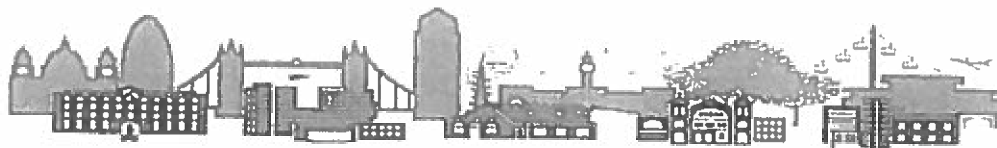
NHS
Barts Health
NHS Trust

Barts Health NHS Trust
Accountable Report
2017/18



ANNUAL REPORT - ACCOUNTABILITY REPORT

Accountability report

CORPORATE GOVERNANCE REPORT

NHS bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by the Secretary of State for Health. This section takes account of the Department of Health guidance for NHS trusts in the manual for accounts.

The Trust Board

The Trust Board is a unitary board accountable for setting the trust's strategic direction, vision and values, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the trust and the local community. The board consists of the chairman, chief executive, four executive directors and seven non-executive directors (NEDs) all with voting rights, plus four other executive directors who attend board meetings in a non-voting capacity. The number of NEDs is one higher than most NHS trusts, reflecting the size and complexity of Barts Health's agenda as the largest trust in England. As at 1 April 2018, there were no executive or non-executive vacancies. During 2017/18, two NExT directors have also been invited to attend Board meetings in a non-voting capacity and participate in Board committee meetings. Others may be invited to attend board meetings for specific items as agreed with the chairman.

The Trust Board meet regularly in public so that it can discharge its duties (the board met 9 times in public during 2017/18, including the annual general meeting). The Trust Board has responsibility for the Trust's strategy, quality and safety of healthcare services, education, training and research. Day-to-day responsibility for implementing the trust's strategy and delivering operational requirements is delegated through the chief executive to the executive directors and their teams. Key duties are set out in the Trust's standing orders and standing financial instructions and board terms of reference, which are reviewed every two years.

Board appointments

The chairman and chief executive take into account the required skills, qualifications, experience and diversity of the board's composition as part of the recruitment process to the board of Barts Health. The nominations and remuneration committee help to identify the skills and experience required for new appointments to executive director positions, while the chairman works with NHS Improvement to identify the skills and experience required for any new appointments to NED positions.

Independence of NEDs

One of the NEDs is nominated by Queen Mary University of London. Excluding this NED position, there are six NEDs and four executive directors. Gautam Dalal is the senior independent director and vice chairman of the Trust. NEDs are generally appointed for an initial four-year term, with the chairman monitoring the composition of the board, its skills and knowledge in the light of any NED changes or potential reappointment of NEDs for second terms of office.

Board members – biographies of board members (as at 1 April 2018)

Mr Ian Peters (chairman) joined Barts Health NHS Trust as chairman on 1 April 2017. After a successful career in financial services and energy, Ian retired in 2015 from Centrica, the parent company of British Gas, where he held a number of senior roles including managing director. He is a trustee and treasurer of the charity Carers UK and chairs a number of small technology companies. Ian also took on the role of vice chair of the Peabody housing association when it merged with Family Mosaic during summer 2017. He has formerly served as a non-executive director at Central and North West London NHS Foundation Trust.

Ms Alwen Williams (chief executive) has been a manager in the NHS since 1980, working in primary care, community and acute services, commissioning and joint planning. She became chief executive of Tower Hamlets Primary Care Trust (PCT) in June 2004, was seconded to the post of chief executive of East London and the City Alliance of PCTs in 2009 and in January 2011 became the chief executive of NHS East London and the City. In December 2011 Alwen also took on the role of chief executive of NHS Outer North East London leading the two primary care trust clusters which cover all the London boroughs in north east London: City and Hackney, Newham, Tower Hamlets, Barking and Dagenham, Havering, Redbridge and Waltham Forest. From April 2013, Alwen assumed the national role of director of delivery and development for the NHS Trust Development Authority. On 1 June 2015, Alwen moved to Barts Health NHS Trust as interim chief executive and became substantive chief executive on 21 October 2015.

Mr Gautam Dalal (non-executive director, vice chairman and senior independent director) is a chartered accountant and a former senior audit partner at KPMG London. From 2000 to 2003 he was chairman and chief executive of KPMG's practice in India, which he helped to establish. He was formerly a non-executive director of Barts and The London NHS Trust from September 2010 to March 2012. Gautam is a member of the Governing Body and Honorary Treasurer of the School of Oriental and African Studies and is board member of Camellia plc and ZincOx Resources plc. Previously he was a founder board member of the UK India Business Council, a trustee of The National Gallery and a member of the Asian Business Association Committee

of the London Chamber of Commerce. Gautam is also the Trust Board's vice-chairman and senior independent director.

Mr Alastair Camp (non-executive director) became an associate non-executive director with NHS Tower Hamlets in 2008, before becoming chair of the primary care trust and then vice-chairman of NHS East London and the City until March 2012. His business career has included 34 years with Barclays plc, during which he led businesses in the UK and overseas. These included appointments as managing director (Caribbean and Bahamas), managing director (UK Small Business Banking) and managing director (UK Mid Corporate Banking), where he served on the UK Banking Executive Board. He was also Barclays Group corporate responsibility director and a trustee of the Barclays Group Pension Fund. Alastair is a Magistrate and trustee of the London Institute of Banking and Finance pension fund. He holds a Masters Degree in Business Administration and is a fellow of the Chartered Institute of Bankers.

Professor Steve Thornton (non-executive director) is vice-principal and executive dean (health) of Barts and The London School of Medicine and Dentistry and assumed his role as non-executive director in February 2016. Previously he had held the position of pro vice chancellor and executive dean of medicine at the University of Exeter. Prior to this he has held positions at the universities of Newcastle, Cambridge, Warwick and (as dean) the Peninsula College of Medicine and Dentistry. Professor Thornton is a clinical scientist whose speciality is obstetrics and gynaecology. He continues to undertake leading roles at The Royal College of Obstetricians and Gynaecologists and Medical Schools Council, where he has recently been elected to the executive team.

Dr Thoreya Swage (non-executive director) has significant experience in the NHS both as a clinician in psychiatry and a senior manager in various NHS purchasing organisations covering the acute sector as well as primary care development. Her previous NHS executive experience was as executive director of a health authority with a remit to develop primary care services including GP commissioning and GP fundholding. Since 1997 Thoreya has run a successful management consultancy business during which time she has developed particular expertise in the field of service reviews and redesign, strategic development, clinical governance, commissioning and procurement with the NHS and independent sector, and education and training. During 2006-07 she was deputy medical director at the commercial directorate at the Department of Health with the responsibility to set up the clinical governance processes for the National Independent Sector Treatment Programme. She has taught at King's College, London and has researched and written a number of published articles. Thoreya is also a non-executive director at Frimley Health NHS Foundation Trust.

Mr Mark Higson (non-executive director) joined Barts Health NHS Trust in October 2016. He has had a wide ranging career and has managed major

transformations at board level in a number of complex, global businesses. From 2007 to 2014 he led a strategic review and transformation programme as the managing director of operations at Royal Mail. An engineer by background, in prior years Mark was a director at BPB Plc, a global building materials producer, and has also worked in international businesses in the chemicals, food and aerospace industries. He has a passion for achieving high performance in safety, customer service and operating efficiency by developing leaders and fully engaging people in continuous improvement.

Ms Natalie Howard (non-executive director) joined Barts Health NHS Trust in December 2017. Natalie joined AgFe in 2010 as a Partner and heads the firm's real estate lending group. Natalie started her career in 1989 at Paribas. Subsequently she worked at Charterhouse; Morgan Stanley, where she was a founding member of their European CMBS business; Barclays Capital, where she helped establish their CMBS programme and was responsible for the real estate lending group; and Lehman Brothers where she was the Managing Director in charge of the firm's real estate debt funds for Europe and Asia.

Ms Margaret Exley (non-executive director) joined Barts Health NHS Trust in January 2018. Following her early career in the Civil Service, Margaret has developed her career in organisational and culture change and has founded and led a number of consultancies including Kinsley Lord and, currently SCT Consulting. She has in recent times provided organisational development support at NHS England, Department of Health and at HM Treasury board level.

Dr Tim Peachey (deputy chief executive) is a consultant in anaesthesia, who was initially seconded part-time to Barts Health to support the Trust's improvement programme (in his capacity as the NHS Trust Development Authority's associate medical director). Tim's former roles at the Royal Free London NHS Foundation Trust included chief clinical information officer and he has previously held posts as clinical director, medical director, divisional director and interim chief executive of Barnet and Chase Farm Hospitals NHS Trust in the 18 months prior to its acquisition by the Royal Free. As deputy chief executive, Dr Tim Peachey holds board-level responsibility for information and ICT, corporate governance and communications, estates and facilities.

Ms Caroline Alexander (chief nurse) joined Barts Health in 2016, bringing her significant nursing leadership experience at director level across a breadth of portfolios - healthcare provision, commissioning and system leadership. She was director of nursing and therapies for Tower Hamlets PCT and then director of nursing and quality for NHS ELC then NHS NEL clusters of primary care trusts. Caroline was regional chief nurse for NHS England in London for three years before taking up her current post of chief nursing officer for Barts Health. Caroline graduated as a nurse in 1987 from Edinburgh University (BSc/RGN) and has an MSc in Nursing Studies from South Bank University.

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Caroline was a 2008 Florence Nightingale Leadership Scholar. She is a visiting professor at Bucks New University.

Professor Alistair Chesser (chief medical officer) trained as a medical student at Cambridge and The Royal London Hospital, undertaking his junior doctor training at St Bartholomew's, Whipps Cross and The Royal London. He then conducted research as part of the William Harvey Institute at QMUL before being appointed as a consultant nephrologist at Barts and The London in 2003. Alistair has worked as associate dean for undergraduates and as the clinical academic group director for emergency care and acute medicine at Barts Health since 2012 prior to his appointment as chief medical officer in 2016.

Ms Chrisha Alagaratnam (chief finance officer) was formerly interim chief executive at Epsom and St Helier University Hospitals NHS Trust and has worked in the NHS for 20 years. As director of finance and performance, Epsom and St Helier achieved breakeven in 2014-15 and she led the work to identify efficiencies and effectiveness while simultaneously, creating room for investments to meet stringent London quality standards. Chrisha's portfolio at the time also included her role as deputy chief executive and leading on the organisational progress towards foundation trust status. Prior to working at Epsom and St Helier, Chrisha also worked at Croydon Health Services NHS Trust, where she was interim director of finance and information as well as director of the foundation trust in 2010. Chrisha is a fellow of the Association of Chartered Certified Accountants.

Mr Michael Pantlin (director of people) joined Barts Health on 1 October 2012 from the Royal Surrey County Hospital NHS Foundation Trust. Previously he was with the Royal Bank of Scotland in commercial and retail banking sectors across England and Wales. Prior to this, Michael headed HR for the specialist brands of the Thomson Travel Group. Originally, during his professional training, Michael spent some time working at the Mildmay Hospital, which specialises in palliative care for HIV/AIDS. He moved to the private sector knowing that one day he wanted to return to a similar organisation.

Mr Andrew Hines (director of corporate development) has spent the last 23 years in leadership roles in the NHS, working at Board level in a number of organisations. After graduating from Cambridge University he joined the NHS Management Training Scheme, and he has spent the bulk of his career in senior healthcare leadership roles in acute and specialist NHS provider organisations in London and the South of England, including Surrey and Sussex Healthcare NHS Trust and Great Ormond Street Hospital for Children NHS Foundation Trust. He has held board level responsibility for operations, strategy, business development, communications, IT and estates & facilities. Over the last six years Andrew has held senior regional leadership roles in London. As interim regional director for the NHS Trust Development Authority he was responsible for oversight of the performance of London's NHS Trusts,

before setting up NHS Improvement's London regional team and leading on strategic and operational planning as regional Chief Operating Officer.

Mr Tony Halton (director of clinical operations) oversees the performance of the clinical operations across the Barts Health Group, to ensure that our patients receive clinical services which are safe, compassionate, high quality, timely, accessible and efficient. He joined Barts Health in 2012 as Group Director for Clinical Support Services. He is an experienced NHS senior leader and has previously as a Chief Nurse, Chief Operating Officer and in government as the Programme Director for Modernising Nursing Careers at the Department of Health.Tony is proud to be a Registered Nurse. His clinical experience majored in the care of people with HIV/AIDS and he feels privileged to have worked with people with very complex care needs. The principles of providing high quality and personalised care inform how he works to influence care delivery that is outstanding.Tony is also an accredited Executive Coach and specialises in developing leaders, career transition, resilience, organisational change and achieving results in challenging and complex situations

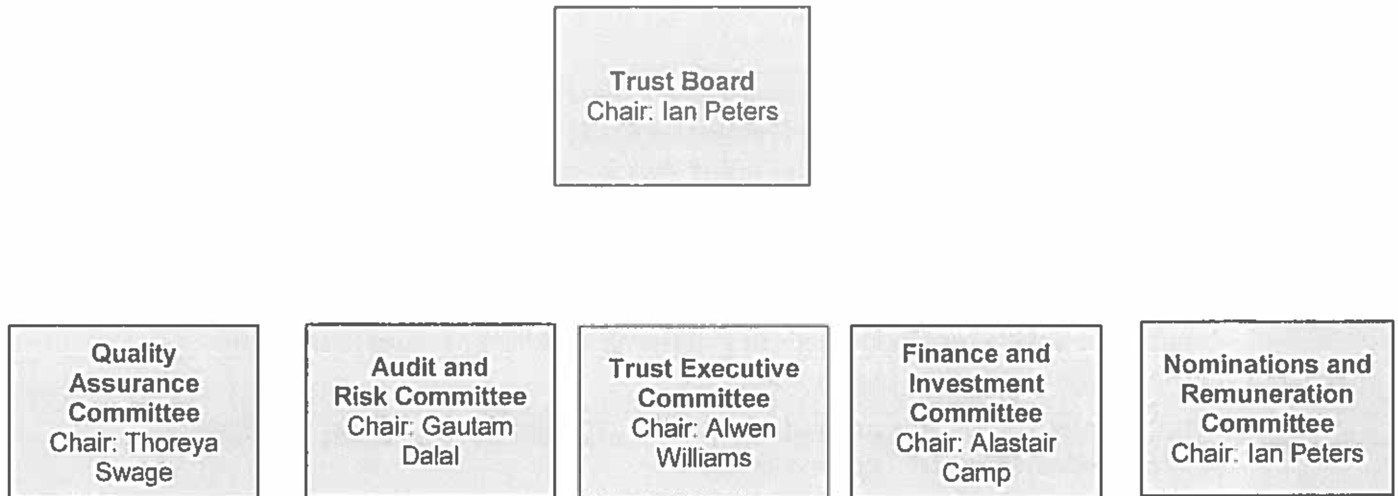
Mr Ralph Coulbeck (director of strategy) began his career on the NHS Management Training Scheme and has worked in the NHS, parliament and government. He was previously director of strategy at the NHS Trust Development Authority and also worked as chief adviser to the NHS chief executive Sir David Nicholson. Ralph Coulbeck was appointed director of strategy for the Trust in April 2016.

Trust Board and board committees

The membership for the trust board is published on the Trust's website. The trust board elects to establish board committees to assist it to carry out its functions, which can include the implementation of time-limited board committees or board committee sub-groups. The approved board committee structure and current chairs as at 1 April 2018 are shown below in Chart 1.

Terms of reference for board committees are subject to review on a two-yearly basis. Exception reports are provided to the Trust board (based on use of a standard proforma reporting template) by each of the board committees following their meetings. Board assurance committees also produce an annual report summarising how each has met its duties during the year. These reports are available with the Trust board meeting papers on the website.

Chart 1



Audit and risk committee

The following are key duties of the audit and risk committee (an assurance committee of the board):

- To provide assurance to the board based on review of the establishment and maintenance of an effective system of governance, risk management and internal control across the trust's activities that support the achievement of the organisation's objectives. The audit and risk committee is assisted in this duty by the quality assurance committee, which has responsibility for providing assurance in relation to clinical quality and safety aspects.
- To ensure that there is an effective internal audit function put in place by management that meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the audit and risk committee, chief executive and board.
- Consideration of the major findings of internal audit work and the management response and ensuring coordination between the internal and external auditors to optimise audit resources.
- To review the work and findings of the external auditor and consider the management responses to their work.
- To act as an auditor panel, making recommendations to the board on appointment and removal of external audit partners, and to agree the approach to be taken to maintain objectivity of external auditors in the event that the external audit partner is commissioned by the trust to undertake any non-audit work.
- To review proposed changes to the standing orders and standing financial instructions.

- To review the annual accounts to determine their completeness, objectivity, integrity and accuracy before they are presented to the trust board.

The chair of the audit and risk committee is a chartered accountant with a strong background in corporate finance and audit. Membership is in line with good practice recommendations and a self-assessment of the committee's performance is conducted annually. Exception reports are provided to the trust board (based on use of a standard proforma reporting template) following each meeting. At its meeting on 13 September 2017, the trust board received the audit and risk committee's annual report, which confirmed compliance with key duties set out in it terms of reference and identifying areas requiring further assurance.

Membership: 3 non executive directors (Mr Gautam Dalal – chair, Mr Mark Higson –vice chair, Dr Thoreya Swage).

In attendance: chief executive (min. once per year), deputy chief executive, chief finance officer, director of corporate development, NExT director (Ms Ashantel Lachhani)

Quality assurance committee

The quality assurance committee is a standing assurance committee of the trust board (reporting via the audit and risk committee) and acts on its behalf to monitor, review and report on the quality of clinical services provided by the trust. In carrying out its role, the quality assurance committee supports the audit and risk committee through providing dedicated time and resources to review, for example, clinical aspects of assurance work carried out by internal audit and the clinical audit functions. There is a shared membership of the audit and risk committee and the quality assurance committee and the chair of the quality assurance committee has relevant clinical experience and qualifications.

The terms of reference include a remit to examine on the board's behalf key aspects of operational delivery, given its close relationship to the quality agenda. During 2017/18, the quality assurance committee included a specific focus on implementation of the trust's improvement plan, performance against national access standards and quality and safety arrangements at site and clinical board level. Exception reports are provided to the trust board (based on use of a standard proforma reporting template) following each meeting. At its meeting on 25 October 2017, the audit and risk committee reviewed the quality assurance committee's annual report, which confirmed compliance with key duties set out in it terms of reference.

Membership: 3 non executive directors (Dr Thoreya Swage – chair, Ms Margaret Exley – vice chair, Prof Steve Thornton) chief executive and/or

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deputy chief executive, chief medical officer, chief nurse, director of clinical operations, NHSI improvement director.

Nominations and remuneration committee

The Trust's nominations and remuneration committee comprises the chairman and all NEDs. The chief executive and the director of human resources usually attend meetings. The committee has delegated authority from the trust board to appoint and remove the chief executive and, together with the chief executive, to appoint and remove other executive directors. Appointments to non-executive director posts are approved externally by NHS Improvement, which also sets the remuneration and terms and conditions for chairs and NEDs of NHS trusts. Appointment, removal, remuneration, allowances and terms and conditions of office for executive directors (and the structure of remuneration, allowances and terms and conditions for other defined senior officers) and any changes to these terms is determined by the nominations and remuneration committee with due regard to performance and national guidance. Exception reports (based on use of a standard proforma reporting template) accompanied by oral updates from the chair are provided to the trust board following each meeting.

The remuneration of all board members is published in the remuneration section of this report and covers all remuneration received.

Membership: Chairman and all non executive directors

Finance and investment committee

In addition to the above statutory committees, the trust board is supported by a finance and investment committee. This committee undertakes, on behalf of the trust board, objective scrutiny of the trust's financial plans, investment policy and major investment decisions. The committee reviews the trust's monthly financial performance and identifies the key issues and risks requiring discussion or decision by the trust board. Exception reports (based on use of a standard proforma reporting template) are provided to the trust board following each meeting. Although not a board assurance committee, the finance and investment committee monitors its performance against key duties set in its terms of reference and last reviewed its terms of reference in May 2016.

Membership: Four non executive directors (Mr Alastair Camp – chair, Ms Natalie Howard – vice chair, Mr Gautam Dalal, Mr Mark Higson), chief executive, deputy chief executive, chief finance officer, director of people, director of financial improvement, NExT director (Ms Kim Kinnaird).

Trust Executive Committee (executive committee)

While not a Board committee chaired by a NED, the Trust Executive Committee, chaired by the Chief Executive, is the principal executive committee. It leads on implementation of the Trust's clinical, operational and financial strategy and plans; and ensuring appropriate integration of clinical services and sites, between clinical and corporate functions and within the Trust and with external partners.

Membership: Executive directors (voting and non-voting), hospital/CSS managing directors, director of estates and facilities, director of communications

Attendance at trust board and principal board committees

Committee	Number of meetings held	Average attendance rate in 2017-18
Trust board (parts 1 and 2)	18	88%
Audit and risk committee	4	83%
Quality assurance committee	7	85%
Nominations and remuneration committee	3	86%
Finance and investment committee	12	81%

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Attendance by members of board committees, 2017-18

*The below figures indicate the number of meetings attended by the relevant member/total number of meetings held during their period in post

Board member	Trust board part 1 (excluding AGM)	Trust board part 2	Audit and risk committee	Quality assurance committee	Nominations and remuneration committee	Finance and investment committee
Ian Peters	7/8 (88%)	8/10 (80%)		2/2 (100%)	3/3 (100%)	
Gautam Dalal	7/8 (88%)	9/10 (90%)	4/4 (100%)		3/3 (100%)	7/11 (64%)
Thoreya Swage	8/8 (100%)	9/10 (90%)	4/4 (100%)	7/7 (100%)	3/3 (100%)	
Alastair Camp	8/8 (100%)	10/10 (100%)			2/3 (67%)	11/11 (100%)
Steve Thornton	6/8 (75%)	9/10 (90%)		2/7 (29%)	3/3 (100%)	
Mark Higson	7/8 (88%)	9/10 (90%)	2/4 (50%)		1/3 (33%)	8/11 (73%)
Natalie Howard	1/2 (50%)	1/2 (50%)			1/1 (100%)	2/3 (67%)
Margaret Exley	2/2 (100%)	2/2 (100%)			1/1 (100%)	
Karen West	6/6 (100%)	7/8 (88%)			0/1 (0%)	6/7 (86%)
Tracey Fletcher	5/5 (100%)	7/8 (88%)		4/4 (100%)	1/1 (100%)	

Alwen Williams	8/8 (100%)	10/10 (100%)		4/4 (100%)		10/11 (91%)
Chrisha Alagaratnam	4/8 50(%)	4/10 (40%)				4/11 (36%)
Caroline Alexander	8/8 (100%)	10/10 (100%)		7/7 (100%)		
Alistair Chesser	8/8 (100%)	9/10 (90%)		7/7 (100%		
Tim Peachey	8/8 (100%)	10/10 (100%)		7/7 (100%)		10/11 (91%)
Michael Pantlin	7/8 (88%)	8/10 (80%)				8/11 (73%)
Ralph Coulbeck	8/8 (100%)	9/10 (90%)				
Tony Halton	6/7 (86%)	7/9 (78%)		5/7 (71%)		
Andrew Hines	4/4 (100%)	5/5 (100%)				
Jacqueline Totterdell	1/1 (100%)	0/1 (0%)				
Ian Walker	2/2 (100%)	2/2 (100%)				
Lesley Stephen (director of recovery)						4/4 (100%)
Bill Boa (director of financial improvement)						4/4 (100%)

Board effectiveness

During 2017/18, substantive appointments and reappointments have been made to non-executive and executive director roles to strengthen and consolidate the effectiveness of the trust board and in support of the group model. In line with best practice, an externally-facilitated Well Led assessment will incorporate a review of board development. This will be conducted during early 2018/19 and the output of this will also link in with the planned development of a Trustwide quality improvement approach.

Trust board appraisals

The process for appraisals has been established with the chair of NHS Improvement conducting appraisals for the trust chairman; the chairman or vice chairman conducting appraisals for the non-executive directors and the chief executive; and the chief executive conducting appraisals for executive directors. These are completed on an annual basis during quarter one each year. Appraisals of executive and non-executive director performance for 2017-18 are scheduled for completion by the end of the first quarter of 2018-19 (with all executive director appraisals booked in diaries). The output of the review of executives' performance against objectives will be reported to the trust's nominations and remuneration committee for review, in line with the committee's terms of reference.

Board members - interests, gifts and hospitality; fit and proper persons regulations; declarations and expenses

The staff policies and remuneration section of this report includes details of all non-executive director and executive director interests, including related party transactions. As a standing item at every board and board committee meeting, members are asked to declare any new interests, gifts or hospitality and these are minuted. Board members are also required to complete and sign a declaration of interest form on an annual basis (details of declared interests are included in this annual report). Fit and proper persons self-assessments are also completed annually in line with national fit and proper persons regulations. This addresses the requirement for directors to confirm/provide evidence to support their fitness to practice and for organisations to satisfy themselves in this regard. The trust office (on behalf of the chairman) maintains records of the following for each executive director and non-executive director:

- An annual self-declaration on fitness to practice completed and signed by each individual.
- Disclosure and barring service status checks.
- Confirmation of a central check against register of individuals subject to bankruptcy restrictions, sequestration or debt relief orders.
- Confirmation of professional qualifications.

The annual report and accounts summarise non-executive director and executive director expenses claimed following review on a six monthly basis by the audit and risk committee.

Modern Slavery Act – Board Statement

On 1 March 2017, the trust board issued a declaration regarding its arrangements to support compliance with the Modern Slavery Act 2015 and this has been reproduced below to reconfirm this commitment.

'Barts Health NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015, and we expect our staff and suppliers to comply with the legislation.

The Trust has updated relevant Trust policies to highlight obligations where any issues of modern slavery or human trafficking might arise, particularly in our guidelines on safeguarding adults and children, tendering for goods and services, and recruitment and retention.

The procurement process has been reviewed to ensure that human trafficking and modern slavery issues are considered at an early stage, with self-certification for potential suppliers that their supply chains comply with the law. We procure many goods and services under frameworks endorsed by the Cabinet Office and Department of Health, under which suppliers such as Crown Commercial Services and NHS Supply Chain adhere to a code of conduct on forced labour. We uphold professional practices relating to procurement and supply, and ensure procurement staff attend regular training on changes to procurement legislation.

The Trust requires all new staff to complete a safeguarding course, which covers obligations under the Act. We also require external agencies supplying temporary staff to demonstrate compliance with the legislation. All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices.

The Trust Board believes that the Trust is following good practice in implementing steps to prevent slavery and human trafficking'.

System development and integrated care

The Trust has a key role in wider system developments at both borough and STP level:

- As a key partner within the East London Health Care Partnership, a STP partnership covering all commissioners and providers within north east London, leading and contributing to a range of work areas, including its estates strategy (which includes the redevelopment of Whipps Cross, changes to emergency care at King George's hospital and considering options for future development of Mile End and Homerton hospitals) and

collaborative productivity, including initiatives to reduce costs of procurement and pathology services.

- The development of an Accountable Care System (ACS) in Waltham Forest will be a key focus in 2018/19. Partners in the ACS are Barts Health, NELFT, Waltham Forest CCG, Waltham Forest Local Authority and the Waltham Forest GP Federation (Fednet).
- Barts Health is a key partner in the developing of the Newham Integrated Care system, working with partners in primary, community and social care, including ELFT, Newham Health Collaborative and London Borough of Newham.
- Tower Hamlets Together brings together health and care commissioners and providers who are working together to deliver integrated health and care services for the population of Tower Hamlets. Key partners include: Barts Health NHS Trust; East London Foundation Trust; London Borough of Tower Hamlets; and Tower Hamlets GP Care Group.

The chief Executive, director of strategy and other executives represent the Trust on key sector and borough groups supporting the above work. Further details of this work are captured in the Trust's business plan 2018/19.

Risk management and systems of control

The trust board is accountable for delivery of the trust's objectives and robust risk reporting is a key aspect of this. Approval of the trust's risk management policy is reserved to the trust board.

Board assurance framework

The board assurance framework sets out the principal risks to achievement of the trust's strategic objectives, while the annual governance statement (included in the next section of the report) provides a year-end assessment of the trust's systems of control and key issues that materialised during the year, thereby informing plans for 2018-19.

The principal risks to the trust objectives in the board assurance framework (BAF) are detailed in Appendix 1 of this report section.

BAF entries are identified through review of the trust's main risk reporting tool (the risk register) and through discussions with board directors, informed by performance reporting and assurances received in-year. The board assurance framework format includes an explicit link between the entries shown and related high risks appearing on the risk register. Although the trust board owns the board assurance framework, the executive risk management committee, chaired by the chief executive, plays a key role in monitoring the key risks to the organisation, with the board seeking assurances directly or through its assurance committees (with specific lead roles assigned to board committees to seek assurance on the BAF entries as reflected above). The audit and risk committee received and reviewed the BAF and highest risks on the risk register during the year ahead of Board submission to provide assurance on the effectiveness of risk escalation and monitor the development of risk management processes.

The above entries describe the principal risks to the trust's operational, clinical quality, financial, workforce, strategic and academic objectives. The trust reported moderate success in mitigating board assurance framework risk scores downwards during 2017/18. The year end version of the BAF identified one board assurance framework entries that had been sufficiently addressed to reduce it to its target risk score (enabling its removal). Although fewer 20-scored risks remained the BAF still reflected a significant proportion of high risk score entries, with some increasing risk scores during the year. This was as a result of increased operational and financial pressures and some weaknesses in controls identified during the year. The year-end BAF scores signalled the organisation's continued high risk profile despite progress identified internally and by external stakeholders and regulators. In light of the ongoing risks faced (in part due to the wider health economy climate), it is anticipated that the trust's strategic risk appetite will be low as it enters 2018/19.

Risk register and overarching risk management system

During the year work has continued to strengthen and improve risk management systems and processes across the organisation. CQC inspections in 2014 had indicated that risk management systems and processes were not fully embedded at a hospital-level and, as a consequence, not working effectively. The development of the group model and enhanced site-based leadership has led to improved risk management maturity.

The trust risk management committee has met regularly throughout the year and maintains corporate oversight of risk in the organisation. At each meeting the committee reviews the trust's high level risks and receives a quarterly metrics report that details site and directorate performance. During the year,

the risk management committee and audit and risk committee have approved a revised risk management policy and reviewed and agreed the overall direction and approach for developing the trust's risk management strategy.

In addition to new site-based governance arrangements for the management of risk, risk management training continued in 2017/18. This comprised drop-in sessions at our major hospitals which were well attended and well evaluated in addition to ad hoc bespoke training. We will continue to offer training on risk management, targeting key roles with risk management involvement.

Thematic review of our risks has continued to inform the approach to mitigation. This has worked well in the case of risks related to medical equipment. This subset of our risk register forms a key component in the process of replacing medical equipment, allowing equipment to be replaced in a prioritised way so that we make best use of the resource available.

ANNUAL GOVERNANCE STATEMENT 2017/18

BARTS HEALTH NHS TRUST

1. Scope of responsibility

As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, while safeguarding the public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

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

As Chief Executive I am accountable to the Trust Board. I am also accountable, via the NHS Accounting Officer, to Parliament for the stewardship of resources within the Trust.

2. Governance framework and purpose of the system of internal control

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

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and

- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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The system of internal control has been in place in Barts Health NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

2017/18 was a year of improvement for Barts Health. The Trust's overall group operating model governance structure was strengthened, with support to the Trust Executive Committee through Hospital Management Boards providing operational leadership at site level and refreshed Clinical Boards providing a focus on clinical strategy and standardisation across sites. Progress was made against the Trust's quality improvement plan, with significant improvements identified by the Care Quality Commission following re-inspections of services at The Royal London, Newham University and Whipps Cross University Hospitals (reflected in overall improved ratings for each hospital). A 'good' rating was awarded to St Bartholomew's Hospital as well as an overall improvement in the rating for the Trust following its May 2017 Well Led review from 'inadequate' to 'requires improvement'. The Trust's quality improvement plan has been recalibrated for 2018/19 accordingly, to focus on *getting to good and outstanding* ratings. A further CQC Well Led assessment is anticipated in early 2018/19. The Trust continued to face financial challenges in 2017/18 and reported a deficit of £145m (£109m after STF funding), in line with the deficit control total target set by NHS Improvement, and is now working towards achieving a breakeven position in coming years. The Trust's immediate objectives remain focused on exiting financial and quality special measures during 2018/19.

Trust Board and Committee structure

The role of the Trust Board is to govern the organisation effectively and in so doing to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. The Board has complied with the relevant aspects of the HM Treasury/Cabinet Office Corporate Governance Code. The Trust is not required to comply with the UK Code of Corporate Governance. With reference to the requirements of the Trust's Standing Orders and Standing Financial Instructions, the Chief Finance Officer and the Trust Secretary retain oversight of the arrangements for the discharge of statutory functions and no gaps in legal compliance have been identified. The below section supports the Trust's approach to compliance with NHS provider licence condition 4 in terms of effective governance structures, responsibilities of directors and subcommittees, the submission of timely and effective information, reporting lines and board oversight.

The Trust Board has met on a monthly basis to consider strategic priorities and met8 times during the year in public (not including the Annual General Meeting). Voting members comprise the Chair, seven non executive directors and five corporate

executive directors (including the Chief Executive). Four corporate executive directors attend the Board in a non-voting capacity; and they have been joined by two NExT Directors (as part of a development programme to support potential non executive director candidates).

There have been two changes to the Board's voting membership during 2017/18 with two new Non Executive Directors, Natalie Howard and Margaret Exley, joining the Board in December 2017 and January 2018, filling vacancies which had arisen during the year. There were no Trust Board vacancies at the end of the financial year.

Trust Board meetings are held in public and the papers are made available on the Trust website in advance of each meeting. The Board regularly reviews performance against national standards and regulatory requirements via an Integrated Performance Report and a summary of performance against these priorities in 2017/18 is included in the Trust's Annual Report. The Board places a strong emphasis on the quality and safety of patient care and, in addition to performance reports, regularly hears directly from patients, carers and staff including through patient and staff stories and conducting ward and department visits.

Following his substantive appointment at the end of 2016/17, the Chairman undertook an initial review of Board membership, including an assessment of individual and collective strengths and development needs. A 'Well Led' self-assessment process commenced in April 2018 and during quarter 1 of 2018/19 this will be extended to include an external independent and peer review aspect. This process will provide an appropriate independent assessment of Board development and any recommendations for ways of working during 2017/18. A CQC re-inspection in relation to the Essential Standards 'Well Led' domain is scheduled to take place in early 2018/19.

The principal committees established by the Trust Board to support it in undertaking its responsibilities are:

Audit and Risk Committee
The Audit and Risk Committee has overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. It is supported in this role by the Quality Assurance Committee.

Quality Assurance Committee
The Quality Assurance Committee monitors, reviews and reports on the quality of services provided by the Trust. This includes the review of governance and internal control systems at Trust and site level to ensure the

delivery of safe, high quality, patient-centred care; quality indicators flagged as of concern through escalation reporting or as requested by the Trust Board; and progress in implementing the Trust's quality improvement plan and action plans to address identified shortcomings in the quality of services, for example following CQC inspections.

Nominations and Remuneration Committee
The Nominations and Remuneration Committee has delegated authority from the Trust Board to appoint and remove the Chief Executive and, together with the Chief Executive, to appoint and remove the other Executive Directors. It also determines the overall remuneration policy of the Trust; sets the remuneration, allowances and other terms and conditions of office for the Trust's Executive Directors; and recommends and monitors the structure of remuneration for senior managers.

Finance and Investment Committee
The Finance and Investment Committee undertakes on behalf of the Trust Board objective scrutiny of the Trust's financial plans, investment policy and major investment decisions. The Committee reviews the Trust's monthly financial performance and identifies the key issues and risks requiring discussion or decision by the Trust Board. During the year, there has been a significant focus on the implementation and delivery of the Trust's Financial Recovery Plan, in line with objectives to exit Financial Special Measures.

Trust Executive Committee (executive committee)
While not a Board committee chaired by a NED, the Trust Executive Committee, chaired by the Chief Executive, is the principal executive committee. It leads on implementation of the Trust's clinical, operational and financial strategy and plans; and ensuring appropriate integration of clinical services and sites, between clinical and corporate functions and within the Trust and with external partners.

During the year, the chairs of Board committees reported on their discussions and drew issues to the attention of the Trust Board as appropriate through Minutes, written exception reports to each Board meeting held in public and a committee annual report on compliance with terms of reference.

Attendance at Trust Board and principal Board committees

Committee	Number of meetings held	Average attendance rate in 2016/17
Trust Board (Parts 1 and 2)	25	92%
Audit and Risk Committee	4	62%
Quality Assurance Committee	8	68%
Nominations and Remuneration Committee	2	88%
Finance and Investment Committee	12	81%

A more detailed breakdown of attendance records by individual Trust Board members is provided in the Accountability section of the Trust's Annual Report.

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

The Trust Board and its assurance committees have a key role in review of the effective use of resources. The Trust Board retains oversight of the overall business planning process, budgets and use of staffing resources and establishment. The Finance and Investment Committee meets monthly and has a key role in review of investment decisions and monthly financial performance. In 2017/18, the Audit and Risk Committee focused on the effectiveness of controls in relation to payroll arrangements, major programme procurement arrangements and staff expense claims management. The Committee also reported to the Trust Board on its assurance of risk management arrangements, whistleblowing mechanisms, waiver processes, and accounting policy. The Quality Assurance Committee provided assurance to the Trust Board on efficient and effective quality in patient care, with a focus on improving learning from Never Events, serious incidents and complaints. The Committee monitored progress against the Trust's quality improvement plan and key safety metrics such as pressure ulcers.

Quality Accounts

The Trust's 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. Barts Health NHS Trust produces its Quality Accounts as an element of its Annual Report.

The accuracy of the Trust's Quality Account and an assessment of whether this presents a balanced view of controls in place is provided through internal review; stakeholder engagement and consultation; and data checking processes as part of the Trust's data quality arrangements. The Trust's External Auditors undertook an audit of the 2016/17 Quality Account including a deep dive review of selected quality

indicators and the findings have been taken into account for the production of the 2017/18 Quality Account, which is due to be agreed by the Board in June 2018.

The Trust Board approved the 2016/17 Barts Health Quality Account element of the Annual Report in June 2017, further to review by the Quality Assurance Committee.

3. The risk and control framework and risk assessment

As designated Accountable Officer, I have overall accountability for risk management in the Trust. During 2017/18, the Chief Nurse and, following his appointment, the Director of Corporate Development have led on risk management issues at Board level.

Capacity to handle risk

The leadership framework for risk management is summarised below:

- The Audit and Risk Committee meets four times a year and oversees the overall performance of the risk management system. It provides assurance to the Trust Board that effective governance, risk management and internal control systems are in place across the Trust's activities, including the development of the Board Assurance Framework and how this is informed by the high risk register. The Board's Quality Assurance Committee meets on a bimonthly basis and monitors, reviews and reports on the quality of services provided by the Trust. It provides assurance to the Audit and Risk Committee and the Trust Board that effective arrangements are in place to ensure that the Trust's services deliver safe, high quality, patient-centred care. Key risks are highlighted to and reviewed by the Trust Board both as part of its regular monitoring of performance and in the context of specific issues that arise.

- The Trust's Risk Management Committee, which is chaired by the Director of Corporate Development, provides executive oversight of risk management issues. The Risk Management Committee meets monthly and is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust and providing assurance to the Audit and Risk Committee that this is the case.

Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction which all staff attend. There is guidance on the type of courses that staff need to attend and the frequency of attendance required. Attendance at risk management training is monitored and feedback given to sites and corporate directorates via a central

monitoring database which allows corrective action to be taken by management teams as required.

The Risk and Control framework

The Trust has a comprehensive Risk Management Policy, refreshed and approved during 2017/18 and this is available to all staff on the Trust's intranet site. The policy describes the Trust's overall risk management approach, responsibilities for risk at each level of the organisation, the risk management process and the Trust's risk identification, evaluation and control system. The latter includes the 5x5 (impact x likelihood) risk matrix used to evaluate risks in the Trust.

- The Risk Management Committee reviews the Trust's risk register on an ongoing basis. All new risks with a proposed score of 15 and above (classified as 'High') are reviewed by the Risk Management Committee. The Committee has also undertaken a rolling review of hospital site and corporate directorate risks with a score of 12 and above. The Risk Management Committee reviews all risk register entries with a score of 20 or above at each meeting.

- The Risk Management function (which transferred from the Corporate Nursing to the Corporate Development directorate during 2017/18) is focused on integrated risk management – the process of identification, assessment, analysis and management of risks at every level in the organisation and the aggregation of results at a corporate level.

- For each of the Trust's sites, the Director of Nursing leads on governance and risk issues and is responsible for coordinating and embedding risk management processes within the site, including management of the local risk register. Site Hospital Management Boards have responsibility for monitoring, managing and where necessary escalating risks on their risk registers. Risk training has been undertaken with sites during the year to help strengthen risk identification, evaluation and monitoring. Staff at all levels are encouraged to report incidents and record risks on the Trust's Datix information systems (with the Trust's benchmarked incident reporting rate having improved in 2017/18).

- The Director of Corporate Development is the Trust's Senior Information Risk Owner (SIRO). Working closely with the Caldicott Guardian, the SIRO has been responsible for taking ownership of information risk at Board level and advising the Chief Executive accordingly.

Board Assurance Framework

The Board Assurance Framework is reviewed by the Risk Management Committee at each meeting and formally reviewed by the Trust Board at least three times a year. Risks on the Assurance Framework are assigned both a lead Corporate Director and a lead Trust Board assurance committee and the respective committees review at each of their meetings progress against those risks assigned to the committee.

The principal risks on the Trust's Board Assurance Framework as approved by the Board at the end of 2017/18 are summarised at Appendix 1. The Board Assurance Framework is based around the Trust's strategic objectives and identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls. It also details some gaps in control and assurance in relation to the risks, including strategic objectives related to quality of care, service delivery, workforce, finance, infrastructure and information systems, together with actions to address them. The actions include identifying additional resources, putting in place new systems, processes, operating procedures and monitoring arrangements, strengthening project and programme management, and effective working with partner organisations.

The organisation's highest scored risks to achievement of its strategic objectives, as at the end of 2017/18, are included on the Board Assurance Framework and relate to:

- Emergency care access and flow.
- Achieving Income and Expenditure improvements and delivering Cost Improvement Plans consistent with the required underlying financial run rate.

The Board Assurance Framework is updated through both a 'top down' assessment by Directors of key risks and a 'bottom up' review of high and significant risks on the Trust's risk register.

The 2017/18 Internal Audit report on the Board Assurance Framework, in draft at the point of producing this Annual Governance Statement, concluded a reasonable assurance rating, identifying recommendations for further work on supporting processes to map key controls and assurances consistently and its application and use in resource decision-making. Action will be taken by the Executive to address the recommendations identified in the audit report once it has been finalised.

Counter Fraud

The Trust's Local Counter Fraud service ensures that the annual plan of proactive work minimises the risk of fraud within the Trust and is fully compliant with NHS Protect's Counter Fraud Standards for providers. Preventative measures include reviewing Trust policies to ensure they are fraud-proof utilising intelligence, best practice and guidance from NHS Protect. Detection exercises are undertaken where a known area is at high risk of fraud and the National Fraud Initiative (NFI) data matching exercise is conducted bi-annually.

Fraud is deterred by publicising proven cases of NHS fraud and staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature across the Trust's sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the Audit and Risk Committee at each meeting.

External assurance

The Care Quality Commission's reports following their re-inspections of the Trust (including its Well Led review) received during 2017/18 demonstrate that some progress has been made in embedding risk management systems and processes and the use of risk registers, but further improvement and greater consistency is still required. This remains a key priority for the hospital sites and for the Barts Health group as a whole.

Stakeholder involvement

Partners and stakeholders are involved in managing risks which impact on them through their involvement in and contributions to many aspects of the work of the Trust, including for example:

Patients and the public

- The work of the local Healthwatches, Overview and Scrutiny Committees and Health and Wellbeing Boards.
- Regular meetings of the Trust Board held in public which include patient stories and the opportunity for patients and members of the public to ask questions.
- Feedback provided via the Trust's Patient Advice and Liaison Service and specific patient representative groups, the National Inpatient Survey (and other specific national surveys of areas including cancer services and maternity) and the results of Friends and Family Test surveys.

Barts Health
NHS Trust

Staff

- The adoption of a We Improve quality improvement approach to staff engagement and staff-led change (adopting successful interventions from 2016/17 activities) which has continued during 2017/18.
- A strong focus on encouraging staff to raise concerns and the web-based Speak In Confidence system and guardian services.
- Ward development initiatives including improved information sharing.
- Monitoring of Staff Survey findings, and related executive and senior staff roadshows and visits to wards and departments.

Partners

- Regular performance discussions with commissioners, NHS England and NHS Improvement (NHSI).
- Joint working groups for emergency care and RTT.
- Stakeholder membership of Trust committees and working groups.
- Joint strategic planning with healthcare and academic partners, including NHSI, NHS England, CCGs, Queen Mary University of London and UCL Partners.

Compliance issues

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This is overseen by the Trust Board.

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

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

The Trust is compliant with registration requirements of the CQC but not fully compliant with all CQC essential standards of quality and safety. Details of non-compliance are set out in Section 4.

Information governance and data security

Information governance and data security risks are managed and controlled within this policy framework. The Trust is committed to ensuring that it manages all the information which it holds and processes in an efficient, effective and secure manner through the application of robust information governance policies and procedures to support the delivery of high quality patient care. The Information Governance Team also runs a programme of unannounced ward and department spot checks.

The Trust's self-assessment against the information governance toolkit standards was informed by the routine annual internal audit review of the evidence with an overall score of 74%.

The Trust has implemented the national Information Governance Assurance Programme, with a specific focus on the handling of person identifiable data. A data transfer database is in place, person identifiable data flows are reviewed and arrangements are in place to ensure their security, and the risk register has been reviewed to ensure that it appropriately reflects information governance risks. The processes and controls in place have been monitored by the Trust's Information Governance Committee. The Trust recordedtwo serious untoward data security breaches during the year which have been reported to the Information Commissioner's Office (ICO). Further details on data security and disruption associated with data losses, including a ransomware attack are provided in Section 4.

Elective waiting time data

During September 2014, the Trust Board concluded that the quality of Referral to Treatment (RTT) waiting time data was insufficient to continue national reporting. Since then the Trust has been engaged in a variety of actions designed to return the Trust to national reporting as well as achieving compliance against the national RTT waiting time standard. As a part of this process, the Trust has undertaken a pathway validation exercise, to validate waiting time data recorded for all patients currently waiting for treatment. The Trust has also engaged in a project designed to identify the sources of poor quality data, followed by meaningful intervention designed to address underlying issues.

The Trust Board agreed, following a series of nationally prescribed checks, of the integrity of the data to resume RTT national reporting in 2018/19. As national reporting resumes, waiting list data and underpinning electronic logic will be subject to regular spot-checks as well as biannual full data quality reviews and annual internal audits.

Update on significant control issues in 2016/17

The Trust identified a number of significant control issues in its Annual Governance Statement for 2016/17. In 2016/17, the Trust reported 12 Never Events. Following work to support shared learning across the Trust sites, with a focus on addressing any recurring themes (which had previously included incidents in dentistry and in nasogastric tube management), the overall number of Never Events reduced to 8 in 2017/18. Further work will focus on reducing this further in 2018/19, including the development of tailored surgical safety checklists as part of the National Safety Standards for Invasive Procedures programme. Updates on all other 2016/17 significant control issues are provided in Section 4 below.

4. Review of effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The Head of Internal Audit Opinion for 2017/18 concludes that, for the systems that have been reviewed, [reasonable] assurance can be given that controls are generally sound and operating effectively. However, it notes that there are defects in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.

My review has also been informed by:

- Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of risk management and internal control.

- Performance against national and local standards and segmentation under the Single Operating Framework.

- The findings of inspections of services at St Bartholomew's, Whipps Cross University, Newham University and The Royal London Hospitals (as well as the Trust as a whole and 'Well Led' assessment) by the Care Quality Commission (CQC)as published during 2017/18.

- The Trust's ongoing assessment of compliance with the CQC's Essential Standards of Quality and Safety.

- The work of Internal Audit through the year, with coverage of the audit plan determined by a risk-based assessment. Details of the Internal Audit reports completed during 2017/18 and the basis for the overall Head of Internal Audit Opinion - that a reasonable level of assurance on the Trust's systems of controls can be gained - are set out in his report to the Audit and Risk Committee. This identified that 14 audit reports provided significant or reasonable assurance while 4 provided limited assurance. One of the finalised audit reports, relating to Cerner Millennium disaster recovery arrangements, contained findings that Internal Audit regard as significant control issues recommending disclosure in this Annual Governance Statement.

- The outcomes of the Trust's clinical audit programme, the effectiveness of which has improved during the course of the year.

- The results of External Audit's work on the Trust's annual accounts and local tailored performance management reviews.

- Patient and staff surveys and feedback and other sources of external scrutiny and accreditation including clinical peer review arrangements.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Risk Management Committee and the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Key roles have been as follows:

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the Integrated Performance Report and detailed financial nd quality and safety reports, and through Board and committee reporting on progress against other strategic objectives.

- The Audit and Risk Committee has overseen the effectiveness of the risk management arrangements. The Audit and Risk Committee has placed a focus this year on workforce arrangements including employment checks and temporary staffing controls.

- The Risk Management Committee has reviewed the Trust's risk register and the Board Assurance Framework and monitored key clinical and non-clinical risks highlighted by Trust committees and individual managers.

- Executive managers have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.

- Both Internal and External Audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

The Trust has identified the following significant control issues and the actions which have been or are being taken to address them.

CQC essential standards of quality and safety
Barts Health is registered with the Care Quality Commission (CQC) without conditions. The Trust was placed in quality special measures in March 2015 in response to a CQC inspection which rated Whipps Cross University Hospital as 'inadequate' and imposed four Warning Notices, combined with Trust-wide challenges in meeting national waiting time standards and the financial position. A comprehensive quality improvement plan, titled *Safe and Compassionate*, was developed and approved by the Trust Board in September 2015, and refreshed in September 2016, with the latest iteration, *Safe and Compassionate 3: getting to good and outstanding* launched in March 2018.

Significant progress has been made during 2017/18 against the identified priorities and CQC re-inspections of services at Whipps Cross University Hospital in May 2017, The Royal London Hospital in June 2017 and Newham University Hospital in July 2017 confirmed improvements and upgraded ratings at each site. During the year, a 'good' rating was achieved for services at St Bartholomew's Hospital following its inspection in May 2017, with an overall improvement in the rating for the Trust from 'inadequate' to 'requires improvement'. Further work is planned as part of a refreshed *Safe and Compassionate 3: getting to good and outstanding* quality improvement plan to assure progress against any remaining 'must do' requirements from previous inspection reports, to secure improved ratings for three domains within surgical services that remain rated as 'inadequate' and to reflect a revised level of ambition for excellence in clinical service delivery.

Data security and cyber attack
On 20 April 2017, the Trust suffered a loss of 9 disks in one of the main Storage Area Networks, resulting in a lengthy process to reinstate systems by restoring via back-ups.

On 12 May 2017, the Trust declared a major incident following a ransomware attack (Wannacry ransomware) that affected many organisations across the world. As a result, ICT networks and key clinical and information systems reliant on Microsoft

operating systems were shut down, with an immediate impact on operational activity. The vast majority of the Trust's clinical systems and file shares were restored by 25 May 2017 (with most completed earlier than this) and all Trust PCs were swept and restored subsequently. During the affected period the Trust cooperated fully with instructions from NHS Digital and other government agencies.

The overall impact of these incidents included significant immediate operational disruption, delays to treatment time and costs associated with loss of clinical activity and patient treatment income. Major incident processes during the incident placed an overriding emphasis on assessing and addressing potential quality and safety risks. The Trust adopted an established harm review process methodology to check the impact of delays in treatment arising from the cyber attack (with the exercise confirming low levels of risks to patients).

Overall, the Trust has invested approximately £12m within 13 months in overhauling its ICT networks, data storage and PC infrastructure, eliminating use of outmoded operating systems and mitigating risks of data losses and cyber attacks of this severity in future.

During the year, there were two serious untoward incidents involving personal data which were reported to the Information Commissioner in accordance with national guidance. The ICO decided not to take any further action in relation to both of the incidents.

The first case related to an ocular coherent tomography (OCT) machine going missing from the department. This machine had a hard drive with minimal patient information on it. An investigation concluded that the loss was unlikely to have arisen from a theft. The second case related to a portable ultrasound machine being stolen; in this case, the machine had minimal patient information on it.

The incidents were fully investigated and the resulting recommendations implemented. The Trust continues to take steps to ensure the secure management of patient and staff information. This has been facilitated through enhancements to our information security systems and processes, embedding clear policies and procedures in our staff's daily work and ensuring that staff receive appropriate information governance training. As at 29 March 2018, 86% of staff had received information governance training and passed a test of comprehension in the past 12 months.

National performance standards (emergency care, diagnostics and 62-day cancer waiting times)

The Trust underachieved against the national standard for emergency care waiting times in 2017/18. Attendances rose significantly during the year, with

unprecedented levels of demand experienced during winter. During this period, the Trust's performance benchmarked well when compared with peers, with recognition of significant commitment of Trust staff and acknowledgement that winter plan arrangements had worked effectively. Action plans and trajectories have been agreed with commissioners and regulators to improve performance in early 2018/19.

The Trust's previously strong track record on performance against the diagnostic 6-week wait standard and cancer 62-day waiting time standard was significantly affected by the ICT disruption highlighted in the above section, with the related targets not met consistently throughout 2017/18. The Trust returned to compliance with the diagnostic standard from December 2017 onwards, and with all cancer standards from August 2017 onwards (excepting one month where cancer screening performance dipped below the national target).

18 Weeks RTT data quality

As described above, the Trust suspended national reporting of 18 Weeks RTT performance in autumn 2014 due to data quality issues resulting from significant difficulties associated with the implementation of the Cerner Millennium electronic patient record system at Whipps Cross and compounded by the failure of an RTT validation database. An extensive work programme continues with partners to improve data quality and allow the Trust to recommence national reporting as soon as possible. [Following its meeting on 9 May 2018, the Trust Board formally confirmed its decision to recommence reporting against this standard with immediate effect].

Financial performance

The Trust continued to face financial challenges in 2017/18, with ICT disruption and unprecedented emergency demand during winter having an impact on patient treatment income from non-emergency activity. A further key driver of the Trust's deficit was underachievement of CIP savings on non-pay, primarily associated with drugs and supplies costs inflation. The Trust reported a deficit of [£114.9m] for 2017/18, in line with the deficit control total target set by NHS Improvement. The Trust's objectives remain focused on exiting financial special measures during 2018/19 and this will require evidenced progress against a challenging financial plan for 2018/19.

MHRA reinspection of manufacturing facilities

In November 2017, the Medicines Healthcare Regulatory Agency undertook an inspection of the Trust's facilities for pharmacy and radiopharmacy manufacturing, in accordance with Good Manufacturing Practice (GMP) standards. Although no formal regulatory action was taken, the inspection team found insufficient progress against recommendations made at a prior visit and an escalation meeting was held in January 2018. To prioritise quality improvements, the Trust has engaged a series of

measures to assure progress against an agreed action plan. A follow-up visit by the MHRA is anticipated in October 2018.

Clinical information system disaster recovery

Internal Audit's limited assurance review of a clinical information system disaster recovery process identified a gap in risk assessing disaster recovery process options at the time of a move from a national to locally managed contract (a number of years ago). The Audit and Risk Committee noted a reducing need for traditional disaster recovery arrangements where cloud and other technological advances allowed the prioritisation of repairs during downtime for business continuity purposes (with other trusts using this clinical system adopting the same approach as Barts Health). Audit recommendations have been followed up by the informatics team and the current level of risk is considered to be low.

5. Conclusion

My review has established that Barts Health NHS Trust has a reasonable system of internal controls that supports the achievement of the trusts policies, aims and objectives. The below significant internal control issues (detailed in the above section)have associated plans to ensure that these have been or are being resolved:

- CQC essential standards of quality and safety.
- Data security and cyber attack.
- National performance standards (emergency care, diagnostics and 62-day cancer waiting times).
- 18 Weeks RTT data quality.
- Financial performance.
- MHRA reinspection of manufacturing facilities.
- Clinical information system disaster recovery.

During 2017/18, the Trust has further embedded its group model and supporting governance arrangements at corporate, site and clinical board level to further strengthen the Trust's systems and processes for controls and assurance, and support the delivery of the Trust's quality and financial improvement plans.

Alwen Williams CBE
Chief Executive
Barts Health NHS Trust **23 May 2018**

Appendix 1: Board Assurance Framework - principal risks at 31 March 2018

Board assurance framework - risk entry	
1. A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety (A2) (CMO)	
2. Failure to deliver change in inadequate rated services or embedding Safe and Compassionate improvements impairs the organisational culture and delivery of best practice standards (A1) (CN)	
3.A failure to deliver 18 Weeks Referral to Treatment Time recovery plans impacts on patient experience and risks patient harm (A3) (DCO)	
4.Failure to address patient flow and capacity issues impacts on emergency care access and patient experience (A3) (DCO)	
5. The aim to exit financial special measures is impaired by a) failure to achieve I&E improvements (including securing asset receipts) and b) delivery of CIPs consistent with the required underlying position/run rate. (B1) (CFO)	
6. PFI costs (outside the scope of the Trust's savings programme) impact on long term financial sustainability. (B1) (CFO)	
7. Failure to implement the clinical and organisational strategy impacts on sustainability of access, performance and quality of services; and the development of the organisational model. (C6) (DS)	
8. Delivery of recruitment and retention objectives are impaired by continued high vacancy rates in hard-to-recruit specialties/sites and the impact of Brexit (D6) (DWD)	
9. A failure to effectively communicate across a large organisation to lead and embed consistent values behaviours and accountability. (D2) (DWD)	
10. Risk of not delivering workforce and patient equalities and inclusion goals impact on delivery of key objectives (D4) (DWD)	
11. Failure to successfully implement clinical boards, networks and matrix working (D1) (DS)	
12. Failure to address ICT infrastructure remediation, business continuity arrangements and interdependencies (E5) (DCEO)	
13a. Capital funding constraints prevent adequate investment in medical equipment to support effective and timely care (E1) (DCO) 13b. Capital funding constraints prevent adequate investment in estates improvements and backlog maintenance, including fire safety, to support effective and timely care (E1) (DCEO)	
14. Clinical and operational pressures adversely impact on organisational focus on research agenda (F1) (CMO)	

Lead committee roles (no colour = reserved to the Trust Board)

Audit and risk committee

Quality assurance committee

Finance and Investment Committee

Staff Policies

Key workforce policies are held on the Trust's We Share intranet site with accompanying guidance, support and forms to assist staff using these.
These policies include a Human Rights, Equality and Diversity policy and Recruitment and Selection policy which set out the process for ensuring fair employment, training and career development opportunities for individuals with protected characteristics.

Remuneration policies

For the purposes of this report, this section relates to substantive officers of the Trust whose remuneration is not governed by national policy, such as Agenda for Change terms and conditions - and specifically applies to voting and non-voting Trust Board members.
The Secretary of State for Health determines nationally the remuneration of the chairman and non executive directors, with terms of appointment and renewal determined by NHS Improvement.

Appointment and removal, remuneration, allowances and terms and conditions of office for executive directors (and the remuneration, allowances and terms and conditions of office for other defined senior officers) is determined by the Trust's nominations and remuneration committee with due regard to national guidance. Executive director performance against organisational and individual objectives is monitored through the formal appraisal process.

Sickness absence data

Sickness absence data	2017/18	2016/17
	Number	Number
Total days lost	109391	105678
Total staff years	14902	14566
Averages working days lost	7.34	7.26

Early Retirements on ill health grounds	2017/18	2016/17
	Number	Number
Number of persons retired early on ill health grounds	6	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	111,29	364

Consultancy expenditure

Operating expenses	2017/18	2016/17
	£000s	£000s
Consultancy services	5,898	12,107

Off-payroll Engagements

For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Number of new engagements which include contractual clauses giving the Barts Health NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	N/A
assurance has not been received	N/A
engagements terminated as a result of assurance not being received	N/A

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	0

Exit Packages (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£000s	WHOLE NUMBERS ONLY	£000s	WHOLE NUMBERS ONLY	£000s	WHOLE NUMBERS ONLY	£000s
Less than £10,000	14	46,629						
£10,000 - £25,000	3	45,226						
£25,001 - £50,000	3	115,639						
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Totals	20	207,494	-	-	-	-	-	-

Agrees to A below

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

Analysis of Other Departures	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice*		
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval**		
Total	0	0

A – agrees to total in table 1

Staff composition (as at 31st March 2018)

Gender	Headcount	%
Female	11,612	72%
Male	4,443	28%
Total	16,055	100%

Staff Cost (subject to audit)

	2017/18				2016/17			
	Total	Permanently employed cost	Agency and other cost	Internal bank cost	Total	Permanently employed cost	Agency and other cost	Internal bank cost
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	735,058	735,058			734,479	578,844	75,279	80,356
Social Security costs	77,139	77,139			66,995	66,995		
NHS Pensions Scheme	76,832	76,832			67,460	67,460		
Termination Benefits	207	207			179	179		
Total	889,236	889,236	-	-	869,113	713,478	75,279	80,356
Less costs capitalised as part of assets	333	333			30		30	
Total	888,903	888,903	-	-	869,083	713,478	75,249	80,356

Senior manager numbers by band

Salary bands	Number of senior managers
Less than £5,000	4
£5,000 - £10,000	5
£10,001 - £15,000	1
£15,001 - £20,000	1
£20,001 - £25,000	
£25,001 - £30,000	
£30,001 - £35,000	
£35,001 - £40,000	
£40,001 - £45,000	
£45,001 - £50,000	
£50,001 - £55,000	
£55,001 - £60,000	
£60,001 - £65,000	1
£65,001 - £70,000	
£70,000 - £75,000	
£75,001 - £80,000	
£80,001 - £85,000	1
£85,001 - £90,000	
£90,001 - £95,000	
£95,001 - £100,000	
£100,001 - £105,000	
£105,001 - £110,000	
£110,001 - £115,000	
£115,001 - £120,000	
£120,001 - £125,000	1
£125,001 - £130,000	
£130,001 - £135,000	
£135,001 - £140,000	
£140,001 - £145,000	1
£145,001 - £150,000	
£150,001 - £155,000	
£155,001 - £160,000	1
£160,001 - £165,000	1
£165,001 - £170,000	1
£170,001 - £175,000	
£175,001 - £180,000	
£180,001 - £185,000	1
£185,001 - £190,000	
£190,001 - £195,000	
£195,001 - £200,000	
£200,001 - £205,000	
£205,001 - £210,000	
£210,001 - £215,000	1
£215,001 - £220,000	
£220,001 - £225,000	
£225,001 - £230,000	
£230,001 - £235,000	
£235,001 - £240,000	
£240,001 - £245,000	1
£245,001 - £250,000	
£250,001 - £255,000	
£255,001 - £260,000	
£260,001 - £265,000	
£265,001 - £270,000	
£270,001 - £275,000	
£275,001 - £280,000	
£280,000 - £285,000	
>£285,001	
Total	**21**

Fair Pay (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Barts Health NHS Trust in the financial year 2017/18 was £240k to £245k (2016/17, £240 to £245). This was 7.1 times (2016/17, 7.1) the median remuneration of the workforce, which was £34k (2016/17 £34k).

In 2017/18, no employees received remuneration in excess of the highest paid director (this was the same in 2016/17). Remuneration ranged from the bands £15k-£20k to £240k-£245k (2016/17 £15k-£20k to £240k-£245k)

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

Remuneration Salaries and Allowances (subject to audit)

Name and title	2017-18					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Mr Ian Peters, Chair [1] [5]	60 to 65	37	0	0	0	60 to 65
Mr Gautam Dalal, Non-Executive Director and Vice Chair	5 to 10	0	0	0	0	5 to 10
Mr Alastair Camp, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Prof Steve Thornton, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Dr Thoreya Swage, Non Executive Director [5]	5 to 10	14	0	0	0	5 to 10
Ms Tracey Fletcher, Non Executive Director (to 01.11.17)	0 to 5	0	0	0	0	0 to 5
Ms Karen West, Non Executive Director (to 01.11.17)	0 to 5	0	0	0	0	0 to 5
Mr Mark Higson, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Ms Natalie Howard, Non-Executive Director (from 01.12.17) [1]	0 to 5	0	0	0	0	0 to 5
Ms Margaret Exley, Non-Executive Director (from 01.01.18) [1]	0 to 5	0	0	0	0	0 to 5
Ms Alwen Williams, Chief Executive [2]	240 to 245	0	0	0	0	240 to 245
Dr Tim Peachey, Deputy Chief Executive [2]	140 to 145	0	0	0	0	140 to 145
Prof Alistair Chesser, Chief Medical Officer	210 to 215	0	0	0	60 to 62.5	270 to 275
Ms Caroline Alexander, Chief Nurse	155 to 160	0	0	0	400 to 402.5	555 to 560
Ms Chrisha Alagaratnam, Chief Financial Officer [4]	180 to 185	0	0	0	0	180 to 185
Ms Jacqueline Totterdell, Chief Operating Officer (to 30.04.17)	15 to 20	0	0	0	905 to 907.5	920 to 925
Mr Michael Pantlin, Director of People [2]	165 to 170	0	0	0	0	165 to 170
Mr Ralph Coulbeck, Director of Strategy	120 to 125	0	0	0	25 to 27.5	150 to 155
Mr Ian Walker, Director of Corporate Affairs and Trust Secretary (to 12.05.17)	10 to 15	0	0	0	5 to 7.5	20 to 25
Mr Tony Halton, Director of Clinical Operations (from 01.04.17) [1]	160 to 165	0	0	0	45 to 47.5	210 to 215
Mr Andrew Hines, Director of Corporate Development (from 29.08.17) [1]	80 to 85	0	0	0	57.5 to 60	140 to 145
Mr John Bacon, Chair (Until 17.10.16) [3]						

[1] Individual was not in Director post with the Trust at 31 March 2017; comparative figures not available
[2] All pension related benefit cannot be calculated; individual is not an active member of the NHS Pension Scheme
[3] Included solely to reflect Board arrangements for the prior period; the listed individual has not been a Board member for any part of the 2017/18 reporting period.
[4] Where "All pension related benefits" calculation results in a negative figure; submit zero in column (e)
[5] Expense payments (taxable benefits): This relates to miscellaneous travel and parking expenses.

* Amounts are for the salary paid during the year and are not necessarily the senior manager's annual salary.

A Williams
Chief Executive

23/05/2018
Date

Name and title	2016-17					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Mr John Bacon, Chair (Until 17.10.16)	20 to 25	0	0	0	0	20 to 25
Mr Alastair Camp, Acting Chair (from 17.10.16) and Non Executive Director and Vice Chair (until 16.10.16)	5 to 10	0	0	0	0	5 to 10
Mr Gautam Dalal, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Prof Steve Thornton, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Dr Thoreya Swage, Non Executive Director [5]	5 to 10	18	0	0	0	5 to 10
Ms Tracey Fletcher, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Ms Karen West, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Mr Mark Higson, Non Executive Director (from 10.10.16) [1]	0 to 5	0	0	0	0	0 to 5
Ms Alwen Williams, Chief Executive	240 to 245	0	0	0	620 to 622.5	860 to 865
Dr Tim Peachey, Deputy Chief Executive	200 to 205	0	0	0	0	200 to 205
Ms Caroline Alexander, Chief Nurse [1] [2]	155 to 160	0	0	0	0	155 to 160
Ms Jacqueline Totterdell, Interim Chief Operating Officer [4]	180 to 185	0	0	0	0	180 to 185
Prof Alistair Chesser, Chief Medical Officer	210 to 215	0	0	0	172.5 to 175	385 to 390
Ms Chrisha Alagaratnam, Chief Financial Officer	180 to 185	0	0	0	247.5 to 250	430 to 435
Mr Michael Pantlin, Director of Workforce Development	165 to 170	0	0	0	0	165 to 170
Mr Ralph Coulbeck, Director of Strategy [1] [2]	100 to 105	0	0	0	0	100 to 105
Mr Ian Walker, Director of Corporate Affairs and Trust Secretary	120 to 125	0	0	0	27.5 to 30	150 to 155
Mr Philip Wright, Acting Chair (until 31.07.15) [3]						
Prof Richard Trembath, Non Executive Director (until 12.09.15) [3]						
Prof Mike Curtis, Non Executive Director (from 13.09.15 until 31.01.16) [3]						
Ms Anne Whitaker, Non Executive Director [3]						
Ms Angela Greatley, Associate Non Executive Director (from 01.05.15) [3]						
Mr Paul Brickell, Associate Non Executive Director (until 01.11.15) [3]						
Mr Peter Morris, Chief Executive (until 31.05.15) [3]						
Mr Ian Miller, Interim Chief Financial Officer (until 14.06.15) [3]						
Dr Steve Ryan, Chief Medical Officer (until 19.07.15) [3]						
Ms Jan Stevens, Interim Chief Nurse [3]						
Prof Joanne Martin, Director of Academic Health Sciences (Interim Chief Medical Officer from 20.07.15 until 02.02.16) [3]						
Ms Frances O'Callaghan, Director of Strategy (until 31.10.15) [3]						

[1] Individual was not in Director post with the Trust at 31 March 2016; comparative figures not available
[2] All pension related benefit cannot be calculated; comparative figure not available as at 31st March 2016
[3] Included solely to reflect Board arrangements for the prior period; the listed Individual has not been a Board member for any part of the 2016/17 reporting period.
[4] Where the calculation results in a negative figure; submit zero in column (e)
[5] Expense payments (taxable benefits): This relates to miscellaneous travel and parking expenses.

* Amounts are for the salary paid during the year and are not necessarily the senior manager's annual salary.

Composition of Board by Gender

Composition of the Board by Gender 2017/18	Headcount	%
Female	9	43%
Male	12	57%
Total	21	100%

Pension Benefits (subject to audit) 2017/18

Name and title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2017	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2018	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Ms Alwen Williams, Chief Executive	[1]	[1]	[1]	[1]	[1]	[1]	[1]	0
Dr Tim Peachey, Deputy Chief Executive	[1]	[1]	[1]	[1]	[1]	[1]	[1]	0
Prof Alistair Chesser, Chief Medical Officer	2.5 to 5	5 to 7.5	70 to 75	185 to 190	1,185	137	1,334	0
Ms Caroline Alexander, Chief Nurse	17.5 to 20	42.5 to 45	45 to 50	115 to 120	494	347	846	0
Ms Chrisha Alagaratnam, Chief Financial Officer	-2.5 to -5	-22.5 to -25	55 to 60	145 to 150	1,040	-178	873	0
Ms Jacqueline Totterdell, Chief Operating Officer	37.5 to 40	117.5 to 120	65 to 70	205 to 210	561	303	870	0
Mr Michael Pantlin, Director of People	[1]	[1]	[1]	[1]	[1]	[1]	[1]	0
Mr Ralph Coulbeck, Director of Strategy	0 to 2.5	0 to 2.5	5 to 10	0 to 5	26	16	42	0
Mr Tony Halton, Director of Clinical Operations	2.5 to 5	7.5 to 10	50 to 55	160 to 165	915	81	1,005	0
Mr Andrew Hines, Director of Corporate Development	2.5 to 5	0 to 2.5	45 to 50	110 to 115	631	55	692	0
Mr Ian Walker, Director of Corporate Affairs and Trust Secretary	0 to 2.5	0 to -2.5	15 to 20	35 to 40	252	20	275	0

[1] Individual is not an active member of the NHS Pension Scheme

Interests - Directors

Name	Organisation	Description	Start Date (if not whole year)	End Date (if not whole year)
Mr Ian Peters				
	Friends of Peterhouse Ltd	Chairman	06/04/2017	
	The Floow	Chairman	06/04/2017	
	Tock Insurance	Chairman	06/04/2017	
	Switchee Ltd		06/04/2017	
	Peabody Housing Trust	Vice Chairman	06/04/2017	
	Mitie PLC	Advisor to CEO	06/04/2017	01/03/2018
	Employers for Carers	Chairman	06/04/2017	
	Carers UK	Treasurer and Trustee	06/04/2017	23/10/2017
	British Gas Services Ltd	Chairman	06/04/2017	31/12/2017
	Advizzo Ltd	Chairman	06/04/2017	
	Bain and Company	Strategic Advisor	06/04/2017	
	Ensek Ltd	Chairman	21/09/2017	
	Sagacity Solutions	Strategic Advisor	01/05/2018	
Mr Alastair Camp				
	London Institute of Banking & Finance	Chairman, pension fund	12/07/2014	
	Local Justice Area	Magistrate at the South West Devon Local Area	01/01/2017	
	China Fleet Trust	Trustee	01/01/2017	
Dr Thoreya Swage				
	Thoreya Swage	Sole Trader	01/01/2012	
	Frimley Health NHS Foundation Trust	Non-Executive Director	15/05/2015	
	RD Capital Partners LLP	Honorary Advisor		31/12/2017
Mr Gautam Dalal				
	Law Society	Chair - Audit Committee	01/12/2015	06/12/2017
	ZincOx Resources Plc	NED	10/01/2011	
	School of Oriental and African Studies	Treasurer and Member of Governing Body	01/09/2010	
	National Gallery	Member of Audit and Finance Committees	26/03/2017	
	Camellia Plc		01/03/2018	
Ms Karen West				
	Newham CCG	Partner acts as a lay member		
Ms Tracey Fletcher				
	Digibridge CIC	Chair		
	Significant Seams CIC			
	Dame Kelly Holmes Trust	Trustee / Director		
	Tracey Fletcher Consulting	Director - Consulting to Enterprises and Charities		
Mr Mark Higson				
	McKinsey & Co	Senior Advisor	26/10/2016	
	Wolseley UK	Managing Director	01/03/2018	
Professor Steve Thornton				
	Wellbeing for Women	Trustee	01/03/2017	
	Ferring Pharmacy	Consultancy advice	01/01/2016	
	General Medical Council	Chair, UKMed	01/03/2017	
	Glaxo Smith Kline	Consultancy advice	01/01/2016	
	Hologic	Consultancy advice	01/01/2016	
	Medcity	Board member	01/01/2017	
	Medical Schools Council	Executive	01/03/2017	
	Queen Mary University of London	Vice Principal, Health (primary employer)	17/01/2016	
	Royal College of Obstetricians and Gynaecologists	Various roles	01/01/2016	
	UCLP	Board member	01/01/2016	
Ms Natalie Howard				
	AgFe Ltd	Partner	01/12/2017	
Ms Margaret Exley				
	SCT consulting	Director	01/01/2018	
Miss Ashantel Lachhani				
	Diabetes UK	Full-time employment	12/01/2018	
	NHS London Information Governance Forum	Co Chair NHS London Information Governance Forum	12/01/2018	
	Royal Society of Medicine	Senior Associate	12/01/2018	
Ms Kim Kinnaird				
	Lloyds Banking Group	Full time Employment	01/01/2018	
Ms Alwen Williams	No interests declared			

Dr Tim Peachey	Isle of Wight NHS Trust	Non Executive Director	01/04/2018
Ms Chrisha Alagaratnam	No interests declared		
Professor Alistair Chesser	Deloitte LLP	Family member is a partner	11/09/2016
Mr Ian Walker	No interests declared		
Mr Michael Pantlin	No interests declared		
Ms Jacqueline Totterdell	NHS IMAS	Partner (unpaid)	
Ms Caroline Alexander	Buckinghamshire New University	Honorary Visiting Professor	
Mr Ralph Coulbeck	Barts Health	Spouse has employment training contract	07/03/2018
Mr Andrew Hines	No interests declared		
Mr Tony Halton	No interests declared		

Compensation for loss of office (subject to audit)

Commentary
In 2017/18 there was no redundancy payment for the efficiency of the service (one in 2016/17, at a cost of £133k)

Payments to past directors

Commentary
N/A

NHS
Barts Health
NHS Trust

Barts Health NHS Trust
Annual Accounts
For the Year Ended 31st March 2018

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

value for money is achieved from the resources available to the trust;

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

effective and sound financial management systems are in place; and

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

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

A Williams

Chief Executive

23/05/2018

Date

Statement of Directors' Responsibilities in Respect of the Accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

A Williams — 23/05/2018

Chief Executive — **Date**

E. Alagorahman — 23/05/2018

Chief Finance Officer — **Date**

Independent Auditor's Report to the Directors of Barts Health NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Barts Health NHS Trust (the 'Trust') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and the notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

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; and

• have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by 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

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.

Who we are reporting to

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

Material uncertainty related to going concern

We draw attention to note 1.1 in the financial statements, concerning the Trust's ability to continue as a going concern, which indicates that the Trust has submitted a financial plan for 2018/19 to NHS Improvement that delivers a £64.4 million deficit after delivery of a £61.9 million savings programme. The Trust has also submitted a provisional financial plan for 2019/20 to NHS Improvement that delivers a £26.4 million deficit after delivery of a £65.0 million savings programme. As stated in note 1.1, the Trust is reliant on £7.0 million of non-recurrent savings during 2018/19 in order to achieve the 2018/19 control total.

Independent Auditor's Report to the Directors of Barts Health NHS Trust

The provisional financial plan includes a requirement for up to £104.9 million of cash support for 2018/19, of which £51.7 million is required to maintain revenue cash flows and £53.2 million is required to support essential capital investment. NHS Improvement has not, as at the date of our report, confirmed the support for 2018/19 and 2019/20. These events or conditions, along with the other matters explained in note 1.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are 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 course of our work, including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources, 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.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Independent Auditor's Report to the Directors of Barts Health NHS Trust

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 23 May 2018 we referred a matter to the Secretary of State under Section 30(b) of the Local Audit and Accountability Act 2014 in relation to Barts Health NHS Trust's breach of its break-even duty for the three-year period ending 31 March 2018.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities in Respect of the Accounts, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine 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 Directors are 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 Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Risk Committee is Those Charged with Governance.

Auditor's responsibilities for the 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 on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Independent Auditor's Report to the Directors of Barts Health NHS Trust

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects Barts Health NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

• The Trust incurred an adjusted retained deficit of £108.8 million in 2017/18;

• The Trust's medium term financial plan shows a deficit control total of £64.4 million for 2018/19 prior to receipt of Provider Sustainability Funding. This plan is based on the Trust achieving: a challenging cost improvement programme of £61.9 million; an increase of £28 million in Patient Treatment Income; £60 million in profit from disposal of assets; and all the financial and operational conditions to attain £55 million of Provider Sustainability Funding;

• The Trust remains in the Department of Health and Social Care's Financial Special Measures programme due to the size of the current deficit; and

• The Care Quality Commission (CQC) review of the Trust's Whipps Cross University Hospital site in July 2016 rated services provided by the hospital as "inadequate". The CQC also inspected the Trust's Royal London Hospital site in July 2016 and its Newham General Hospital site in November 2016, and rated both hospitals as "requires improvement". The CQC has rated the Trust as "requires improvement" overall, highlighting significant concerns in safety, effectiveness, responsiveness and leadership.

• Due to the level of concerns raised across the Trust in previous CQC inspections, the Trust was placed in special measures on 16 March 2015 by NHS Improvement. The Trust remains in special measures.

These matters arise primarily due to weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services and responding to service delivery issues raised by regulators.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintaining statutory functions, and understanding and using appropriate financial and performance information to support informed decision making and performance management.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Independent Auditor's Report to the Directors of Barts Health NHS Trust

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. 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.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Barts Health NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Paul Grady

Paul Grady
Engagement Lead

for and on behalf of Grant Thornton UK LLP

30 Finsbury Square
London
EC2A 1AG

24 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	4.1	1,299,810	1,266,131
Other operating income	4.4	212,916	222,702
Operating expenses	5.1	(1,550,806)	(1,540,502)
Operating surplus/(deficit) from continuing operations		(38,080)	(51,669)
Finance income	9	892	129
Finance expenses	10	(71,192)	(64,727)
PDC dividends payable		-	-
Net finance costs		(70,300)	(64,598)
Other gains / (losses)	11	81	7,130
Deficit for the year from continuing operations		(108,299)	(109,137)
Deficit for the year		(108,299)	(109,137)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments		(2,742)	(22,229)
Revaluations		113,056	4,450
Other reserve movements		-	1,178
Total comprehensive income for the period		2,015	(125,738)

Financial Performance for the year

		2017/18	2016/17
Retained decificit for the year		(108,299)	(109,137)
Impairments (excluding IFRIC 12 impairments)		1,730	40,396
Adjustments in respect of donated gov't grant asset reserve elimination		(1,794)	(740)
Remove impact of 1617 STF post accounts reallocation		(419)	0
Adjusted retained deficit		(108,782)	(69,481)

Statement of Financial Position as at 31st March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	583	896
Property, plant and equipment	13	1,318,840	1,223,112
Trade and other receivables		4,971	3,009
Total non-current assets		1,324,394	1,227,017
Current assets			
Inventories	15	27,408	29,695
Trade and other receivables	16	213,979	166,045
Cash and cash equivalents	17	3,024	3,316
Total current assets		244,411	199,056
Current liabilities			
Trade and other payables	18	(158,732)	(132,775)
Borrowings	19	(26,184)	(26,027)
DH capital loan	19	(118,062)	(3,869)
Provisions	21	(2,890)	(2,113)
Other liabilities	18.2	(18,009)	(18,821)
Total current liabilities		(323,877)	(183,605)
Total assets less current liabilities		1,244,928	1,242,468
Non-current liabilities			
Borrowings	19	(1,017,271)	(1,043,376)
DH loan	21	(310,933)	(289,095)
Provisions	7	(14,673)	(15,377)
Total non-current liabilities		(1,342,877)	(1,347,848)
Total assets employed		(97,949)	(105,380)
Financed by			
Public dividend capital		327,050	321,634
Revaluation reserve		267,389	157,075
Income and expenditure reserve		(692,388)	(584,089)
Total taxpayers' equity		(97,949)	(105,380)

The notes on pages 13 to 55 form part of these accounts.

The financial statements on pages 9 to 12 were approved by the Board on 23rd May 2018 and signed on its behalf by

A Williams

Chief Executive

23/05/2018

Date

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	321,634	157,075	(584,089)	(105,380)
Surplus/(deficit) for the year	-	-	(108,299)	(108,299)
Impairments	-	(2,742)	-	(2,742)
Revaluations	-	113,056	-	113,056
Public dividend capital received	5,416	-	-	5,416
Taxpayers' equity at 31 March 2018	327,050	267,389	(692,388)	(97,949)

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	306,535	173,677	(474,953)	5,259
Surplus/(deficit) for the year	-	-	(109,137)	(109,137)
Impairments	-	(22,229)	-	(22,229)
Revaluations	-	4,450	-	4,450
Public dividend capital received	15,099	-	-	15,099
Other reserve movements	-	1,177	1	1,178
Taxpayers' equity at 31 March 2017	321,634	157,075	(584,089)	(105,380)

Information on reserves

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

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash Flows from Operating Activities			
Operating surplus / (deficit)		(38,080)	(51,669)
Non-cash income and expense:			
Depreciation and amortisation	5.1	49,361	51,374
Net impairments	5.1	1,730	40,396
Income recognised in respect of capital donations	4.4	(6,795)	(6,036)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(53,421)	(34,857)
(Increase) / decrease in inventories		2,287	(7,825)
Increase / (decrease) in payables and other liabilities		31,261	(38,595)
Increase / (decrease) in provisions		33	(1,326)
Net cash generated from / (used in) operating activities		(13,624)	(48,538)
Cash Flows from Investing Activities			
Interest received		892	129
Purchase of property, plant, equipment and investment property		(35,986)	(42,104)
Sales of property, plant, equipment and investment property		3,677	139
Receipt of cash donations to purchase capital assets		-	324
Net cash generated from / (used in) investing activities		(31,417)	(41,512)
Cash Flows from Financing Activities			
Public dividend capital received		5,416	15,099
Movement on loans from the Department of Health and Social Care		136,030	155,529
Capital element of PFI, LIFT and other service concession payments		(26,501)	(23,053)
Other interest paid		(70,196)	(62,435)
PDC dividend (paid) / refunded		-	5,009
Net cash generated from / (used in) financing activities		44,749	90,149
Increase / (decrease) in cash and cash equivalents		(292)	99
Cash and cash equivalents at 1 April - brought forward		3,316	3,217
Cash and cash equivalents at 1 April - restated		3,316	3,217
Cash and cash equivalents at 31 March		3,024	3,316

Notes to the Accounts

1 Basis of preparation

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

1.1 Accounting convention

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

Going Concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The Trust is also required to follow the guidance contained within the Department of Health and Social Care Group Accounting Manual as regards going concern matters.

In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust has submitted a financial plan for 2018/19 to NHS Improvement which delivers a £64.4 million deficit after delivery of a £61.9 million savings programme which has been agreed by the Trust Board and is embedded in the budget. The Trust board have recognised that this is a highly demanding plan, which is subject to a high degree of risk, and dependent upon the full delivery of cost reduction targets, realisation of recurrent savings, and the adherence to agreed budgets.

The Trust has also taken into account the level of historic loans with the Department of Health and Social Care (DHSC). Given the need to continue to deliver public services, the DHSC will not force the Trust to make loan repayments where this will have a detrimental effect on the provision of healthcare to the public. The Trust is working towards achieving an improved financial position, which will make it less reliant on cash support from the DHSC in the future.

The Trust has also submitted a provisional financial plan for 2019/20 to NHS Improvement which delivers a £26.4 million deficit after delivery of a £65.0 million savings programme which has been agreed by the Trust Board.

The underlying financial performance of the Trust within the 2018/19 plan is a deficit of £64.4 million and the Trust is reliant upon £7.0 million of non-recurrent savings during 2018/19 in order to achieve the 2018/19 control total. The plan includes a requirement for up to £104.9 million of cash support from the Department of Health and Social Care, of which £51.7 million is required to maintain revenue cash flows, whilst £53.2 million is required to support essential capital investment.

NHS Improvement has not, at the date of approval of the financial statements, confirmed the support for 2018/19 and 2019/20.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2017/18 Department of Health and Social Care Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

1.2 Acquisitions and discontinued operations

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

1.3 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. Barts Charity is independent of the Trust and therefore consolidation is not required.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

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

Department of Health and Social care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

In determining the MEA, the Trust has to make assumptions that are practically achievable, however the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because all staff are contracted to work across all sites, and the catchment area for patients using the services has been taken into account when deciding on an appropriate alternative site.

Notes to the Accounts (cont.)

The Trust does not intend to implement any of the theoretical assumptions that underpin the MEA valuation

For the purpose of the MEA valuation, the Trust has defined all of St Bartholomews Hospital and an element of the Royal London Hospital as buildings that provide specialist health care services. The MEA valuation in the accounts assumes that these services could theoretically be provided from a location in Waltham Forest, as all staff are contracted to work across all sites and the patients will need specialist healthcare which will only be available from specialist centres.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for Whipps Cross University Hospital would be a multi storey building, which would occupy less land.

For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

The MEA valuations used by the Trust have been provided to the Trust by the Valuation Office Agency. The Trust has used component lives based upon contractual information provided by the Valuation Office Agency to depreciate buildings and dwellings on a component basis.

The Trust does not have any contractual arrangements that contain material embedded leases that are required to be capitalised under IFRIC 4 (Determining whether an arrangement contains a lease).

The Trust uses the standard Department of Health and Social Care model to account for its PFI schemes.

The Trust has estimated the provision for pensions relating to former staff using estimates provided by the NHS Pension Agency provided at the time of the member's early retirement. These are updated if the member dies or if it becomes apparent that the provision is not sufficient to meet the liability.

1.4.2 Key sources of estimation uncertainty

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

The Trust has a dispute with NHS England (London) Specialised Commissioning regarding work that has been undertaken during the year. The Trust requested for two independent expert reviews and has received opinion on the matter which has been used to assess the appropriate level of income to be included within the financial statement. The outcomes collaborate the Trust view that this work is payable. The dispute will now progress through the contractual dispute resolution process.

Revenue - Note 1.5 and Note 4.1 to 4.4

The basis of calculation for partially completed spells is detailed in note 1.5.

Asset Lives – Note 1.10

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and physical asset verification exercises.

The minimum and maximum estimated economic lives of each class of asset are disclosed in note 1.10, and the carrying values of property, plant and equipment and intangible assets in notes 15 and 16 respectively.

Land and Buildings Valuations – Note 13.1

Land and Building assets were revalued at 31st March 2018. This valuation was carried out by Ros Johnson MA(Hons) MRICS, Principal Surveyor, DVS Property Services arm of the Valuation Office Agency using a Modern Equivalent Asset valuation methodology. The valuation methodology is set out in the RICS guidance, the Treasury FReM, Treasury Guidance on asset valuations and the IFRS (IAS16) guidance.

Provision for Impairment of Receivables – Note 16.1

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable. The Trust follows the guidance issued in the DH Group Accounting Manual in relation to the recommended rate for Injury Cost Recovery receivables.

1.5 Revenue

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

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

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

The pharmacy production department makes goods for sale. The department obtains prices by adding overheads to the total direct costs. The price arrived at is then evaluated against the current market prices.

1.6 Employee Benefits

Short-term employee benefits

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

Pension costs

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

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

Where staff are not eligible for the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST).

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other expenses

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

Property, plant and equipment

1.8 Recognition

Property, plant and equipment is capitalised where

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

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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

Subsequent expenditure

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

1.9 Intangible assets

Recognition

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 where the cost is at least £5,000.

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

Notes to the Accounts (cont.)

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated
- the technical feasible of completing the intangible so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic or service delivery benefits,
- adequate financial, technical and other resources are available to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenses attributable to the intangible asset during its development

Measurement

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

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

1.10 Depreciation, amortisation and impairments

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

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

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

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

Useful economic lives of Property, Plant and Equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below. In addition, within the Furniture and Fittings category the Trust holds a number of paintings with indefinite life, although the total value is immaterial. There are 38 paintings in total with an overall value of £21k as at 31st March 2018.

Economic Lives of Non-Current Assets	Min Life Years	Max Life Years
Intangible Assets		
Software Licences	2	5
Property, Plant and Equipment		
Buildings exc Dwellings	2	72
Dwellings	3	72
Plant & Machinery	5	10
Transport Equipment	2	7
Information Technology	5	12
Furniture and Fittings	10	15

1.11 Donated assets

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

1.12 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.13 Leases

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

The Trust as lessee

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

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

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

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

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

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

The Trust as lessor

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

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

1.14 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

1.14 Private Finance Initiative (PFI) transactions (cont)

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

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

Further details of PFI transactions are included in notes 22 and 23

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

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.
The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

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

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

Other assets contributed by the NHS trust to the operator

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

1.15 Inventories

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

1.16 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust cash management. Cash, bank and overdraft balances are recorded at current values.

1.17 Provisions

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016/17: positive 0.24%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.42% (2016/17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016/17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016/17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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

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

1.18 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 21.1 but is not recognised in the trust's accounts.

1.19 Non-clinical risk pooling

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

1.20 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year. The liability is valued at fair value at the end of the reporting period.

1.21 Contingencies

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

Contingent liabilities are not recognised, but are disclosed, unless the probability of a transfer of economic benefits is remote.

1.22 Financial Instruments

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, ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

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 exactly estimated 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.

Notes to the Accounts (cont.)

Financial Instruments (cont)

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Other financial liabilities

All 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 exactly estimated 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.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" 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 cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly through the use of bad debt provision.

Other financial liabilities

All 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 exactly estimated 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.

Financial Instruments (cont)

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" 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 cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Provisions are based on the average percentage recovery rate of income received for current and prior financial years, according to each category of receivable.

1.23 Public dividend capital

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

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

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

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

1.24 Value added tax

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

1.25 Foreign exchange

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March.

1.26 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 HM Treasury's *FReM*. Details of third party assets are given in Note 17.1 of the accounts.

1.27 Losses and special payments

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

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

1.28 Gifts

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

2.0 Operating segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations, since all policies, procedures and governance arrangements are Trust wide. As an NHS Trust, all services are subject to the same regulatory environment and standards set by our external performance managers. Accordingly, the Trust operates one segment.

	2016/17 £000s	2015/16 £000s
Income	**1,512,726**	1,488,833
Segment deficit	**(108,299)**	(109,137)

3.0 Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The Trust had no individual income generation activity whose full cost exceeded £1m or was otherwise material.

Note 4 Operating income from patient care activities

Note 4.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
Elective income	156,626	149,029
Non elective income	346,601	303,833
First outpatient income	61,518	60,915
Follow up outpatient income	60,599	72,855
A & E income	60,108	53,637
High cost drugs income from commissioners (excluding pass-through costs)	123,498	111,860
Other NHS clinical income	452,427	449,413
Community services		
Community services income from CCGs and NHS England	18,854	44,754
Income from other sources (e.g. local authorities)	-	-
All services		
Private patient income	5,617	3,679
Other clinical income	13,962	16,156
Total income from activities	1,299,810	1,266,131

Note 4.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	516,258	464,554
Clinical commissioning groups	741,797	753,220
Department of Health and Social Care	253	174
Other NHS providers	9,612	14,509
NHS other	421	379
Local authorities	11,541	13,460
Non-NHS: private patients	5,617	3,679
Non-NHS: overseas patients (chargeable to patient)	9,414	9,872
NHS injury scheme	4,526	6,241
Non NHS: other	371	43
Total income from activities	1,299,810	1,266,131
Of which:		
Related to continuing operations	1,299,810	1,266,131
Related to discontinued operations	-	-

Note 4.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18 £000	2016/17 £000
Income recognised this year	9,414	9,872
Cash payments received in-year	1,245	1,239
Amounts added to provision for impairment of receivables	5,628	6,582
Amounts written off in-year	1,715	1,256

Note 4.4 Other operating income

	2017/18 £000	2016/17 £000
Research and development	46,267	48,215
Education and training	77,040	77,693
Receipt of capital grants and donations	6,795	6,036
Charitable and other contributions to expenditure	93	140
Non-patient care services to other bodies	6,950	7,879
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	36,607	45,832
Rental revenue from operating leases	3,109	1,956
Other income		
Pharmacy sales	1,602	1,841
Property rental (not lease income)	4,807	3,500
IT Turnaround support	660	520
Other	28,986	29,090
Total other operating income	**212,916**	**222,702**
Of which:		
Related to continuing operations	212,916	222,702
Related to discontinued operations	-	-

5. Operating Expenses

Note 5.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	8,789	5,834
Purchase of healthcare from non-NHS and non-DHSC bodies	7,768	7,756
Staff and executive directors costs	888,903	869,083
Remuneration of non-executive directors	109	68
Supplies and services - clinical (excluding drugs costs)	139,780	128,159
Supplies and services - general	75,578	42,918
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	174,632	164,628
Consultancy costs	5,898	12,107
Establishment	9,508	9,103
Premises	53,356	49,853
Transport (including patient travel)	12,649	18,026
Depreciation on property, plant and equipment	49,048	51,022
Amortisation on intangible assets	313	352
Net impairments	1,730	40,396
Increase/(decrease) in provision for impairment of receivables	2,253	2,988
Change in provisions discount rate(s)	185	1,426
Audit fees payable to the external auditor		
audit services- statutory audit	131	180
other auditor remuneration (external auditor only)	9	12
Internal audit costs	-	-
Clinical negligence	44,715	40,650
Legal fees	1,257	853
Insurance	1,143	1,145
Research and development	24,718	17,676
Education and training	4,842	3,412
Rentals under operating leases	3,882	6,021
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	30,253	57,600
Hospitality	49	6
Other	9,308	9,228
Total	**1,550,806**	**1,540,502**
Of which:		
Related to continuing operations	1,550,806	1,540,502
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit of the Trust Quality Accounts	9	12
Total	9	12

Note 5.3 Limitation on auditor's liability

The limiation on auditors liabilibty for external audit work is £2m (2016/17: £0m)

Note 5.4 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	794	8,158
Other	936	32,238
Total net impairments charged to operating surplus / deficit	**1,730**	**40,396**
Impairments charged to the revaluation reserve	2,742	22,229
Total net impairments	**4,472**	**62,626**

Note 6 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	698,076	578,844
Social security costs	73,664	66,995
Apprenticeship levy	3,475	-
Employer's contributions to NHS pensions	76,832	67,460
Pension cost - other	-	-
Termination benefits	207	179
Temporary staff (including agency)	36,982	155,635
Total gross staff costs	889,236	869,113
Total staff costs	889,236	869,113
Of which		
Costs capitalised as part of assets	333	30

Note 6.1 Retirements due to ill-health

	2017/18	2016/17
Number of persons retired early on ill health grounds	6	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	524	364

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

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Note 6.2 Staff Cost

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	698,076	-	698,076	578,844
Social security costs	73,664	-	73,664	66,995
Apprenticeship levy	3,475	-	3,475	-
Employer's contributions to NHS pensions	76,832	-	76,832	67,460
Termination benefits	207	-	207	179
Temporary staff		36,982	36,982	155,635
Total gross staff costs	852,254	36,982	889,236	869,113
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	852,254	36,982	889,236	869,113
Of which				
Costs capitalised as part of assets	333	-	333	30

2016/17 Temporary staff was inclusive of both Bank and agency staff. The 2017/18 includes only agency staff.

Note 6.3 Average number of employees (WTE basis)

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	2,274	357	2,631	2,524
Ambulance staff	-	-	-	-
Administration and estates	3,390	371	3,761	3,724
Healthcare assistants and other support staff	1,521	-	1,521	951
Nursing, midwifery and health visiting staff	4,710	973	5,683	5,693
Nursing, midwifery and health visiting learners	-	367	367	865
Scientific, therapeutic and technical staff	1,549	225	1,774	2,016
Healthcare science staff	614	14	628	449
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	14,058	2,307	16,365	16,222
Of which:				
Number of employees (WTE) engaged on capital projects	4	-	4	1

Note 6.4 Exit Packages

Reporting of compensation schemes - exit packages 2017/18

	Number of Compulsory Redundancies Number	Number of Other Departures Agreed Number	Total Number of Exit Packages Number
Exit package cost band (including any special payment element)			
<£10,000	14	-	14
£10,001 - £25,000	3	-	3
£25,001 - 50,000	3	-	3
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	20	-	20
Total resource cost (£)	£208,000	£0	£208,000

Note 6.4 Exit Packages (cont)

Reporting of compensation schemes - exit packages 2016/17

	Number of Compulsory Redundancies Number	Number of Other Departures Agreed Number	Total number of Exit Packages Number
Exit package cost band (including any special payment element)			
<£10,000	21	-	21
£10,001 - £25,000	3	-	3
£25,001 - 50,000	1	-	1
£50,001 - £100,000	1	-	1
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	27	-	27
Total resource cost (£)	£312,701	£0	£312,701

Note 7 Pension costs

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

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

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

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

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be 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.

Note 8 Operating leases

Note 8.1 Barts Health NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Barts Health NHS Trust is the lessor.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	3,109	1,956
Contingent rent	-	-
Other	-	-
Total	3,109	1,956

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	3,279	1,971
- later than one year and not later than five years;	10,758	1,382
- later than five years.	90,354	3,990
Total	104,391	7,343

Note 8.2 Barts Health NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Barts Health NHS Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	3,882	6,021
Contingent rents	-	-
Less sublease payments received	-	-
Total	3,882	6,021

	<------31 March 2018		------>	31 March 2017
	Buildings	Other	Total	
	£000	£000	£000	£000
Future minimum lease payments due:				
- not later than one year;	3,623	136	3,759	6,405
- later than one year and not later than five years;	6,534	8	6,542	19,109
- later than five years.	401	-	401	2,357
Total	10,558	144	10,702	27,871
Future minimum sublease payments to be received	-	-	-	-

Note 9 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	892	129
Total	892	129

Note 10.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	10,782	6,702
Finance leases	275	332
Interest on late payment of commercial debt	1	-
Main finance costs on PFI and LIFT schemes obligations	36,588	37,334
Contingent finance costs on PFI and LIFT scheme obligations	23,506	20,148
Total interest expense	**71,152**	**64,516**
Unwinding of discount on provisions	40	211
Other finance costs	-	-
Total finance costs	**71,192**	**64,727**

Note 10.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	-

Note 11 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	81	3,358
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	81	3,358
Fair value gains / (losses) on financial liabilities	-	3,772
Total other gains / (losses)	81	7,130

Note 12.1 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	2,028	670	2,698
Additions	-	-	-
Gross cost at 31 March 2018	2,028	670	2,698
Amortisation at 1 April 2017 - brought	1,161	641	1,802
Provided during the year	284	29	313
Amortisation at 31 March 2018	1,445	670	2,115
Net book value at 31 March 2018	583	-	583
Net book value at 1 April 2017	867	29	896

Note 12.2 Intangible assets - 2016/17

	Software licences £000	Internally generated information technology £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	2,008	670	2,678
restated	2,008	670	2,678
Additions	20	-	20
Valuation / gross cost at 31 March 2017	2,028	670	2,698
Amortisation at 1 April 2016 - as previously	809	641	1,450
Amortisation at 1 April 2016 - restated	809	641	1,450
Provided during the year	352	-	352
Amortisation at 31 March 2017	1,161	641	1,802
Net book value at 31 March 2017	867	29	896
Net book value at 1 April 2016	1,199	29	1,228

Note 13.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	134,092	1,067,334	4,377	5,572	153,262	170	38,266	1,025	1,404,098
Additions	-	11,252	324	7,675	13,588	-	3,424	-	36,263
Impairments	-	(2,739)	(3)	-	-	-	-	-	(2,742)
Revaluations	1,070	111,929	57	-	-	-	-	-	113,056
Reclassifications	(151)	270	-	(5,510)	1,077	-	4,314	-	-
Disposals / derecognition	-	-	-	-	(1,693)	-	(6,434)	-	(8,127)
Valuation/gross cost at 31 March 2018	135,011	1,188,046	4,755	7,737	166,234	170	39,570	1,025	1,542,548
Accumulated depreciation at 1 April 2017 - brought forward	-	67,403	419	-	84,312	159	28,177	516	180,986
Provided during the year	-	27,166	349	-	16,423	8	5,033	69	49,048
Impairments	-	1,730	-	-	-	-	-	-	1,730
Disposals / derecognition	-	-	-	-	(1,622)	-	(6,434)	-	(8,056)
Accumulated depreciation at 31 March 2018	-	96,299	768	-	99,113	167	26,776	585	223,708
Net book value at 31 March 2018	135,011	1,091,747	3,987	7,737	67,121	3	12,794	440	1,318,840
Net book value at 1 April 2017	134,092	999,931	3,958	5,572	68,950	11	10,089	509	1,223,112

13.2 Note 13.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under constructi on £000	Plant & machiner y £000	Transport equipme nt £000	Informati on technolog y £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	132,017	1,026,790	4,405	33,307	135,468	170	36,874	864	1,369,895
Additions	-	28,051	-	5,242	18,765	-	957	161	53,176
Impairments	-	(21,722)	(28)	(479)	-	-	-	-	(22,229)
Revaluations	2,075	2,375	-	-	-	-	-	-	4,450
Reclassifications	-	32,060	-	(32,498)	3	-	435	-	-
Disposals / derecognition	-	(220)	-	-	(974)	-	-	-	(1,194)
Valuation/gross cost at 31 March 2017	134,092	1,067,334	4,377	5,572	153,262	170	38,266	1,025	1,404,098
Accumulated depreciation at 1 April 2016 - as previously stated	-	-	-	-	67,239	134	22,615	468	90,456
Provided during the year	-	27,344	157	-	17,886	25	5,562	48	51,022
Impairments	-	40,134	262	-	-	-	-	-	40,396
Disposals/ derecognition	-	(75)	-	-	(813)	-	-	-	(888)
Accumulated depreciation at 31 March 2017	-	67,403	419	-	84,312	159	28,177	516	180,986
Net book value at 31 March 2017	134,092	999,931	3,958	5,572	68,950	11	10,089	509	1,223,112
Net book value at 1 April 2016	132,017	1,026,790	4,405	33,307	68,229	36	14,259	396	1,279,439

Note 13.3 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018									
Owned - purchased	135,011	320,046	3,053	6,973	53,654	-	12,608	430	531,775
Finance leased	-	5,942	418	-	-	-	-	-	6,360
On-SoFP PFI contracts and other service concession arrangements	-	732,251	-	-	-	-	-	-	732,251
Owned - government granted	-	520	-	-	-	-	-	-	520
Owned - donated	-	32,988	516	764	13,467	3	186	10	47,934
NBV total at 31 March 2018	135,011	1,091,747	3,987	7,737	67,121	3	12,794	440	1,318,840

Note 13.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned - purchased	134,092	292,580	3,053	4,580	55,355	-	9,997	503	500,160
Finance leased	-	6,781	609	-	740	-	-	-	8,130
On-SoFP PFI contracts and other service concession arrangements	-	670,831	-	-	-	-	-	-	670,831
Owned - government granted	-	391	-	610	-	-	-	-	1,001
Owned - donated	-	29,348	296	382	12,855	11	92	6	42,990
NBV total at 31 March 2017	134,092	999,931	3,958	5,572	68,950	11	10,089	509	1,223,112

Note 14 Investment Property

The Trust holds no investment property (nil in 2016/17).

Note 15 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	11,289	12,292
Consumables	15,753	17,072
Energy	366	331
Total inventories	27,408	29,695
of which:		
Held at fair value less costs to sell	27,408	29,695

Note 16 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	158,621	120,265
Capital receivables (including accrued capital related income)	-	3,525
Accrued income	38,194	19,604
Provision for impaired receivables	(20,873)	(20,556)
Prepayments (non-PFI)	8,200	5,085
Prepayments (PFI)	14,119	25,905
Prepayments (PFI financial close)	100	100
VAT receivable	14,741	10,941
Other receivables	877	1,176
Total current trade and other receivables	213,979	166,045
Non-current		
Prepayments (PFI financial close)	4,971	3,009
Total non-current trade and other receivables	4,971	3,009
Of which receivables from NHS and DHSC group bodies:		
Current	135,386	85,330
Non-current	-	-

Note 16.1 Provision for impairment of receivables

	31 March 2018 £000	31 March 2017 £000
At 1 April as previously stated	20,556	18,698
Increase in provision	8,344	10,031
Amounts utilised	(1,936)	(1,130)
Unused amounts reversed	(6,091)	(7,043)
At 31 March	20,873	20,556

Note 16.2 Credit quality of financial assets

Ageing of impaired financial assets	31 March 2018 Trade and other receivables £000	31 March 2017 Trade and Other Receivables £000
0 - 30 days	981	1,332
30-60 Days	594	769
60-90 days	572	410
90- 180 days	1,413	1,685
Over 180 days	17,313	16,360
Total	20,873	20,556
Ageing of non-impaired financial assets past their due date		
0 - 30 days	9,759	12,339
30-60 Days	2,320	4,341
60-90 days	1,656	1,092
90- 180 days	4,331	3,187
Over 180 days	20,617	16,055
Total	38,683	37,014

Note 17 Cash and cash equivalents

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

	31 March 2018 £000	31 March 2017 £000
At 1 April	**3,316**	**3,217**
Net change in year	(292)	99
At 31 March	3,024	3,316
Broken down into:		
Cash at commercial banks and in hand	57	163
Cash with the Government Banking Service	2,967	3,153
Total cash and cash equivalents as in SoFP	3,024	3,316
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	3,024	3,316

Note 17.1 Third party assets held by the trust

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

	31 March 2018 £000	31 March 2017 £000
Bank balances	76	90
Monies on deposit	-	-
Total third party assets	76	90

Note 18 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	117,210	87,540
Capital payables	4,288	11,359
Accruals	14,770	28,552
Social security costs	10,715	328
VAT payables	-	-
Other taxes payable	10,033	391
PDC dividend payable	-	-
Accrued interest on loans	1,611	655
Other payables	105	3,950
Total current trade and other payables	158,732	132,775

Note 18.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below.

	31 March 2018 £000	31 March 2017 £000
Outstanding pension contributions	11,129	121

Note 18.2 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	18,009	18,821
Total other current liabilities	18,009	18,821

Note 19 Borrowings

	31 March 2018 £000	31 March 2017 2017 £000
Current		
Loans from the Department of Health and Social Care	118,062	3,869
Other loans	-	-
Obligations under finance leases	1,650	1,505
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	24,534	24,522
Total current borrowings	144,246	29,896
Non-current		
Loans from the Department of Health and Social Care	310,933	289,095
Other loans	-	-
Obligations under finance leases	4,441	6,012
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	1,012,830	1,037,364
Total non-current borrowings	1,328,204	1,332,471

Note 20 Finance leases

Note 20.1 Barts Health NHS Trust as a lessee

Obligations under finance leases where Barts Health NHS Trust is the lessee.

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	6,544	8,350
of which liabilities are due:		
- not later than one year;	1,852	1,783
- later than one year and not later than five years;	4,692	6,488
- later than five years.	-	79
Finance charges allocated to future periods	(453)	(833)
Net lease liabilities	6,091	7,517
of which payable:		
- not later than one year;	1,650	1,505
- later than one year and not later than five years;	4,441	5,936
- later than five years.	-	76
Total of future minimum sublease payments to be received at the reporting date	-	-

Note 21 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	16,718	741	31	-	17,490
Transfers by absorption	-	-	-	-	-
Change in the discount rate	185	-	-	-	185
Arising during the year	615	157	96	613	1,481
Utilised during the year	(1,310)	-	(31)	-	(1,341)
groups	-	-	-	-	-
Reversed unused	(231)	(61)	-	-	(292)
Unwinding of discount	40	-	-	-	40
At 31 March 2018	16,017	837	96	613	17,563
Expected timing of cash flows:					
- not later than one year;	1,344	837	96	613	2,890
- later than one year and not later than five years;	5,375	-	-	-	5,375
- later than five years.	9,298	-	-	-	9,298
Total	16,017	837	96	613	17,563

Amount included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31st March 2018	647,867
As at 31st March 2017	531,618

Early Departure Costs are for the relevant pension obligations arising from early retirements of Trust staff.

Legal Claims are based upon estimates provided by NHS Litigation Agency and the Trust solicitors.

Note 21.1 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(165)	(178)
Gross value of contingent liabilities	(165)	(178)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(165)	(178)

Note 21.2 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	3,055	1,391
Total	3,055	1,391

Note 22 On-SoFP PFI, LIFT or other service concession

Note 22.1 Imputed finance lease obligations

Barts Health NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	1,658,279	1,719,390
Of which liabilities are due		
- not later than one year;	60,286	61,110
- later than one year and not later than five years;	232,111	234,684
- later than five years.	1,365,882	1,423,596
Finance charges allocated to future periods	(620,915)	(657,504)
Net PFI, LIFT or other service concession arrangement obligation	1,037,364	1,061,886
- not later than one year;	24,534	24,522
- later than one year and not later than five years;	97,460	96,657
- later than five years.	915,370	940,707

Note 22.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	5,015,136	4,995,120
Of which liabilities are due:		
- not later than one year;	117,221	113,430
- later than one year and not later than five years;	498,930	472,748
- later than five years.	4,398,985	4,408,942

Note 22.3 Analysis of amounts payable to service concession

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	118,716	142,364
Consisting of:		
- Interest charge	36,588	37,334
- Repayment of finance lease liability	24,522	21,602
- Service element and other charges to operating expenditure	30,253	57,600
- Capital lifecycle maintenance	3,847	5,680
- Revenue lifecycle maintenance	-	-
- Contingent rent	23,506	20,148
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	4,181	-
Total amount paid to service concession operator	122,897	142,364

23. PFI additional information

23.1 Barts and The Royal London Hospitals

The Trust had embarked on the biggest hospital redevelopment programme in Britain, managed through a £1.15 billion capital expenditure PFI contract with Capital Hospitals Ltd (our PFI Partner) to build the new hospitals.

Under the PFI contract, which ends on 25th April 2048, the Trust's PFI provider has constructed two new hospitals and provide facilities management of existing and new premises for the duration of the contract. At the conclusion of the contract, ownership of the assets will revert to the Trust. Under IFRIC 12, the asset is treated as an asset of the Trust with an internal rate of return on the finance lease of 3.2755% (excluding contingent rent) or 7.5% (including estimated contingent rent in note 29.3).

The first phases of Barts (phase 1A & 1B) were commissioned in March 2010, and the second phases (phase 2A & 2B) were commissioned in September 2014. The remaining phase of Barts was commissioned in 2015/16 (phase 3).

The first phases of The Royal London (Phase 1A & 1B) were commissioned between November 2011 and February 2012 and the second phases (Phase 2A and 2B) were commissioned in March 2014.

23.2 Barts Hospital and The Royal London Hospital PFI Scheme committed future charges: services and building maintenance

2017/18

	Total £000s	Lifecycle Replacement £000s	Services Received £000s
Within One Year	27,300	4,683	22,617
Between One and Five Years	129,559	34,828	94,731
Later than Five Years	1,274,034	415,925	858,109
Total	1,430,893	455,436	975,457

Lifecycle replacement is a contractual payment that the Trust makes to the PFI partner for the maintenance of the buildings.

2016/17

	Total £000s	Lifecycle Replacement £000s	Services Received £000s
Within One Year	23,980	4,683	20,479
Between One and Five Years	116,146	34,828	86,887
Later than Five Years	1,245,777	415,076	830,701
Total	1,385,903	454,587	938,067

23.3 Barts Hospital and The Royal London Hospital PFI Scheme committed future charges: provision of buildings

2017/18

	Total £000s	Repayment of Borrowings £000s	Interest £000s	Contingent Rent £000s
Within One Year	81,243	23,966	32,571	24,706
Between One and Five Years	332,437	94,084	122,716	115,637
Later than Five Years	2,936,985	889,991	421,552	1,625,442
Total	3,350,665	1,008,041	576,839	1,765,785

2016/17

	Total £000s	Repayment of Borrowings £000s	Interest £000s	Contingent Rent £000s
Within One Year	74,591	21,482	34,075	19,034
Between One and Five Years	317,614	93,532	128,807	95,275
Later than Five Years	3,044,917	938,552	481,383	1,624,982
Total	3,437,122	1,053,566	644,265	1,739,291

The Trust has to make a contractual rental payment to the PFI partner for the use of the building during the PFI contract, which is known as contingent rent. The payment is linked to movements in the Retail Price Index (RPI) and a future RPI of 2.5% has been assumed in the calculation of these figures (as per guidance issued by the Department of Health and Social Care Private Finance Unit).

23. PFI additional information (cont)

23.4 Newham University Hospital

The Newham University Hospital PFI scheme is managed through a contract with John Laing (Healthcare Support Newham Limited - HSNL) which ends on 31st March 2039. At the conclusion of the contract, ownership of the assets will revert to the Trust. Under IFRIC 12, the asset is treated as an asset of the Trust with an internal rate of return on the finance lease of 11.198% (excluding contingent rent) or 15% (including estimated contingent rent in note 29.6).

23.5 Newham University Hospital PFI Scheme committed future charges: services and building maintenance

	Total £000s	Lifecycle Replacement £000s	Services Received £000s
Within One Year	3,317	519	2,798
Between One and Five Years	13,640	1,788	11,852
Later than Five Years	81,418	20,747	60,671
Total	98,375	23,054	75,321

2016/17	Total £000s	Lifecycle Replacement £000s	Services Received £000s
Within One Year	4,855	541	4,314
Between One and Five Years	10,220	1,948	8,272
Later than Five Years	66,286	20,783	45,503
Total	81,361	23,272	58,089

Lifecycle replacement is a contractual payment that the Trust makes to the PFI partner for the maintenance of the buildings.

23.6 Newham University Hospital PFI Scheme committed future charges: provision of buildings

	Total £000s	Repayment of borrowings £000s	Interest £000s	Contingent Rent £000s
Within One Year	5,361	567	3,182	1,612
Between One and Five Years	23,293	3,377	11,934	7,982
Later than Five Years	106,552	25,380	28,961	52,211
Total	**135,206**	**29,324**	**44,077**	**61,805**

	Total £000s	Repayment of borrowings £000s	Interest £000s	Contingent Rent £000s
Within One Year	4,492	119	3,259	1,114
Between One and Five Years	21,476	2,619	12,553	6,304
Later than Five Years	115,700	27,183	34,760	53,757
Total	141,668	29,921	50,572	61,175

There are no future phases for the Newham University Hospital PFI Scheme as it has been handed over to the Trust in full.

The Trust has to make a contractual rental payment to the PFI partner for the use of the building during the PFI contract, which is known as contingent rent. The payment is linked to movements in the Retail Price Index (RPI) and a future RPI of 2.5% has been assumed in the calculation of these figures (as per guidance issued by the Department of Health Private Finance Unit)

Note 24 Carrying values of financial assets

Assets as per SoFP as at 31 March 2018	Loans and Receivables £000	Assets at Fair Value Through the I&E £000	Held to Maturity £000	Available-for-Sale £000	Total Book Value £000
Trade and other receivables excluding non financial assets	197,692	-	-	-	197,692
Cash and cash equivalents at bank and in hand	3,024	-	-	-	3,024
Total at 31 March 2018	200,716	-	-	-	200,716

Assets as per SoFP as at 31 March 2017	Loans and Receivables £000	Assets at Fair Value Through the I&E £000	Held to Maturity £000	Available-for-sale £000	Total Book Value £000
Trade and other receivables excluding non financial assets	164,293	-	-	-	164,293
Cash and cash equivalents at bank and in hand	3,316	-	-	-	3,316
Total at 31 March 2017	167,609	-	-	-	167,609

Note 24.1 Carrying values of financial liabilities

Liabilities as per SoFP as at 31 March 2018	Other Financial Liabilities £000	Liabilities at Fair Value Through the I&E £000	Total Book Value £000
Borrowings excluding finance lease and PFI liabilities	428,995	-	428,995
Obligations under finance leases	6,091	-	6,091
Obligations under PFI, LIFT and other service concession contracts	1,037,364	-	1,037,364
Trade and other payables excluding non financial liabilities	137,984	-	137,984
Total at 31 March 2018	1,610,434	-	1,610,434

Liabilities as per SoFP as at 31 March 2017	Other Financial Liabilities £000	Liabilities at Fair Value Through the I&E £000	Total Book Value £000
Borrowings excluding finance lease and PFI liabilities	292,964	-	292,964
Obligations under finance leases	7,517	-	7,517
Obligations under PFI, LIFT and other service concession contracts	1,061,886	-	1,061,886
Trade and other payables excluding non financial liabilities	132,056	-	132,056
Total at 31 March 2017	1,494,423	-	1,494,423

Note 24.2 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	282,230	161,952
In more than one year but not more than two years	323,719	202,420
In more than two years but not more than five years	81,165	185,014
In more than five years	923,320	945,037
Total	1,610,434	1,494,423

25 Financial Instruments

25.1 Financial risk management

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

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

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

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

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Socail Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Fair Value

In reporting the value of financial assets and liabilities in notes 25.2 and 25.3, the Trust has assessed that, given the nature of those financial assets and liabilities, fair value is equal to current value, and as such no additional disclosure is required.

Financial Instruments (cont)

25.2 Financial Assets

	<--- Loans & Receivables --->	
	2017/18	2016/17
	£000s	£000s
Receivables - NHS	150,093	85,835
Receivables - non-NHS	47,600	78,458
Cash at bank and in hand	3,024	3,316
Total at 31st March	200,717	167,609

25.3 Financial Liabilities

	<--- Other --->	
	2017/18	**2016/17**
	£000s	**£000s**
NHS payables	19,477	25,114
Non-NHS payables	118,507	106,942
Other borrowings	428,995	292,964
PFI & finance lease obligations	1,043,455	1,069,403
Total at 31st March	1,610,434	1,494,423

26 Events after the end of the reporting period

The Trust is planning to dispose of some of the Whitechapel site in the 2018/19 financial year.

Note 27 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	63	92	39	90
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	279	1,944	142	1,344
Stores losses and damage to property	1	1	25	16
Total losses	343	2,037	206	1,450
Special payments				
Ex-gratia payments	78	47	106	41
Total special payments	78	47	106	41
Total losses and special payments	421	2,084	312	1,492
Compensation payments received		-		-

Note 27.1 Gifts

Disclosure of gifts is only required if the total value of gifts made exceeds £300,000.

Note 28 Related Parties

Barts Health NHS Trust has had a significant number of material transactions with the Department of Health and Social Care, and with other entities for which the Department of Health and Social Care is regarded as the parent Department. During the year none of the Department of Health and Social Care ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Barts Health NHS Trust

Dr Thoreya Swage (non-executive director) is a non executive director of Frimley Health NHS Foundation Trust. Details of the income/expenditure amounts owed to/from Frimley Health NHS FT are included in notes 28.1 and 28.2 below.

The table below only shows those entities which exceed either:

a) The total amount owed to / owed by the related party as at 31 March 2018 exceeds £1m and / or

b) The total income/expenditure transacted with the related party exceeds £10m

Note 28.1 Amounts owed to/from related parties

	Amounts owed to related party		Amounts due from related party	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Barking, Havering & Redbridge NHS Trust	593	2,667	1,478	2,621
Common Council of the City of London	3,794	190	0	0
Community Health Partnerships	906	135	0	79
Department of Health and Social Care	0	0	235	430
East London NHS FT	1,026	1,656	5,430	4,410
Frimley Health NHS FT	2	2	7	7
Health Education England	40	86	88	1,003
HM Revenue and Customs	20,748	719	14,741	10,941
Homerton University Hospital NHS FT	1,542	1,052	2,011	2,001
Newham London Borough Council	1,140	265	24	0
NHS Basildon and Brentwood CCG	0	0	1,053	2,393
NHS Blood and Transplant	253	1,461	34	0
NHS Camden CCG	0	0	118	490
NHS City and Hackney CCG	40	76	2,011	1,234
NHS Enfield CCG	4	4	62	46
NHS England	32	27	86,228	29,348
NHS Haringey CCG	51	8	0	856
NHS Herts Valleys CCG	0	0	657	606
NHS Improvement (TDA legal entity)	60	66	408	249
NHS Islington CCG	4	4	1,014	1,116
NHS Mid Essex CCG	0	0	1,993	1,367
NHS Newham CCG	4,238	2,533	6,679	2,569
NHS Pension Scheme	11,404	121	0	0
NHS Property Services	4,730	4,522	0	0
NHS Redbridge CCG	585	622	861	874
NHS Slough CCG	0	0	554	1,435
NHS Thurrock CCG	0	0	534	2,724
NHS Tower Hamlets CCG	1,752	1,587	1,790	3,719
NHS Waltham Forest CCG	984	1,044	2,098	1,254
NHS West Essex CCG	82	12	1,405	1,480
Queen Mary University of London	539	1,056	1,493	2,574
Royal Free London NHS FT	1,882	1,332	2,850	4,153
Tower Hamlets London Borough Council	9,907	611	866	737
University College London NHS FT	1,344	4,785	2,306	3,012

Note 28 Related Parties (cont)

Note 28.2 Income/expenditure with related parties

	Income from Related Party		Expenditure with Related Party	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Barts Health Charity	7,035	6,777	269	5
BOA & Associates Consultancy Limited	0	0	119	0
Department of Health and Social Care	38,284	39,878	0	0
Frimley Health NHS FT	18	31	12	9
Health Education England	77,658	78,687	11	39
HM Revenue and Customs	0	0	77,150	66,995
NHS Barking and Dagenham CCG	23,747	24,352	0	0
NHS Barnet CCG	2,422	0	0	0
NHS Camden CCG	2,272	0	0	0
NHS City and Hackney CCG	28,601	30,156	0	0
NHS Enfield CCG	6,433	0	0	0
NHS England	567,546	513,841	60	8
NHS Haringey CCG	5,963	0	0	0
NHS Havering CCG	11,312	12,601	0	0
NHS Islington CCG	6,676	0	0	0
NHS Newham CCG	201,666	188,865	1,507	269
NHS Pension Scheme	0	0	76,832	67,460
NHS Redbridge CCG	67,974	66,205	0	0
NHS Resolution	0	248	45,584	41,448
NHS Tower Hamlets CCG	170,748	186,806	402	249
NHS Waltham Forest CCG	144,198	140,546	0	0
NHS West Essex CCG	22,736	21,435	10	12
Queen Mary University of London	3,780	3,341	14,631	9,180
Royal Free London NHS FT	9,398	13,399	7,904	6,739
Tower Hamlets London Borough Council	4,571	4,899	0	609
University College London NHS FT	2,321	1,744	9,243	10,118

Note 29 Better Payment Practice Code

Non-NHS Payables	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Total non-NHS trade invoices paid in the year	184,464	927,402	201,749	1,098,972
Total non-NHS trade invoices paid within target	121,871	764,919	147,334	943,818
Percentage of non-NHS trade invoices paid within target	66.07%	82.48%	73.03%	85.88%

NHS Payables	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Total NHS trade invoices paid in the year	4,616	264,063	3,605	264,576
Total NHS trade invoices paid within target	2,235	236,892	1,932	250,202
Percentage of NHS trade invoices paid within target	48.42%	89.71%	53.59%	94.57%

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

Note 30 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	115,237	147,476
Finance leases taken out in year	0	0
Other capital receipts		
External financing requirement	115,237	147,476
External financing limit (EFL)	115,814	147,792
Under / (over) spend against EFL	577	316

Note 31 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	36,263	53,196
Less Disposals	(71)	(306)
Less Donated and granted capital additions	(6,795)	(6,036)
Plus Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	29,397	46,854
Capital Resource Limit	33,196	47,745
Under / (over) spend against CRL	3,799	891

Note 32 Breakeven duty financial

	2017/18 £000	2016/17 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(108,782)	(69,481)
Remove impairments scoring to Departmental Expenditure Limit	-	-
Add back income for impact of 2016/17 post-accounts STF reallocation	419	-
Add back non-cash element of On-SoFP pension scheme charges	-	-
IFRIC 12 breakeven adjustment	-	-
Breakeven duty financial performance surplus / (deficit)	(108,363)	(69,481)

Note 32.2 Breakeven duty financial

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	409	(38,270)	(79,642)	(134,881)	(69,481)	(108,363)
Breakeven duty cumulative position	409	(37,861)	(117,503)	(252,384)	(321,865)	(430,228)
Operating income	1,324,338	1,288,172	1,319,964	1,342,594	1,488,833	1,512,726
Cumulative breakeven position as a percentage of operating income	0.03%	-2.94%	-8.90%	-18.80%	-21.62%	-28.44%

Barts Health NHS was formed on the 1st April 2012.