 Past due date but not impaired receivables

	31 March 2018 £000	31 March 2017 £000
Up to 30 days	**2,936**	570
30 to 60 days	**816**	445
60 to 90 days	**505**	172
90 to 180 days	**518**	415
Over 180 days	**2,217**	2,175
	6,992	3,777

As explained earlier, provision for doubtful debts is made on the basis of past experience. As a result not all debts that are past their due date are provided in full. The Trust does not hold any collateral or other credit enhancements over these balances, nor does it have any right of offset against any amounts owed by the Trust to the customer.

None of the provision for doubtful debts includes receivables from companies which have been placed in liquidation.

The directors consider that the carrying amount of trade and other receivables is approximately equal to their fair value.

The maximum exposure to credit risk at the reporting date is the carrying value of each class of trade receivable.

There were no investments and other financial assets to disclose in this note.

16. Cash and cash equivalents	31 March 2018 £000	31 March 2017 £000
Cash at commercial banks and in hand	**351**	264
Cash with the Government Banking Service	**13,435**	6,795
Cash and cash equivalents as in Statement of Financial Position	**13,786**	7,059

17. Trade and Other Payables	31 March 2018 £000	31 March 2017 £000 Restated
Deferred Income	**752**	359
Trade Payables	**16,109**	11,149
Capital payables (including capital accruals)	**5,737**	914
Tax and social security costs	**4,203**	4,025
Other Payables	**1,651**	2,407
Accruals	**13,446**	11,793
Total Current	**41,898**	30,647
Of which receivables from NHS and DHSC group bodies:		
Current	**10,262**	5,146
Non-current	**-**	-

The restatement reflected above is detailed in note 1.24.

18. Borrowings	31 March 2018 £000	31 March 2017 £000
18.1 Current		
Capital Loans from the Department of Health and Social Care	**1,836**	1,836
Working capital loans from the Department of Health and Social Care	**36,700**	36,700
	38,536	38,536
18.2 Non-Current		
Capital Loans from the Department of Health and Social Care	**21,048**	21,417
Working capital loans from the Department of Health and Social Care	**44,032**	18,284
	65,080	39,701
Total Borrowings	**103,616**	78,237

18. Borrowings (continued)

18.3 Capital Loans from the Department of Health and Social Care

Capital loans from the Department of Health and Social Care have been made available and are at a fixed interest rate. Details of each loan are given below.

		31 March 2018 £000	31 March 2017 £000
4.7% loan of £1.6m repayable by instalments every six months commencing March 2007	25 Years	**864**	928
4.9% loan of £8.4m repayable by instalments every six months commencing July 2008	25 Years	**4,906**	5,255
4.49% loan of £16m total facility repayable by instalments every six months commencing March 2012	25 Years	**11,570**	12,252
1.90% loan of £6.3m total facility repayable by instalments every six months commencing September 2015	10 Years	**4,077**	4,818
1.5% interim revenue support loan of £36.7m repayable March 2019. (Extended from March 2018)	3 Years	**36,700**	36,700
1.5% interim revenue support loan of £18.284m repayable March 2020.	3 Years	**18,284**	18,284
1.5% interim revenue support loan of £7.672m repayable March 2021.	3 Years	**7,672**	-
1.5% interim revenue support loan of £18.076m repayable March 2021.	3 Years	**18,076**	-
1.82% loan of £8.961m repayable by instalments every six months commencing when fully drawn.	25 Years	**1,467**	-
		103,616	**78,237**

19. Provisions for Liabilities and Charges

	Pensions relating to other staff £000	Legal claims £000	Other £000	**Total £000**
At 1 April 2017	1,129	119	6,223	7,471
Arising during the year	-	95	-	95
Utilised during the year	(128)	(9)	(1,145)	(1,282)
Reversed unused	-	(114)	(250)	(364)
Unwinding of discount	138	-	-	138
At 31 March 2018	**1,139**	**92**	**4,828**	**6,058**
Expected timing of cashflows:				
Within one year	92	92	4,828	5,012
Between one and five years	1,047	-	-	1,047
	1,139	**92**	**4,828**	**6,058**

19.1 Provisions for Liabilities and Charges

	2017/18 £000	2016/17 £000
Current	**5,012**	6,402
Non-Current	**1,047**	1,069
	6,058	7,471

Provisions for legal claims represents the gross estimated liability from employer and public liability cases and other outstanding legal claims based on contractual or employment liabilities. Employer and public liability cases are managed by NHS Litigation Authority through the Liabilities to Third Party scheme and the NHS Litigation Authority share of the provision is included in its accounts.

There were no pension provisions relating to former directors.

Included within provisions is £4.4m (£4.6m in 2016/17) for employment tribunals. There is no provision for contract income challenges (£0.3mm in 2016/17).

20. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £2,417k (31 March 2017 £3,491k).

21. Post Balance Sheet Events

There are no post balance sheet events.

22. Notes to Statement of Cash Flows

	2017/18 £000	2016/17 £000
Reconciliation of Operating Surplus to Net Cash Flow from Operating Activities		
Operating surplus/(deficit) from continuing operations	**(20,518)**	(11,154)
Operating deficit	**(20,518)**	(11,154)
Adjustment for non-cash items:		
Depreciation and amortisation	**9,408**	9,545
Impairments	**(749)**	3,212
Loss on Disposal		
Non-cash donations/grants credited to income	**(37)**	(140)
Changes in Working Capital:		
Decrease/(Increase) in Trade and Other Receivables	**(1,228)**	(4,947)
Increase in Inventories	**703**	(366)
Increase/(Decrease) in Trade and Other Payables	**6,407**	(6,518)
(Decrease)/Increase in Provisions	**(1,551)**	(1,484)
Other movements in operating cash flows	**(1)**	1
Net cash inflow from operating activities	**(7,566)**	(11,851)

23. Related Party Transactions

The Trust is a corporate body established by the Secretary of State. The Independent Regulator of NHS Foundation Trusts (Monitor operating as NHSI) and other Foundation Trusts are considered related parties. The Department of Health and Social Care is regarded as a related party as it exerts influence over a number of financial and operating policies of the Trust. The Trust had a significant number of transactions with the Department of Health and Social Care and with entities for which the Department of Health and Social Care is regarded as the parent department.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue and capital payments from Basildon and Thurrock University Hospitals Charitable Trust. The Trust is Corporate Trustee of this charity and therefore it is considered a related party.

The related party transactions described above are summarised in the table below. Where individual trusts or Government Departments transactions are not material these have been grouped together.

During the year none of the Board Members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with the Trust other than compensation as disclosed in this note.

24. Related Party Transactions

2017/18	Expenditure with Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Foundation Trusts				
Essex Partnership NHS FT	132	1,018	31	232
North East London NHS FT	131	878	36	89
Southend University Hospital NHS FT	1,454	377	1,045	924
Other	877	50	328	19
English NHS Trusts				
Mid Essex Hospital Trust	101	241	918	591
Other	463	1,188	310	254
Clinical Commissioning Groups (inc. NHS				
NHS Basildon and Brentwood CCG	329	116,637	1,545	1,319
NHS Castlepoint and Rochford CCG	22	10,071	42	1,203
NHS England	15	64,022	4,053	3,736
NHS Havering CCG	6	2,676	320	315
NHS Mid Essex CCG	6	3,698	122	137
NHS North East Essex CCG	1	2,152	0	469
NHS Southend CCG	1	4,001	6	549
NHS Thurrock CCG	87	82,925	945	779
NHS West Essex CCG	1	1,603	89	503
Other	11	5,308	275	1,594
Public Health England	4	72	1	-
Health Education England	6	8,465	-	238
NDPBs				
Other	252	-	-	-
Other DHSC bodies				
Other	150	-	73	-
WGA Special Health Authorities				
NHS Litigation	11,905	-	-	-
Other WGA Bodies				
NHS Blood and Transplant	2,374	-	-	-
HM Revenue and Customs	17,459	-	4,203	442
NHS Pension Scheme	17,967	-	2,493	-
NHS Professionals	352	-	1,131	-
Other	11	28	-	4
Basildon and Thurrock University Hospitals				212
Other Local or Central Government Bodies	43	480	-	90
Department of Health and Social Care	-	-	-	-

24. Related Party Transactions (cont.)

2016/17	Expenditure with Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Foundation Trusts				
North East London NHS FT	366	1,086	10	113
Southend University Hospital NHS FT	1,653	367	1,078	150
Other	1,088	1,028	330	214
English NHS Trusts				
Mid Essex Hospital Services NHS Trust	335	241	179	207
Other	578	1,186	153	137
Clinical Commissioning Groups (inc. NHS England)				
NHS Basildon and Brentwood CCG	396	115,480	2,385	1,314
NHS Castlepoint and Rochford CCG	-	8,429	26	64
NHS England	103	70,761	82	6,075
NHS Havering CCG	-	3,015	17	637
NHS Mid Essex CCG	-	3,493	6	110
NHS North East Essex CCG	-	2,184	-	31
NHS Southend CCG	-	3,775	5	27
NHS Thurrock CCG	-	82,431	755	861
NHS West Essex CCG	-	1,681	1	11
Other	-	5,028	115	1,153
Public Health England	16	72	3	72
Health Education England	5	7,539	-	179
Non Departmental Public Bodies				
Other	173	-	1	-
WGA Special Health Authorities				
NHS Litigation	10,862	-	2	-
Other WGA Bodies				
NHS Blood and Transplant	2,134	-	-	-
HM Revenue and Customs	15,495	-	4,025	1,074
NHS Pension Scheme	17,219	-	2,407	-
Other	264	29	-	-
Basildon and Thurrock University Hospitals	-	-	-	171
Other Local or Central Government Bodies	18	261	-	164
Department of Health	3	-	-	932

24. Related Party Transactions (cont.)

	2017/18 £000	2016/17 £000

Key Management Compensation

Key management includes all those individuals or entities controlled by them that have been identified as Senior Management. Full remuneration details are included in the Remuneration Report. The payables arise as a result of normal trading credit and are due within one month of receipt and bear no interest.

Compensation Payable		
Short Term employment benefits	**670**	1,173
Post Employment Benefits	**74**	102
	744	1,275

There were no amounts due to or from key management personnel as at 31 March 2018 or 31 March 2017.

25. Financial Instruments

Financial Risk Management

The Trust's activities expose it to a variety of financial risks: market risk (including financial markets), credit risk and liquidity risk. The Trust's overall risk management programme focuses on credit risk.

Market risk

Market risk for the Trust is low as there are no significant foreign exchange transactions (although some suppliers prices are affected by foreign exchange fluctuations) and price risk is low as the Trust does not hold investments. Liquidity risk is minimised by regular cash flow forecasting and maintaining a working capital facility.

Where the Trust's Financial Assets and Liabilities are subject to floating interest rates these are all based on the prevailing Base Rate. The Trust is not, therefore, exposed to material interest-rate risk.

The book value of financial instruments is considered to be the same as the fair value.

Credit Risk

Credit risk primarily arises from two sources; cash deposits with banks and financial institutions and credit exposures to customers and other debtors.

Cash deposits with financial institutions are controlled by the Trust's Managing Operating Cash policy and this is regularly monitored by the Finance and Resources committee. The policy provides that deposits may only be made with 'A' rated institutions, or Government Banking services, and in addition operates additional single deposit, banking group and concentration limits.

The majority of the Trust's customers are Clinical Commissioning Groups. As such, credit risk in this area is considered to be limited to disputes over activity rather than the customers' ability to pay. Other customers have an appropriate credit check or settle via cash or using major credit cards before any activity is undertaken. Where debtors exceed any agreed credit terms appropriate provision is made against that class of debt; full details of these provisions are given in note15.

Liquidity risk

The Trust's net operating costs are incurred under contracts with local Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust mainly finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risk.

25. Financial Instruments

Analysis by category	31 March 2018 £000	31 March 2017 £000
All Financial Assets are Loans and Receivables		
NHS Trade and other receivables	12,951	9,325
Trade and other receivables with other bodies	3,201	3,932
Cash and cash equivalents	13,786	7,059
Total	**29,938**	20,316
All Financial Liabilities are Other Financial Liabilities		
Borrowings	103,616	78,237
NHS Trade and other payables	7,218	14,124
Trade and other payables with other bodies	27,232	9,732
Total	**138,066**	102,093

Maturity of financial liabilities	31 March 2018 £000	31 March 2017 £000
In one year or less	65,768	62,392
In more than one year but not more than two years	20,181	1,836
In more than two years but not more than five years	31,439	23,792
In more than five years	20,678	14,073
Total	**138,066**	102,093

26. Third Party Assets

The Trust held £1,970 cash at bank and in hand at 31 March 2018 (31 March 2017: £406) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

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

Accounting valuation

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

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

Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

28. Joint Venture and Subsidiaries

28.1 Joint Venture Performance

The Trust holds a 25.5% share of each of Facilities First LLP and Pathology First LLP. These entities are jointly controlled by the Trust, Southend University Hospital NHS Foundation Trust and Integrated Pathology Partnerships (iPP). The arrangements are treated as a joint venture and are accounted for using equity accounting, such that 25.5% of the surplus/(deficit) made is included in the Trust's Statement of Comprehensive Income and 25.5% of the net assets of the Joint Venture are included in the Statement of Financial Position of the Trust

Group statements have not been prepared as the initial consideration in the Joint Venture is nil. The amounts to be included under entity accounting is also nil. As such there are no material changes to the statement.

	Facilities First	Pathology First	Combined	Combined
	2017/18 £000	2017/18 £000	2017/18 £000	2016/17 £000
Profit and Loss Account				
Turnover	11,545	11,435	**22,980**	23,163
Cost of sales	(11,525)	(11,421)	**(22,946)**	(23,045)
Gross Profit	**20**	**14**	**34**	118
Operating expenditure	(20)	(14)	**(34)**	(118)
Profit/(Loss) before tax	**-**	**-**	**-**	-
Trust's share of profit/(loss) in Statement of Comprehensive Income	**-**	**-**	**-**	-
Statement of Financial Position				
Current assets	613	569	**1,182**	1,396
Payables - amounts due within one year	(613)	(569)	**(1,182)**	(1,396)
Net Assets/(Liabilities)	**-**	**-**	**-**	-
Net Assets/(Liabilities)	**-**	**-**	**-**	-
Share of net assets/(liabilities) recognised in the Statement of Financial Position	**-**	**-**	**-**	-

28.2 Subsidiaries

The Trust has not consolidated the charity accounts of Basildon and Thurrock University Hospitals Charitable Trust because the values involved are not considered to be material in the context of the Trust as a whole.