NHS
Barts Health
NHS Trust

Accountability Report and Annual Accounts

For the year ended 31 March 2019

2018 - 2019

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Contents

NHS
Barts Health
NHS Trust

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 Group Accounting Manual. The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy. Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it. This section forms the basis of the Trust's accountability report and performance report (in conjunction with the Quality Account).

Signed:

Alwen Williams.

Alwen Williams CBE,
Group Chief Executive

Date: 28 May 2019

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Barts Health
NHS Trust

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.

Alwen Williams.

Alwen Williams CBE,
Group Chief Executive

Date: 28 May 2019

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Chief Finance Officer's Foreword to the Accountability Report and Accounts

The Trust plan for 2018/19 was a deficit before Provider Sustainability Funding (PSF) of £56.8m. PSF Funding for 2018/19 was £54.9m and was conditional on the Trust agreeing a control total with NHS Improvement. The Trust was not able to agree a control total for 2018/19 and therefore did not receive PSF funding.

This plan was subject to the outcome of the 2017/18 NHSE Specialist Commissioning dispute. We were notified, in September 2018, that all but £12.9m of the Trust challenges had been successful. As a consequence, the Trust deficit before PSF moved to £69.7m in September 2018. In December 2018 the Trust suffered significant operational pressures with failures in a number of key infrastructure assets that led to reduced operational capacity during our busiest months. The Trust Board approved a revision to the Trust forecast outturn based on these non-recurrent operational pressures and our planned deficit was adjusted to £84.7m. The reported outturn for 2018/19 is a deficit before PSF of £84.2m which is consistent with the forecast submitted in December 2018.

The Trust has continued to focus on improving the delivery of high quality services, and in 2018/19 increased income by around 5.2% from £1,513m in 2017/18 to £1,591m in 2018/19. Total operating expenditure increased in year by 3.4% from £1,551m to £1,603m.

During the year, the Trust delivered £58.9m of cost improvements, slightly below the target of £62m. This performance equated to 3.5% of 2018/19 operating expenses. Each element of the cost improvement programme went through an assessment process to ensure that there were no adverse impacts on the quality of services delivered.

The total capital programme expenditure for the year was £49.2m, of which £2.3m was funded by donations. £24m was spent on land and buildings, £18.7m on plant and equipment, and £7m on Informatics. Included in these amounts was £29.8m relating to the Trusts PFI Lifecycle capital costs. The Trust submitted a capital plan at the start of 2018/19 that was significantly larger, reflecting the high levels of backlog maintenance at sites such as Whipps Cross Hospital.

The intention was to fund this increased capital plan through loan finance from the Department of Health and Social Care. Due to national constraints on capital funding the Trust secured only £5m of loan financing and so the planned capital investment for 2018/19 was significantly lower than envisaged.

In 2018/19, the Trust was removed from quality special measures following a positive report from the Care Quality Commission (CQC), and we now have the impetus and breathing space to chart a fresh course in which we are continually striving to improve all our services for patients. We have a clear view of clinical transformation priorities to be delivered in 2019/20, and those where planning needs to be undertaken to support longer-term change which supports the needs of our local populations, and at the same time ensures the achievement of value for money.

On 12 February 2019 the Care Quality Commission published a "Use of Resources" assessment undertaken by NHS Improvement. This assessment rated the overall use of resources by the Trust as "requires improvement" which reflects the continuing deficit of the Trust and the significant historic borrowings to fund this deficit. The report highlights areas of good and outstanding practice and notes the significant improvements the Trust has made and reflects the need to embed and sustain this progress going forward. It is encouraging to see this progress reflected in our External auditor's value for money opinion on our 2018/19 accounts.

Looking forward, the Trust has submitted a financial plan for 2019/20 to NHS Improvement which delivers a deficit including PSF of £65.4m (PSF of £29.1m), after delivery of a £55.8m savings programme which includes the full year effect of 18/19 schemes. The Trust annual operating plan for 2019/20 includes a total planned capital programme of £71.8m requiring loan financing of £50.5m.

The Trust is working closely with the Department of Health and Social Care and the Regulator to understand and address the structural elements of the Trust deficit. Discussions are in train with NHSI and DHSC on balance sheet restructuring and PFI excess cost mitigation along similar lines to precedent settlements in other PFI Trusts. Note 29 of our Annual Accounts sets out the details of our PFI contracts. The expectations are that resolution to both will substantially eliminate the structural element which is the main residual component of our run rate deficit. The continued progress of the Trust in addressing the drivers of our deficit within our own control and the continued positive engagement with the Department and Regulators means that the Trust is actively and optimistically working towards exiting financial special measures in 2019/20 and returning to financial balance by 2020/21 at the latest .

Bill Boa, Interim Group Chief
Finance Officer

Directors' report

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 and one associate non-executive director 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 busiest trust in England. As at 1 April 2019, there were no executive or non-executive vacancies.

The Trust has participated in the national NExT director programme (designed to identify the next generation of non-executive directors from underrepresented groups). During 2018/19, two NExT directors were invited to attend Board meetings in a non-voting capacity and participate in Board committee meetings (with one of these individuals, Kim Kinnaird, being successfully appointed as an associate NED during the year).

The Trust Board meet regularly in public so that it can discharge its duties (the board met 6 times in public during 2018/19, excluding 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 (with the SOs and SFIs re-approved in 2018).

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. 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 2019)

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 chairs Employers for Carers, having been a Trustee of Carers UK for 14 years. Ian also chairs a number of small technology companies, and is Vice Chair of Peabody Housing Association where he chairs their Development Committee. He has formerly served as a Non Executive Director at Central and North West London NHS Foundation Trust. Ian has his own consulting business specialising in utility sector transformation.

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. He was formerly a non-executive director of Barts and The London NHS Trust from September 2010 to March 2012. From 2000 to 2003 he was chairman and chief executive of KPMG's practice in India, which he helped to establish. Gautam is a board member of Camellia plc, The National Gallery and ZincOx Resources plc. Previously he was a founder board member of the UK India Business Council, a member of the boards of the Law Society, AMREF International and a member of the Governing Body of the School of Oriental and African Studies. 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 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 Queen Mary's University of London, the University of Reading and 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. He is currently Managing Director of Wolesley UK Ltd. 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

Ms Natalie Howard (non-executive director) joined Barts Health NHS Trust in December 2017. Natalie joined DRC Capital as Principal in 2018, following eight years heading AgFe'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. Formerly a NED at St Marys NHS Trust and HM Treasury, she has in recent times provided organisational development support at NHS England and Department of Health at board level.

Mr Shane DeGaris (deputy chief executive) joined Barts Health on 1 September 2018. For the previous six years Shane was chief executive of The Hillingdon Hospitals NHS Foundation Trust, a medium sized acute trust in north west London. Before that he worked at board level in a number of executive roles, including chief operating officer at Hillingdon Hospitals, deputy chief executive at Epsom & St Helier University Hospitals NHS Trust, and director of operations at Barnet & Chase Farm Hospitals NHS Trust.
Shane started his healthcare career in 1990 after training as a physiotherapist in South Australia, working clinically for a number of years before progressing into senior leadership roles in the UK.

Ms Caroline Alexander (chief nurse) graduated as a nurse in 1987 from Edinburgh University (BSc/RGN) and has an MSc in Nursing Studies from South Bank University (2001). From 1987 to 1993 she specialised in nursing older people in Edinburgh and then London at Guy's Hospital as a ward sister.

Caroline then worked for the Foundation of Nursing Studies for three years supporting nurses to use research in practice. In 1998 Caroline returned to the NHS and worked in Tower Hamlets in a range of roles within older people's services. In 2005, Caroline took up her first Director post, as Director of Nursing and Therapies within Tower Hamlets PCT. With the clustering of PCTs in London in 2011, she took on the Director of Nursing and Quality within NHS East London and the City initially and then within NHS North East London when the clusters merged in 2012. Caroline was the Chief Nurse for NHS London for 6 months until she joined NHS England as Regional Chief Nurse for London in April 2013. Caroline took up her current role of Chief Nurse for Barts Health in March 2016. She is delighted to have returned to the East End and to work at the Trust at this important time. Caroline was a 2008 Florence Nightingale Leadership Scholar. She was a Visiting Professor at City University until 2012 and is now a Visiting Professor at Bucks New University. Caroline was awarded Honorary Doctorates from City, University of London in 2017 and Middlesex University in 2018 and she is a Trustee of the Foundation of Nursing Studies.

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.

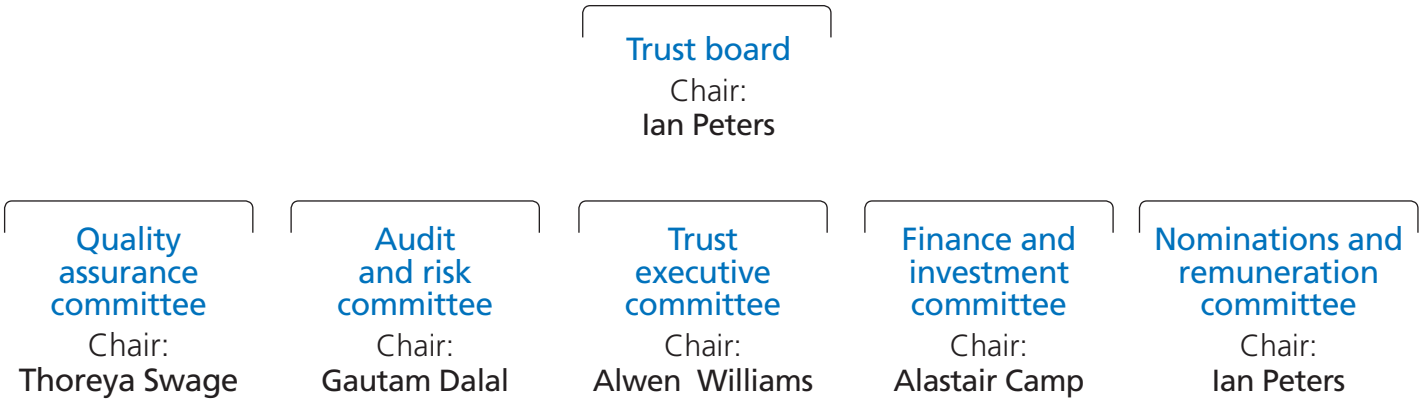
Mr Michael Pantlin (director of people) joined Barts Health on 1 October 2012 from the Royal Surrey County Hospital NHS Foundation Trust. Previously he was with the Royal Bank of Scotland in commercial and retail banking sectors across England and Wales. Prior to this, Michael headed HR for the specialist 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) joined Barts Health in 2017 to lead the development of the Group operating model. Prior to this he was London regional Chief Operating Officer for NHS Improvement, and he has held other system leadership roles as interim London regional director for the NHS Trust Development Authority, and with NHS London. He joined the NHS from Cambridge University as a national management trainee in 1993 and has spent the greater part of his career in acute provider organisations, with a broad range of responsibilities at Board level.

Mr Ralph Coulbeck (director of strategy) was appointed director of strategy for the Trust in April 2016. He 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.

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.



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 12 September 2018, the trust board approved revised terms of reference for the committee and received the audit and risk committee's annual report, which confirmed compliance with the above key duties 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, associate NED.

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 2018/19, the quality assurance committee included a specific focus on implementation of the trust's improvement plan and quality and safety arrangements at site and clinical board level. Exception reports were provided to the trust board (based on use of a standard proforma reporting template) following each meeting. At its meeting on 17 October 2018, 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. At its meeting on 12 September 2018, the trust board approved revised terms of reference for the committee.

Membership: 3 non executive directors (Dr Thoreya Swage – chair, Ms Margaret Exley – vice chair, Prof Steve Thornton) chief executive and/or deputy chief executive, chief medical officer, chief nurse, and quality 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. At its meeting on 12 September 2018, the trust board approved revised terms of reference for the committee.

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 or provided orally) are provided to the trust board following each meeting. The finance and investment committee monitors financial performance against key duties set in its terms of reference. At its meeting on 12 September 2018, the trust board approved revised terms of reference for the committee.

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, associate non-executive 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. As part of development of the group model development, this committee has been revised for 2019/20 and will in future perform an enhanced oversight (but reduced operational) role as a group executive board.

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

Attendance

Attendance by members of board committees, 2018-19

*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	5/6 (83%)	7/8 (88%)			3/3 (100%)	
Gautam Dalal	6/6 (100%)	8/8 (100%)	4/4 (100%)		3/3 (100%)	10/11 (91%)
Thoreya Swage	6/6 (100%)	8/ (100%)	4/4 (100%)	6/6 (100%)	3/3 (100%)	
Alastair Camp	5/6 (83%)	6/7 (86%)			2/3 (67%)	9/11 (82%)
Steve Thornton	4/6 (67%)	6/7 (86%)		5/6 (83%)	1/3 (33%)	
Mark Higson	5/6 (83%)	5/7 (71%)	2/4 (50%)		1/3 (33%)	8/11 (73%)
Natalie Howard	3/6 (50%)	4/7 (57%)			2/3 (67%)	7/11 (64%)
Margaret Exley	6/6 (100%)	6/7 (86%)		5/6 (83%)	0/3 (0%)	
Alwen Williams	6/6 (100%)	8/8 (100%)				10/11 (91%)
Chrisha Alagaratnam	2/6 (33%)	3/8 (38%)				4/11 (36%)
Caroline Alexander	6/6 (100%)	7/7 (100%)		6/6 (100%)		
Alistair Chesser	6/6 (100%)	7/7 (100%)		6/6 (100%)		
Tim Peachey	1/2 (50%)	2/4 (50%)		1/2 (50%)		1/4 (25%)
Shane DeGaris	4/4 (100%)	4/4 (100%)		2/4 (50%)		7/7 (100%)
Michael Pantlin	6/6 (100%)	7/7 (100%)				7/11 (64%)
Ralph Coulbeck	6/6 (100%)	7/7 (100%)				
Tony Halton	2/3 (67%)	2/3 (67%)		1/1 (100%)		
Andrew Hines	6/6 (100%)	8/8 (100%)				
Bill Boa (director of financial improvement/ acting CFO)	4/4 (100%)	5/5 (100%)				10/10 (100%)

Board effectiveness

During 2018/19, 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 review and improvement plan were developed ahead of a formal CQC Well Led assessment during the year (rating the Trust as 'good'). The implementation of this improvement plan will be linked with the development of Trustwide quality improvement methodology and reflect the organisation's wider system leadership role and contribution. As part of this work, a Trust Board awayday focusing on board development, culture, effectiveness and visioning was scheduled for May 2019.

Trust board appraisals

The process for appraisals has been established with the chair and regional director of NHS Improvement responsible for appraisals of 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 2018-19 are scheduled for completion by the end of the first quarter of 2019-20 (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 and professional registration for clinicians.

The Trust's fit and proper persons arrangements were reviewed as part of the CQC Well Led assessment during 2018/19 and no issues were identified.

The annual 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

During 2018/19, the trust engaged in important work with system partners at borough, multi-borough, STP, AHSN and pan-London level. This work included the following elements:

- At borough level, the trust is an active partner in the Tower Hamlets Together programme, the Newham Wellbeing Partnership and the Better Care Together programme in Waltham Forest. Each partnership brings together commissioners, primary care, community care, social care, hospital providers and patient representatives to improve care and increase integration. These borough level partnership have prioritised improvements in urgent and emergency care, end of life care and integrated out of hospital care during 2018/19.
- At multi-borough level, the trust is a key partner in work across the Inner North East London area, comprising Newham, Tower Hamlets, Waltham Forest, Hackney and City of London. Priorities for improvement at this level include the redesign of outpatient services, implementation of same day emergency care standards, and improvements to surgical services.
- At Northeast London level, the trust is a member of the East London Health and Care Partnership which oversees the wider system and supports a range of priorities, including improvement to maternity and cancer services. The redevelopment of Whipps Cross hospital is the ELHCP's highest priority for major estates development.
- The trust is a member of the UCLP Academic Health Science Network and the UCLH cancer collaborative, both of which operate across Northeast and North Central London. The AHSN focuses on collaborative clinical research and the adoption of innovation and the trust is the largest contributor to the North Thames Clinical Research Network.
- The trust is also involved in a range of pan-London partnership for the development of specialised services, strategic planning and estates.

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 2019/20.

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 strategy is reserved to the trust board.

Board assurance framework

The board assurance framework (BAF) 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 2019-20.

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. The format and use of the BAF was strengthened to reflect prior year audit recommendations and observations from Well Led external review. 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 strategic risks 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 success in mitigating board assurance framework risk scores downwards during 2018/19 including those relating to quality of services. The year end version of the BAF identified two board assurance framework entries that had been sufficiently addressed to reduce to the target risk score. The year-end BAF risk scores reflected continuing operational and financial risks despite progress identified internally and by external stakeholders and regulators in managing these. In light of the ongoing risks faced (in part due to challenges facing the wider health economy, including an ageing population and significant emergency care demand increases), it is anticipated that the trust's overall strategic risk appetite will be low as it enters 2019/20; with a planned review of risk appetite in Quarter 1 of 2019/20.

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 2018 indicated that risk management systems and processes were more fully embedded at a hospital-level and group level. The development of the group model and enhanced site-based leadership overall has led to improved risk management maturity, reflected in positive Well Led assessments in 2018.

The trust risk management committee has met regularly throughout the year and maintains corporate oversight of risk in the organisation, reporting regularly to the Trust Executive Committee on its work. At each meeting the committee reviews the trust's high level risks and during 2018/19, has developed and reported key risk reporting metrics.

During the year, the risk management committee and audit and risk committee approved a revised and enhanced risk management strategy.

The risk management function conducted a comprehensive training needs assessment and launched new training materials to be used as part of statutory and mandatory training. We will continue to offer training on risk management, targeting key roles with risk management involvement. An independent assessment of the Trust's risk management function was carried out and has informed resourcing and planning for 2019/20.

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 and triangulation with capital investment processes. This informs the process of replacement of medical equipment, allowing equipment to be replaced in a prioritised way so that we make best use of the finite resource available. Similar risk assessment has informed the prioritisation of funding for fire safety improvements and ICT infrastructure.

Annual governance statement 2018-19

1. Scope of responsibility

As Accountable Officer, 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.

The system of internal control has been in place in Barts Health NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

2018/19 was a year of remarkable progress for Barts Health, including the achievement of a principal objective by exiting quality special measures.

The Trust's overall group model governance structure was strengthened, with support to the trust executive committee through hospital boards and divisional structures providing operational leadership at site level and clinical boards and supporting networks providing a focus on clinical strategy and standardisation across sites. Significant progress has been made during 2018/19 against identified quality improvement priorities and CQC comprehensive inspections of services at Whipps Cross University Hospital, The Royal London Hospital and Newham University Hospital in September 2018 (with associated follow-up visits) confirmed improvements and upgraded ratings at each site, with the majority of the Trust's core services rated as 'good'. A 'good' overall rating was awarded to The Royal London Hospital as well as an overall improvement in the 'Well Led' domain rating for the Trust from 'requires improvement' to 'good'. A CQC and NHS Improvement 'Use of Resources' assessment resulted in a 'requires improvement' rating, recognising the overall deficit while noting significant productivity achievements. The Trust confirmed its exit from quality special measures in February 2018. A three-year Trust quality strategy is being developed accordingly, supported by the introduction of quality improvement methodology. The Trust continued to face financial challenges in 2018/19 and reported a deficit of £84.2m, an adverse variance of £27.5m against its financial plan, and is now working towards achieving a breakeven position in coming years.

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.

There has been only one change to the Board's voting membership during 2019/20 with Shane DeGaris joining the Board as Deputy Chief Executive in September 2018, following the retirement of Tim Peachey. There were no Trust Board vacancies at the end of the financial year.

A 'Well Led' self-assessment process commenced in April 2018 and was accompanied by an external independent review. The output of these processes supported the development of a Well Led improvement plan. The subsequent CQC re-inspection in relation to the Essential Standards 'Well Led' domain during October 2018 provided assurance on progress, with the Trust securing a 'good' rating for this domain.

The principal committees established by the Trust Board to support it in undertaking its responsibilities are the Audit and Risk Committee, Quality Assurance Committee, Nominations and Remuneration Committee, Finance and Investment Committee and Trust Executive Committee (executive committee). Details of the roles of these committees are provided in the accountability report. 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 2018-19
Trust board (parts 1 and 2)	14	86%
Audit and risk committee	4	75%
Quality assurance committee	6	87%
Nominations and remuneration committee	3	73%
Finance and investment committee	11	72%

A 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 2018/19, the Audit and Risk Committee focused on the effectiveness of controls in relation to payroll arrangements, stock control arrangements and financial controls. The Committee also reported to the Trust Board on its assurance of risk management arrangements (including emerging site assurance frameworks), freedom to speak up mechanisms, waiver processes, information governance (e.g. Caldicott Guardian arrangements) and data security standards, and accounting policy. The Quality Assurance Committee provided assurance to the Trust Board on efficient and effective quality of 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.

A CQC and NHS Improvement 'Use of Resources' review during 2018 identified strong productivity and procurement performance (delivering recurrent savings and innovative practice). A 'requires improvement' rating was assigned, reflecting the overall deficit position of the Trust.

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 2017/18 Quality Account including a deep dive review of selected quality indicators and the findings have been taken into account for the production of the 2018/19 Quality Account, which is due to be agreed by the Board in June 2019.

The Trust Board approved the 2017/18 Barts Health Quality Account element of the Annual Report in June 2018, following 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 2018/19, the Director of Corporate Development has led on risk management issues at Board level.

Capacity to handle risk

The governance arrangements for risk management are 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. 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.

The Risk and Control framework

The Trust has a comprehensive Risk Management Policy 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 (consequence x likelihood) risk matrix used to evaluate risks in the Trust.

- The Risk Management Committee reviews the Trust's high risks 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 and corporate directorate risks with a score of 12 and above as well as deep dive thematic reviews. The Risk Management Committee reviews all risk register entries with a score of 20 or above at each meeting.
- The Risk Management function 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 hospitals, 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.

Hospital Management Boards have held responsibility for monitoring, managing and where necessary escalating risks on their risk registers. Risk training has been undertaken with hospitals 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 in the upper quartile). Monthly CEO-led performance review meetings include a review of all hospital and CSS risks scored 15 and above.

- 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 is formally reviewed by the Trust Board 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 (or a deep dive review of an identified principal risk).

The principal risks on the Trust's Board Assurance Framework as approved by the Board at the end of 2018/19 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 organisation's highest scored risks to achievement of its strategic objectives, as at the end of 2018/19, are included on the Board Assurance Framework and relate to:

- A failure to address the underlying run rate position over a two year timeframe through delivery of major transformational CIP schemes, while managing operational pressures within the existing cost-base, impacts on medium term financial sustainability.
- Capital funding constraints preventing adequate investment in medical equipment to support effective and timely care.

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 2018/19 Internal Audit report on the Board Assurance Framework, in draft at the point of producing this Annual Governance Statement, indicated a significant assurance rating, the highest rating received since the formation of the Trust. Action will be taken by the Executive to address the recommendations identified in the audit report, including mapping key controls and assurances consistently.

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 the NHS Counter Fraud Authority'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 the NHS Counter Fraud Authority. 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 and a Trustwide risk assessment carried out in 2018/19.

External assurance

The Care Quality Commission's reports following their re-inspections of the Trust (including its Well Led review) received during 2018/19 demonstrate progress made in embedding risk management systems and processes and the use of risk registers. Further improvement and greater consistency remain a priority for the hospital sites and for the Barts Health group as a whole.

Stakeholder involvement

Partners and stakeholders are involved and engaged in the Trust's business and risks which impact on them through their contributions, 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.

Staff

- The adoption of a We Improve quality improvement approach to staff engagement and staff-led change has been actively reviewed and prioritised going into 2019/20.
- A strong focus on encouraging staff to raise concerns through Guardian of Safe Working, Freedom to Speak Up and Speak In Confidence services.
- Activities to engage and develop staff including leadership development and talent management work, ward development initiatives to improve information sharing, administrative and clerical career development, LNC and Staff Partnership Forum engagement with clinicians and staff representatives.
- Monitoring of Staff Survey findings, and related executive and senior staff roadshows and visits to wards and departments. The Trust has seen a step change in its staff survey ratings over the last four years, reflecting its staff engagement focus.

Partners

- Regular performance discussions with commissioners, NHS England and NHS Improvement (NHSI).
- Board-approved stakeholder management plan and regular reports on impact to the Board.
- Joint working groups for emergency care and RTT and sector work as part of the East London Health and Care Partnership.
- 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.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 has a sustainable development management strategy and plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust is compliant with registration requirements of the CQC. Details of compliance with CQC essential standards of quality and safety are set out in Section 4.

Information governance and data security

Information Governance provides the framework for handling information in a secure and confidential manner. Covering the collection, storage and sharing of information, it provides assurance that personal and sensitive data is managed legally, securely, efficiently and effectively in order to deliver the best possible care and service.

The Director of Corporate Development chairs the Trust's Information Governance Committee, the principal body overseeing the management of information risks.

This group reports into the Trust Executive Committee and oversees the development and submission of the Trust's annual Data Security and Protection toolkit.

The Trust's control and assurance processes for information governance include:

- Information asset owners covering patient and staff personal data areas.
- A trained Caldicott Guardian, a trained Senior Information Risk Owner and a trained Data Protection Officer.
- A risk management and incident reporting process and related risk register.
- Mandatory data security training for all staff.
- Data Protection, Information Security, Records Management and confidentiality policies.
- An annual report submitted to the Trust Board summarising key Information Governance activities and compliance with requirements (including introduction of the Data Security and Protection Toolkit, work of the Caldicott Guardian, General Data Protection Regulation arrangements, Freedom of Information, EU exit preparations, IG risks, training and priorities).

The Trust submitted a rating of 'compliant' in relation to the Data Security and Protection toolkit submission in March 2019. The annual Internal Audit review of the Data Security and Protection toolkit assigned reasonable assurance to the 2018-19 submission.

In 2018-19 there was one serious incident involving a breach of personal-identifiable data which was investigated and reported to the Information Commissioner's Office (ICO) in accordance with national guidance. This incident related to a number of patient notes going missing in Ward 8F, RLH and being found later in a drawer without a tracking label. As a result without the tracking label it was impossible to locate patients' medical records and several patients missed their 12 weeks postnatal appointments. After investigation, the ICO decided no further action was necessary.

To ensure the secure management of patient and staff information, the Trust continually seeks to further develop and improve its 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 2019, 87% of its staff had completed and passed their mandatory annual data security training.

Safe staffing assurance

Each year the Trust Board agrees an Operational Plan that includes finance, demand and workforce planning for the year. Each month, hospital sites report by exception against plan to the Group Executive Board through performance review mechanisms. The Trust's monthly workforce report (part of the integrated performance report to the Trust Board) includes reporting against key performance indicators; staff in post, vacancy fill rate, turnover and absence.

As a part of the annual planning process the Trust Board signs off nursing and midwifery safer staffing workforce plans presented by the Chief Nurse. These plans are developed at ward, hospital and then Group level. The safe staffing plans are then reviewed at six months before revision for the following year. The monthly integrated performance report also details ward-level safer staffing metrics including fill rates and care hours per patient day.

For 2019/20 we are working to establish a process for other clinical groups that aligns with the established nursing midwifery safe staffing practice. These developments will be in line with 'Developing Workforce Safeguards' published in October 2018.

Elective waiting time data

The Trust Board agreed, following a series of nationally prescribed checks and an independent external review of the integrity of its waiting time data, to resume RTT national reporting in 2018/19. The Trust has undertaken extensive pathway validation exercises, to validate waiting time data recorded for all patients currently waiting for treatment; with the remaining validation required on low risk cohorts. The Trust has engaged in work designed to identify the sources of poor quality data, followed by meaningful intervention designed to address underlying issues including staff training needs.

Update on significant control issues in 2017/18

The Trust identified a number of significant control issues in its Annual Governance Statement for 2017/18. A significant ICT remediation programme was undertaken to address identified data security and cyber security weaknesses, providing a strengthened infrastructure; further investment is planned in 2019/20 to support the next stage of data centre and networks improvement.

Improved performance on cancer and diagnostics access in 2018/19 reflected significant work by staff and the absence of major ICT outtages, which had been a factor in the prior year. The Trust returned to national reporting on RTT in 2018/19 and reported progress on performance and data quality metrics. Following Medicines Healthcare Regulatory Agency intervention on pharmacy and radiopharmacy manufacturing in 2017/18, regulatory review meetings have been de-escalated to a quarterly review cycle. Good progress was reported on recommendations relating to a limited assurance review of ICT disaster recovery arrangements. Updates on all other 2017/18 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 has 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 Oversight Framework.
- The Trust's ongoing self-assessment of compliance with the CQC's Essential Standards of Quality and Safety and the findings of inspections of services at Whipps Cross University, Newham University and The Royal London Hospitals (as well as the Trust as a whole) by the Care Quality Commission (CQC) as published during 2018/19.
- The Head of Internal Audit 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 2018/19 concludes that, for the systems that have been reviewed, reasonable assurance can be given that controls are generally sound and operating effectively.
- The work of Internal Audit through the year, with coverage of the audit plan determined by a risk-based assessment. None of the finalised audit reports 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 and 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 risk management arrangements. 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. Executives 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.

Financial performance

The Trust continued to face financial challenges in 2018/19, with emergency demand during winter and a specialist commissioning expert determination process impacting on the level of patient treatment income received for services provided. A further driver of the Trust's deficit was underachievement of planned workforce savings on a recurrent basis. The Trust reported a deficit of £84.2m for 2018/19, in line with the Trust's revised forecast at Month 9. The Trust's objectives remain focused on delivering financial sustainability and a robust transformation programme has been developed to focus on delivering efficiencies.

National performance standards (emergency care and elective waiting times)

The Trust underachieved against the national 4-hour waiting time standard for emergency care waiting times in 2018/19 and recorded two instances of patients waiting on trolleys in excess of 12 hours. Attendances continued to rise significantly during the year. During a challenging winter period, the Trust's performance benchmarked well when compared with peers. Action plans and trajectories have been agreed with commissioners and regulators for 2019/20.

Following its meeting on 9 May 2018, the Trust Board formally confirmed its decision to recommence reporting against the national 18 Weeks referral to Treatment Time standard. This followed significant work to assure on the supporting data quality, validation of the accuracy of clinical data recording, reducing the number of long waiters and addressing the Trust's overall waiting list length. Regulators and commissioners recognised that the Trust would not be able to achieve compliance with the related national standard of 92% compliance in the short term. However, progress was made against agreed local trajectories for incomplete pathway performance, waiting list size and the number of patients waiting over 52 weeks (with the number of breaches of this target reduced to 12 by year end).

CQC essential standards of quality and safety

Significant progress has been made during 2018/19, reflected in the Trust exiting quality special measures in February 2019.

Care Quality Commission comprehensive inspections of services at Whipps Cross University Hospital, The Royal London Hospital and Newham University Hospital in September 2018 (with associated follow-up visits) confirmed improvements and upgraded ratings at each site, with an overall improvement in the 'Well Led' domain rating for the Trust from 'requires improvement' to 'good' and the majority of the Trust's core services now rated as 'good'. A Trust quality strategy to be developed in 2019/20 will focus on steps to develop and further improve services over the next three years. During the course of the inspections, two warning notices (relating to medicines management in Whipps Cross surgical services and maternity services at Newham) were received. Follow-up visits during the year confirmed improvements made and related enforcement requirements withdrawn by the CQC.

Never Events

The Trust reported 13 Never Events during 2018/19 (following 9 Never Events being recorded in 2017/18). Although no cases resulted in significant harm to patients, the volume of cases represented a concern to the Trust Board, resulting in an increasing focus on consistent and early adoption of bespoke surgery safety checklists (as part of NATSSIPs and LOCSSIPs safety initiatives). The quality assurance committee, on behalf of the board, monitors details of Never Events and the delivery of related actions to share and act on learning.

Fire safety remediation and capital constraints

The Trust operated within a constrained capital budget during 2018/19. A proportion of available funding was prioritised for investment in fire safety improvement works. Following review of plans with the London Fire Brigade in-year, the Trust determined that it needed to revise its fire safety improvement work programme to accelerate improvements at Newham. This reprioritisation required additional investment of the limited capital available (which, in combination with the absence of anticipated capital loan funding, impacted on the level of available capital for other priorities including estates backlog maintenance and medical equipment replacement).

Conclusion

My review has established that Barts Health NHS Trust has a sound 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:

- Financial performance.
- Performance against standards for emergency care and elective waiting time standards (18 Weeks Referral to Treatment time).
- CQC essential standards of quality and safety.
- Never events performance.
- Fire safety improvement and capital constraints.

During 2018/19, 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
Group Chief Executive
Barts Health NHS Trust
28 May 2019

Appendix 1: Board assurance framework – principal risks at 31 March 2019

Board assurance framework – strategic risk entries
1. A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety (A2) (CMO)
2. Failure to secure improvements to remaining CQC 'inadequate' rated services or improve systems for early detection and intervention impairs delivery of quality of care and objectives (A1) (CN)
3. A failure to meet agreed 18 weeks referral to treatment time trajectories or sustain data quality requirements impacts on patient experience and reputation (A3) (DCEO)
4. Failure to sustain patient flow improvements and address capacity issues impacts on emergency care access and patient experience (A3) (DCO)
5. A failure to address the underlying run rate position over a two year timeframe through delivery of major transformational CIP schemes, while managing operational pressures within the existing cost-base, impacts on medium term financial sustainability. (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 define in detail and implement the clinical and organisational strategy impacts on sustainability and development. (C6) (DS)
8. A failure to deliver outpatients transformation plans in 2018/19 impacts on service efficiency, patient experience and the volume of referrals to the Trust (C1) (DCEO)
9a. The absence of specific plans and contingencies for exiting the EU on 29 March 2019 in relation to: Cost increases for supply chain goods and services; Stock and cashflow management; Paying patients arrangements; and Research funding impacts on financial plans and sustainability (B) (CFO)
9b The absence of specific plans and contingencies for exiting the EU on 29 March 2019 in relation to: New medicines and products standards; New medicines and products standards; Arrangements for radioactive materials, blood, organs and tissues import and export; Public Health arrangements and business continuity planning assumptions; and Continuity of data transfer agreements impacts on operational resilience and continuity (B) (DCEO)
10. Delivery of recruitment and retention objectives are impaired by continued high vacancy rates in hard-to-recruit specialties/sites and the effect of Brexit impacting on efficient service delivery (D6) (DP)
11. A failure to effectively engage across a large organisation to lead and embed consistent values behaviours and accountability impacts on consistent high quality service delivery. (D2) (DP)
12. A risk of not delivering workforce and patient equalities and inclusion goals impacts on establishing a stable workforce, access and outcome targets (D4) (DP)
13. Failure to sustain ICT resilience, due to infrastructure weaknesses and/or human error, results in significant operational disruption, service diverts or non-delivery of national standards (E5) (DS)
14. Capital funding constraints prevent adequate investment in medical equipment to support effective and timely care
15. A risk of regulatory action in relation to fire safety, as a result of capital funding constraints and lead times for improvement actions, impacting on operational service delivery and quality of care
16. Failure to maximise available resources in the context of reduced educational funding availability results in losses of training posts, reduced recruitment of new starters and adverse impact on workforce objectives

Remuneration Report and Staff Report

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.

Annual salary increases are ordinarily in line with increases for the wider NHS workforce but may be higher where there is a significant change to an individual's responsibilities.

In order to attract high quality candidates to senior posts and to support retention, the nominations and remuneration committee will:

- make decisions in the context of the current market
- take into account independently sourced benchmark data and analysis of pay within relevant NHS, private health and non-healthcare markets
- compare pay with other staff on nationally agreed agenda for change and medical consultant terms and conditions.

Salaries & Allowances (Information has been audited)

Name and title	2018-19					
	Salary	Expense Payments (taxable)	Performance pay and Bonuses	Long term Performance pay and bonuses	All Pension-Related Benefits	Total
	(bands of £5000)	(to nearest £100)	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
Executive Directors						
Ms Alwen Williams, Chief Executive (1)	245 to 250	0	0	0	0	245 to 250
Dr Tim Peachey, Deputy Chief Executive (to 31.08.18) (1)	60 to 65	0	0	0	0	60 to 65
Mr Shane DeGaris, Deputy Chief Executive (from 01.09.18)	110 to 115	0	0	0	130 to 132.5	240 to 245
Prof Alistair Chesser, Chief Medical Officer	210 to 215	0	0	0	47.5 to 50	260 to 265
Ms Caroline Alexander, Chief Nurse	165 to 170	0	0	0	60 to 62.5	225 to 230
Ms Chrisha Alagaratnam, Chief Financial Officer (3)	185 to 190	7	0	0	52.5 to 55	235 to 240
Mr Michael Pantlin, Director of People (1)	165 to 170	0	0	0	0	165 to 170
Mr Ralph Coulbeck, Director of Strategy	125 to 130	0	0	0	32.5 to 35	160 to 165
Mr Tony Halton, Director of Clinical Operations (to 01.10.18)	80 to 85	0	0	0	27.5 to 30	110 to 115
Mr Andrew Hines, Director of Corporate Development	140 to 145	0	0	0	25 to 27.5	170 to 175
Mr Bill Boa, Finance Improvement Director (1) and (2)	135 to 140	0	0	0	0	135 to 140
Non Executive Directors						
Mr Ian Peters, Chair (3)	60 to 65	25	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 (3)	5 to 10	14	0	0	0	5 to 10
Mr Mark Higson, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Ms Natalie Howard, Non-Executive Director	5 to 10	0	0	0	0	5 to 10
Ms Margaret Exley, Non-Executive Director	5 to 10	0	0	0	0	5 to 10

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a "zero" should be substituted for any negative figures.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Note (1): The Pensions Related Benefits figures for these Executive Directors are nil, because they do not currently contribute to the NHS Pensions Scheme.

Note (2): As a result of the Trust being in Financial Special Measures in 2018/19, NHS Improvement imposed as a condition of the Trust's operating licence that a Financial Improvement Director be in post. This post was 50% funded by NHS Improvement, and the payment shown above is net of these recharges.

Note (3): Expense payments (taxable benefits): This relates to miscellaneous travel and parking expenses.

28th May 2019

Alwen Williams CBE, Group Chief Executive

Name and title	2017-18					
	Salary	Expense Payments (taxable)	Performance pay and Bonuses	Long term Performance pay and bonuses	All Pension-Related Benefits	Total
	(bands of £5000)	(to nearest £100)	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5000)
	£000	£00	£000	£000	£000	£000
Executive Directors						
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
Non Executive Directors						
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

[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.

Pensions Table (Information has been audited)

2018/19									
Note	Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31st March 2019	Lump sum at pension age related to accrued pension at 31st March 2019	Cash equivalent transfer value at 1st April 2018	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2019	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
		£000	£000	£000	£000	£000	£000	£000	£00
	Mr Shane DeGaris, Deputy Chief Executive (from 01.09.18)	2.5 to 5	0 to 2.5	40 to 45	20 to 25	433	74	602	0
	Prof Alistair Chesser, Chief Medical Officer	2.5 to 5	0 to 2.5	75 to 80	190 to 195	1,334	174	1,589	0
	Ms Caroline Alexander, Chief Nurse	2.5 to 5	2.5 to 5	50 to 55	120 to 125	846	137	1,033	0
	Ms Chrisha Alagaratnam, Chief Financial Officer	2.5 to 5	0 to 2.5	65 to 70	150 to 155	873	262	1,196	0
1	Mr Ralph Coulbeck, Director of Strategy (1)	2.5 to 5	0	5 to 10	0	42	17	79	0
	Mr Tony Halton, Director of Clinical Operations (to 01.10.18)	0 to 2.5	2.5 to 5	55 to 60	170 to 175	1,005	67	1,195	0
	Mr Andrew Hines, Director of Corporate Development	0 to 2.5	-2.5 to 0	45 to 50	115 to 120	692	108	842	0

Notes

1 This officer is in the 2015 Scheme, under which taking a lump sum on retirement is optional, therefore lump sum figures have not been provided by NHS Pensions.

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, but does include contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

2017/18									
Note	Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
1	Ms Alwen Williams, Chief Executive	0	0	0	0	0	0	0	0
1	Dr Tim Peachey, Deputy Chief Executive	0	0	0	0	0	0	0	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
1	Mr Michael Pantlin, Director of People	0	0	0	0	0	0	0	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)
Non-Executive Directors				
Mr Ian Peters	Mitie PLC	Advisor to CEO		31/01/2018
	The Floow	Chairman		
	Switchee Ltd	<1% Shareholding		
	Sagacity Solutions Ltd	Strategic advisor	01/05/2018	
	Tock Insurance	Chairman		
	Peabody Housing Trust	Vice Chairman		
	Friends of Peterhouse Ltd	Chairman		
	Ensek Ltd	Chairman		
	Bain and Company	Strategic Advisor		
	Advizzo Ltd	Chairman		
	Employers for Carers	Chairman		
Ms Natalie Howard	DRC Capital Ltd	Partner	21/07/2018	
	AGFE Ltd	Partner		20/07/2018
Ms Margaret Exley	SCT consulting	Director		
Mr Alastair Camp	China Fleet Trust	Trustee		
	London Institute of Banking & Finance	Chairman, pension fund		
	Local Justice Area	Magistrate - South and West Devon Local Area		
Dr Thoreya Swage	NEL Clinical Excellence Awards Advisory Committee	Member	29/10/2018	
	Frimley Health NHS Foundation Trust	Non-Executive Director		
	Thoreya Swage	Sole Trader		
Professor Steve Thornton	Queen Mary University of London	Vice Principal, Health (primary employer)		
	Ferring Pharmacy	Consultancy advice		
	General Medical Council	Chair, UKMed		
	Glaxo Smith Kline	Consultancy advice		
	Hologic	Consultancy advice		
	Medcity	Board member		
	Royal College of Obstetricians and Gynaecologists	Various roles		
	UCLP	Board member		
	Wellbeing for Women	Trustee		
	William Harvey Research Foundation		11/03/2019	
	Medical Schools Council	Executive		
	Advisory Board sponsored by Janssen, GSK and Monash University		01/04/2019	
Mr Gautam Dalal	ZincOx Resources Plc	Non-Executive Director		
	SOAS (School of Oriental and African Studies)	Treasurer and Member of Governing Body		31/07/2018
	National Gallery	Member of Audit and Finance Committees		
	Camellia Plc	Non-Executive Director		
Mr Mark Higson	Wolseley UK	Managing Director	15/03/2018	
Executive Directors				
Ms Alwen Williams	No Interests Declared			
Mr Shane DeGaris	No Interests Declared			
Ms Chrisha Alagaratnam	No Interests Declared			
Ms Caroline Alexander	Foundation of Nursing Studies (FONS)	Trustee	01/02/2019	
	Buckinghamshire New University	Honorary Visiting Professor		
Dr Tim Peachey	Isle of Wight NHS Trust	Non-Executive Director	01/04/2018	
Professor Alistair Chesser	Deloitte	Brother in Law is a partner		
Mr Michael Pantlin	Harris Jones Recruitment Ltd	Sister-in-law owns company		
Mr Andrew Hines	No Interests Declared			
Mr Tony Halton	No Interests Declared			
Mr Ralph Coulbeck	Barts Health NHS Trust	Spouse - specialist registrar training contract		01/02/2019

Senior Manager numbers by salary band	Number of senior managers
£5,000 - £10,000	7
£60,001 - £65,000	2
£80,001 - £85,000	1
£110,001 - £115,000	1
£125,001 - £130,000	1
£135,001 - £140,000	1
£140,001 - £145,000	1
£165,001 - £170,000	2
£185,001 - £190,000	1
£210,001 - £215,000	1
£245,001 - £250,000	1
Total	**19**

Composition of Senior Managers by Gender	Headcount	%
Female	6	32%
Male	13	68%
Total	**19**	**100%**

Compensation on early retirement or for loss of office (Information has been audited)

In 2018/19, there were no such payments (none in 2017/18).

Payments to past directors (Information has been audited)

In 2018/19, there were no such payments (none in 2017/18).

Fair Pay (Information has been audited)

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 2018/19 was £240k to £245k (2017/18, £240k to £245k). This was 6.8 times (2017/18, 7.1) the median remuneration of the workforce, which was £36k (2017/18 £34k).

In 2018/19, one individual received remuneration in excess of the highest paid Director* (none in 2017/18). Remuneration ranged from the bands £10k-£15k to £305k-£310k (2017/18 £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.

*The most highly paid individual was an interim appointment during 2018/19. This post has been recruited to substantively in 2019/20.

Staff numbers (Information has been audited)

Average staff numbers	2018/19 Total	2018/19 Permanently employed	2018/19 Other Number	2017/18 Total	2017/18 Permanently Employed	2017/18 Other Number
Medical and dental	**2,714**	2,331	383	**2,631**	2,274	357
Administration and estates	**3,931**	3,566	365	**3,762**	3,390	372
Healthcare assistants and other support staff	**1,939**	1,525	414	**1,521**	1,521	-
Nursing, midwifery and health visiting staff	**5,849**	4,807	1,042	**5,682**	4,710	972
Nursing, midwifery and health learners	**-**			**367**		367
Scientific, therapeutic and technical staff	**1,816**	1,564	252	**1,773**	1,549	224
Healthcare Science Staff	**651**	630	21	**629**	614	15
Other	**-**			**-**		
Total	**16,900**	**14,423**	**2,477**	**16,365**	**14,057**	**2,308**
Of the above - staff engaged on capital projects	**13**	5	8	**4**	4	

Staff Cost (Information has been audited)

	2018/19 Total	2018/19 Permanently employed cost	2018/19 Other	2017/18 Total	2017/18 Permanently employed cost	2017/18 Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	**744,636**	744,636	-	**698,076**	698,076	-
Social Security costs	**78,278**	78,278	-	**73,664**	73,664	-
Apprenticeship levy	**3,698**	3,698	-	**3,475**	3,475	-
NHS Pensions Scheme	**79,117**	79,117	-	**76,832**	76,832	-
Pension cost - other	**-**	-	-	**-**	-	-
Other post employment benefits	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-
Termination Benefits	**541**	541		**207**	207	
Temporary staff	**31,619**	-	31,619	**36,982**	-	36,982
Total	**937,889**	**906,270**	**31,619**	**889,236**	**852,254**	**36,982**
Less costs capitalised as part of assets	**935**	**934**		**333**	**333**	
Total	**936,955**	**905,336**	**31,619**	**888,903**	**851,921**	**36,982**

Staff composition (as at 31st March 2019)

Gender	Headcount	%
Female	11,805	**72%**
Male	4,573	**28%**
Total	**16,378**	**100%**

Sickness absence data (Information has been audited)	2018/19	2017/18
	Number	Number
Total days lost	122,767	109,391
Total staff years	15,035	14,902
Averages working days lost	**8.2**	**7.3**

Trade Union Facility Time Reporting (Information has been audited)

Relevant Union Officials

The total number of employees who were relevant union officials during the relevant period

Number of employees who were relevant	Full-time equivalent employee number
110	106

Percentage of time spent on facility time

Employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of Employees
0%	73
1-50%	36
51-99%	0
100%	1

Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Total cost of facility time	105,262
Total pay bill	937,889,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

Paid trade union activities

As a percentage of total paid facility time hours, hours spent by employees who were relevant union officials during the relevant period on paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	
(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	12%

Exit Packages (Information has been audited)

2018/19						
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	£000s	Number	£000s	Number	£000s
Less than £10,000	29	128	2	9	31	137
£10,000 - £25,000	4	50	1	22	5	72
£25,001 - £50,000	2	79			2	79
£50,001 - £100,000	1	99			1	99
£100,001 - £150,000						
£150,001 - £200,000			1	169	1	169
>£200,000						
Totals	**36**	**356**	**4**	**200**	**40**	**556**

2017/18						
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	£000s	Number	£000s	Number	£000s
Less than £10,000	14	47			14	47
£10,000 - £25,000	3	45			3	45
£25,001 - £50,000	3	116			3	116
£50,001 - £100,000						
£100,001 - £150,000						
£150,001 - £200,000						
>£200,000						
Totals	**20**	**208**	**-**	**-**	**20**	**208**

There were no “Special Payments” in 2018/19 (nil in 2017/18).

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.

2018/19		
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*	2	172
Exit payments following Employment Tribunals or court orders	2	28
Non-contractual payments requiring HMT approval**		
Total	**4**	**200**

There were nil "Other Departures" in 2017/18.

Consultancy expenditure (Information has been audited)

Consultancy expenditure charged to operating expenses	2018/19	2017/18
	£000s	£000s
Consultancy services	5,344	5,898

Off-payroll Engagements (not subject to audit)

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	15
Of which, the number that have existed:	
for less than one year at the time of reporting	15
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, or those that reached six months in duration, between 1 April 2018 and March 2019, for more than £245 per day and that last for longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	17
Of which…	
No. assessed as within the scope of IR35	0
No. assessed as outside the scope of IR35	17
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
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 must include both on payroll and off-payroll engagements.	1

The individual included in the table above is the Trust's Financial Improvement Director, which post was a condition of the Trust's operating licence in 2018/19, and was an arrangement that was mandated, signed-off and part-funded by NHS Improvement.

Notes

Notes

Notes

Annual Accounts

For the year ended 31 March 2019

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, the 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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

28th May 2019

Alwen Williams CBE
Group Chief Executive

28th May 2019

Bill Boa
Interim Group Chief Finance Officer

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 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 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 2018-19; 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.

Conclusions relating to going concern

We draw attention to note 1.3 in the financial statements which indicates that the Trust has submitted a financial plan for 2019/20 to NHS Improvement which delivers a £65.4 million deficit after delivery of a £55.8 million savings programme and receipt of £29.1 million from the Provider Sustainability Fund. As stated in note 1.3, this is a highly demanding plan which is subject to a high degree of risk and is dependent on the full delivery of cost reduction targets, realisation of recurrent savings and the adherence to agreed budgets.

As stated in note 1.3, the plan includes a requirement for up to £108.0 million of cash support from the Department of Health and Social Care (DHSC), of which £65.3 million is required to maintain revenue cash flows, whilst £42.7 million is required to support essential capital investment. NHS Improvement has not confirmed the support.

These events or conditions, along with the other matters as set forth in note 1.3, 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

Independent auditor's report to the Directors of Barts Health NHS Trust

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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the 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 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 2018-19 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.

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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has 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 make 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.

Independent auditor's report to the Directors of Barts Health NHS Trust

We have nothing to report in respect of the above matters except on 28 May 2019 we referred a matter to the Secretary of State:

- under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2019
- under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the Trust setting a deficit budget for the year ending 31 March 2020 and the resultant ongoing breach of the Trust's breakeven duty for the three-year period ending 31 March 2020.

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

As explained more fully in the Statement of Director's Responsibilities, 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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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.

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report we are 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 2019.

Independent auditor's report to the Directors of Barts Health NHS Trust

Basis for qualified 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 a deficit of £87.3 million in 2018/19. The deficit would have been higher were it not for £85 million of gains from one-off transactions, including £64 million from the sale of property and land
- The Trust has set a £65.4 million deficit budget for 2019/20, which includes delivery of a challenging £55.8 million savings programme and anticipated receipt of £29.1 million of Provider Sustainability Funding (PSF). The Trust will only receive this PSF and additional Financial Recovery Fund funding if it meets its financial target agreed with NHS Improvement and specified operational targets
- The Trust has drafted a financial plan to achieve in year financial break-even by 2021/22, but as at 31 March 2019 this plan had not been agreed with NHS Improvement
- The Trust remains in the Department of Health and Social Care's Financial Special Measures programme.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures.
These matters are evidence of weaknesses in the proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

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.

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(1)(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 2019, 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.

Independent auditor's report to the Directors of Barts Health NHS Trust

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.

Use of our report

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.

Paul Grady

Paul Grady
Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
London
28-May-19

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	4	1,359,954	1,299,810
Other operating income	5	166,691	212,916
Operating expenses	7	(1,603,421)	(1,550,806)
Operating surplus/(deficit) from continuing operations		**(76,776)**	**(38,080)**
Finance income	12	425	892
Finance expenses	13	(74,922)	(71,192)
Net finance costs		**(74,497)**	**(70,300)**
Other gains / (losses)	14	63,958	81
Surplus / (deficit) for the year from continuing operations		**(87,315)**	**(108,299)**
Surplus / (deficit) for the year		**(87,315)**	**(108,299)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(9,937)	(2,742)
Revaluations	16	3,696	113,056
Total comprehensive income / (expense) for the period		**(93,556)**	**2,015**

Adjusted financial performance (control total basis):

Surplus / (deficit) for the period		(87,315)	(108,299)
Remove net impairments not scoring to the Departmental expenditure limit	16	293	1,730
Remove I&E impact of capital grants and donations		2,779	(1,794)
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	(419)
Adjusted financial performance surplus / (deficit)		**(84,243)**	**(108,782)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	85	583
Property, plant and equipment	16	1,297,750	1,318,840
Receivables	18	7,131	4,971
Total non-current assets		**1,304,966**	**1,324,394**
Current assets			
Inventories	17	24,398	27,408
Receivables	18	163,174	213,979
Cash and cash equivalents	19	3,193	3,024
Total current assets		**190,765**	**244,411**
Current liabilities			
Trade and other payables	20	(171,933)	(158,732)
Borrowings	23	(148,959)	(144,246)
Provisions	25	(2,030)	(2,890)
Other liabilities	22	(19,634)	(18,009)
Total current liabilities		**(342,556)**	**(323,877)**
Total assets less current liabilities		**1,153,175**	**1,244,928**
Non-current liabilities			
Borrowings	23	(1,321,238)	(1,328,204)
Provisions	25	(13,607)	(14,673)
Total non-current liabilities		**(1,334,845)**	**(1,342,877)**
Total assets employed		**(181,670)**	**(97,949)**
Financed by			
Public dividend capital		336,885	327,050
Revaluation reserve		257,997	267,389
Income and expenditure reserve		(776,552)	(692,388)
Total taxpayers' equity		**(181,670)**	**(97,949)**

The notes on pages 58 to 87 form part of these accounts.

The financial statements on pages 54 to 87 were approved by the Board on the 28th May 2019 and signed on its behalf by:

Alwen Williams

28th May 2019

Alwen Williams CBE, Group Chief Executive

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**327,050**	**267,389**	**(692,388)**	**(97,949)**
Surplus/(deficit) for the year	-	-	(87,315)	**(87,315)**
Other transfers between reserves	-	(3,151)	3,151	**-**
Impairments	-	(9,937)	-	**(9,937)**
Revaluations	-	3,696	-	**3,696**
Public dividend capital received	9,835	-	-	**9,835**
Taxpayers' equity at 31 March 2019	**336,885**	**257,997**	**(776,552)**	**(181,670)**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£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)**

Information on reserves

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. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they 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 reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(76,776)	(38,080)
Non-cash income and expense:			
Depreciation and amortisation	7	51,111	49,361
Net impairments	8	293	1,730
Income recognised in respect of capital donations	5	(2,316)	(6,795)
(Increase) / decrease in receivables and other assets	18	48,745	(53,421)
(Increase) / decrease in inventories	17	3,010	2,287
Increase / (decrease) in payables and other liabilities	20	17,025	31,261
Increase / (decrease) in provisions	25	(1,942)	33
Net cash generated from / (used in) operating activities		**39,150**	**(13,624)**
Interest received	12	425	892
Purchase of intangible assets		(9)	-
Purchase of property, plant, equipment and investment property		(46,226)	(35,986)
Sales of property, plant, equipment and investment property		77,269	3,677
Net cash generated from / (used in) investing activities		**31,459**	**(31,417)**
Cash flows from financing activities			
Public dividend capital received		9,835	5,416
Movement on loans from the Department of Health and Social Care		20,999	136,030
Capital element of finance lease rental payments		(1,826)	(1,979)
Capital element of PFI, LIFT and other service concession payments		(24,534)	(24,522)
Interest on loans		(12,592)	(33,333)
Interest paid on finance lease liabilities		(252)	(275)
Interest paid on PFI, LIFT and other service concession obligations		(62,070)	(36,588)
Net cash generated from / (used in) financing activities		**(70,440)**	**44,749**
Increase / (decrease) in cash and cash equivalents		**169**	**(292)**
Cash and cash equivalents at 1 April - brought forward		**3,024**	**3,316**
Cash and cash equivalents at 31 March	19	**3,193**	**3,024**

Notes to the Accounts

1.1 Basis of preparation

The Department of Health and Social Care (DHSC) 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 2018/19 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 the accounts.

1.2 Accounting convention

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

1.3 Going concern

Barts Health NHS Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

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 2019/20 to NHS Improvement which delivers a £65.4 million deficit after delivery of a £55.8 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 deficit before PSF of £94.5m deficit after delivery of a £55.8m savings programme which includes the full year effect of 18/19 schemes. The deficit, including PSF of £29.1m, is a forecast of £65.4m.

The underlying financial performance of the Trust within the 2019/20 plan is a deficit of £65.4m (£94.5m excluding the provider sustainability fund) and the Trust is reliant upon £9.3m of non-recurrent savings during 2019/20 in order to achieve the 2019/20 control total. The plan includes a requirement for up to £106.3m of cash support from the Department of Health and Social Care (DHSC), of which £65.3m is required to maintain revenue cash flows, whilst £41.0m is required to support essential capital investment. The Trust plans to repay loans of £3.7m in the year to DHSC.

NHS Improvement has not, at the date of approval of the financial statements, confirmed the support for 2019/20 and 2020/21.

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 2018/19 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.

1.4 Critical accounting judgements

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

The following are the judgements that management has made in the process of applying the trust 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.

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 Bartholomew's 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 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.

In 2018/19, the Trust disposed of part of its Whitechapel site to the Department of Health and Social Care. The Trust's management, in the exercise of its judgement, are satisfied that the risks and rewards of ownership of the site had transferred to the Department of Health and Social Care by the 31st March 2019, notwithstanding the lease back by the Trust of some elements of the site. In determining that the full transfer of risk and rewards of ownership of the site has taken place, the Trust is satisfied that it plays no role in the active management of the sites it occupies, other than the role ordinarily assumed by an operational leaseholder. Our judgement is that these leases are operating leases. The lease payments have been charged to expenditure, and the buildings occupied have no value to the Trust (this is supported by the Valuation Office Agency), and are not recognised as non-current assets on the Statement of Financial Position. On this basis, the Trust has recognised in full the profit on disposal of these assets in the financial year 2018/19, and in reaching this conclusion has considered the relevant accounting standards.

1.5 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Partially Completed Spells

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.

Maternity Pathways

Ante and post maternity care is paid on a package price which is charged at the start of the pathway. Revenue is apportioned across financial years on the basis of the number of months in the pathway in the current financial year compared to the number of months in the whole pathway.

Asset Lives – Notes 1.11.4 and 1.12.3

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 these accounting policies, and the carrying values of intangible assets and property, plant and equipment in Notes 15 and 16 respectively.

Land and Buildings Valuations – Note 16

Land and Building assets were revalued at 31st March 2019. 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.

1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.7 Revenue grants and other contributions to expenditure

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

1.8 Other income

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

1.9 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the 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
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.
National Employment Savings Trust (NEST)
Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme.

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

1.10 Expenditure on other goods and services

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

1.11 Property, plant and equipment

1.11.1 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.

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

1.11.2 Measurement

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values 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 on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

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, borrowings costs. Assets are revalued and depreciation commences when the assets 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 lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.11.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.11.4 Useful lives of property, plant and equipment

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

	Min Years	Max Years
Land	-	-
Buildings, excluding dwellings	2	72
Dwellings	4	71
Plant & machinery	5	10
Transport equipment	3	7
Information technology	5	10
Furniture & fittings	10	15

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

1.12 Intangible assets

1.12.1 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.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

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

1.12.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.
Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.
Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

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

1.12.3 Useful economic life of intangible assets

	Min Years	Max Years
Software licences	3	5

1.13 Donated and grant funded assets

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

1.14 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.

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 Note 29.

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 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 Trust to the operator for use in the scheme

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

Other assets contributed by the Trust to the operator

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

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the first in, first out (FIFO) method. 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's cash management. Cash, bank and overdraft balances are recorded at current values.

1.17 Carbon Reduction Commitment (CRC) Scheme

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 will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

1.18 Financial assets and financial liabilities

1.18.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

1.18.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by review of individual receivables. Expected credit losses are not recognised in relation to other NHS bodies, nor Whole of Government Account (WGA) bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.18.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.19 Leases

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

1.19.1 The Trust as lessee

Finance leases

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

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

The annual rental charge 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 leases

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

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

Leases of land and buildings

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

1.19.2 The Trust as lessor

Finance leases

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

Operating 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.

1.20 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 0.29% (2017/18: positive 0.10%) 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.

1.20.1 *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 26 but is not recognised in the Trust's accounts.

1.20.2 *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.

1.21 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 in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.22 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.

In the 2018/19 financial year, the Trust's average net relevant assets was a negative figure, and hence PDC dividends were not payable.

1.23 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.

1.24 Foreign exchange

The functional and presentational currency of the trust is sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
The Trust has no assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.
Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

1.25 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 note 19.1 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

1.26 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.

1.27 Gifts

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

1.28 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.29 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 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.

3 Fees and Charges (Income Generation Activities)

HM Treasury requires bodies to provide additional disclosures for fees and charges raised under legislation, for instance dental and prescription charges, where the full cost exceeds £1 million, or the service is otherwise material in relation to the accounts. The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

An analysis of "Other Income" is shown at Note 5.1 of the accounts.

4 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy Note 1.6.

4.1 Income from patient care activities (by nature)

	2018/19	2017/18
	£000	£000
Elective income	177,072	156,626
Non elective income	366,169	346,601
First outpatient income	57,531	61,518
Follow up outpatient income	127,211	115,010
A & E income	62,641	60,108
High cost drugs income from commissioners (excluding pass-through costs)	120,373	123,498
Other NHS clinical income	397,624	398,016
Community services income from CCGs and NHS England	15,869	18,854
Private patient income	6,372	5,617
Agenda for Change pay award central funding	11,327	0
Other clinical income	17,765	13,962
Total income from activities	**1,359,954**	**1,299,810**

4.2 Income from patient care activities (by source)

	2018/19	2017/18
	£000	£000
NHS England	523,894	516,258
Clinical commissioning groups	782,044	741,797
Department of Health and Social Care	11,367	253
NHS Foundation Trusts	8,047	9,612
NHS other	619	421
Local authorities	9,886	11,541
Non-NHS: private patients	6,372	5,617
Non-NHS: overseas patients (chargeable to patient)	10,168	9,414
Injury cost recovery scheme	7,544	4,526
Non NHS: other	13	371
Total income from activities	**1,359,954**	**1,299,810**
Of which:		
Related to continuing operations	1,359,954	1,299,810

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

	2018/19	2017/18
	£000	£000
Income recognised this year	10,168	9,414
Cash payments received in year	1,072	1,245
Amounts added to provision for impairment of receivables	5,817	5,628
Amounts written off in-year	1,548	1,715

5 Other operating income

	2018/19	2017/18
Other operating income from contracts with customers:	**£000**	**£000**
Research and development (contract)	48,531	46,267
Education and training (excluding notional apprenticeship levy income)	72,077	77,040
Non-patient care services to other bodies	7,070	6,950
Provider sustainability/sustainability and transformation fund income (PSF/STF)	0	36,607
Other contract income*	33,264	36,055
Receipt of capital grants and donations	2,316	6,795
Charitable and other contributions to expenditure	154	93
Rental revenue from operating leases	3,279	3,109
Total other operating income	**166,691**	**212,916**
Of which:		
Related to continuing operations	166,691	212,916

5.1 *Other Contract Income is analysed in further detail below:

	2018/19	2017/18
	£000	**£000**
Car Parking income	1,131	391
Pharmacy sales	1,931	2,801
Property rental (not lease income)	3,490	779
IT recharges (external)	1,004	1,305
Clinical tests	5,232	4,384
Clinical excellence awards	2,729	2,934
Grossing up consortium arrangements	2,601	1,419
Other income not already covered (recognised under IFRS 15)	15,146	22,042
Total "Other" Contract Income	**33,264**	**36,055**

6 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the year that was included within contract liabilities at the previous period end	18,009

7 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	9,452	8,789
Purchase of healthcare from non-NHS and non-DHSC bodies	6,689	7,768
Staff and executive directors costs	936,504	888,806
Remuneration of non-executive directors	110	109
Supplies and services - clinical (excluding drugs costs)	141,628	139,780
Supplies and services - general	82,725	75,578
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	174,910	174,632
Consultancy costs	5,344	5,898
Establishment	9,778	9,508
Premises	53,229	53,356
Transport (including patient travel)	7,592	12,649
Depreciation on property, plant and equipment	51,022	49,048
Amortisation on intangible assets	89	313
Net impairments	293	1,730
Movement in credit loss allowance: contract receivables / contract assets	7,092	-
Movement in credit loss allowance: all other receivables and investments	0	2,253
Change in provisions discount rate(s)	(220)	185
Audit services - statutory audit*	131	131
Other auditor remuneration (external auditor only)*	9	9
Clinical negligence	43,563	44,715
Legal fees	1,178	1,257
Insurance	1,333	1,143
Research and development	22,604	24,718
Education and training	4,111	4,842
Rentals under operating leases	4,207	3,882
Redundancy	450	97
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	26,025	30,253
Hospitality	0	49
Other	13,573	9,308
Total	**1,603,421**	**1,550,806**
Of which:		
Related to continuing operations	1,603,421	1,550,806

7.1 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services (Audit of Quality Accounts)*	9	9
Total	**9**	**9**

* The fee paid to the external auditors includes non recoverable VAT at 20%.

7.2 Limitation on auditor's liability

The limitation on auditors liability for external audit work is £2m (2017/18: £2m)

8 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	92	794
Other	201	936
Total net impairments charged to operating surplus / deficit	**293**	**1,730**
Impairments charged to the revaluation reserve	9,937	2,742
Total net impairments	**10,230**	**4,472**

9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	744,218	698,073
Social security costs	78,278	73,664
Apprenticeship levy	3,698	3,475
Employer's contributions to NHS pensions	79,117	76,832
Pension cost - other	25	3
Termination benefits	450	207
Temporary staff (including agency)	32,103	36,982
Total staff costs	**937,889**	**889,236**
Of which		
Costs capitalised as part of assets	935	333

9.1 Retirements due to ill-health

During 2018/19 there were 9 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £603k (£524k in 2017/18).

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

10 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme.

NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme.

The employer's contribution rate in 2018/19 was 2%, and will rise to 3% in 2019/20.

11 Operating leases

11.1 Barts Health NHS Trust as a lessor

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

	2018/19	2017/18
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	3,279	3,109
Total	**3,279**	**3,109**

	31 March 2019	31 March 2018
Future minimum lease receipts due:	**£000**	**£000**
- not later than one year;	3,011	3,279
- later than one year and not later than five years;	10,306	10,758
- later than five years.	87,857	90,354
Total	**101,174**	**104,391**

11.2 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.

	2018/19	2017/18
Operating lease expense	**£000**	**£000**
Minimum lease payments	4,207	3,882
Total	**4,207**	**3,882**

	31 March 2019	31 March 2018
Future minimum lease payments due:	**£000**	**£000**
- not later than one year;	3,422	3,759
- later than one year and not later than five years;	3,757	6,542
- later than five years.	257	401
Total	**7,436**	**10,702**

12 Finance income

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

	2018/19	2017/18
	£000	**£000**
Interest on bank accounts	425	892
Total finance income	**425**	**892**

13 Finance expenditure

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

	2018/19	2017/18
	£000	**£000**
Interest expense:		
Loans from the Department of Health and Social Care	12,572	10,782
Finance leases	252	275
Interest on late payment of commercial debt	12	1
Main finance costs on PFI and LIFT schemes obligations	35,752	36,588
Contingent finance costs on PFI and LIFT scheme obligations	26,318	23,506
Total interest expense	**74,906**	**71,152**
Unwinding of discount on provisions	16	40
Total finance costs	**74,922**	**71,192**

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

	2018/19	2017/18
	£000	**£000**
Amounts included within interest payable arising from claims under this legislation	12	1

14 Other gains / (losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	63,958	81
Total gains / (losses) on disposal of assets	**63,958**	**81**

In July 2018, the Trust disposed of part of its Whitechapel site to the Department of Health and Social Care, and the net gain is shown above.

15 Intangible assets - 2018/19

	Software licences	Internally generated IT	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - B/F	**2,028**	**670**	**2,698**
Additions	9	-	**9**
Reclassifications	(418)	-	**(418)**
Valuation / gross cost at 31 March 2019	**1,619**	**670**	**2,289**
Amortisation at 1 April 2018 - B/F	**1,445**	**670**	**2,115**
Provided during the year	89	-	**89**
Amortisation at 31 March 2019	**1,534**	**670**	**2,204**
Net book value at 31 March 2019	**85**	**-**	**85**
Net book value at 1 April 2018	**583**	**-**	**583**

15.1 Intangible assets - 2017/18

	Software licences	Internally generated IT	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**2,028**	**670**	**2,698**
Prior period adjustments	-	-	**-**
Transfer to FT upon authorisation	-	-	**-**
Valuation / gross cost at 31 March 2018	**2,028**	**670**	**2,698**
Amortisation at 1 April 2017 - as previously stated	**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**

16 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - B/F	**135,011**	**1,091,747**	**3,987**	**7,737**	**166,234**	**170**	**39,570**	**1,025**	**1,445,481**
Additions	-	12,915	17	23,984	10,542	-	1,779	-	**49,237**
Impairments	-	(9,923)	(14)	-	-	-	-	-	**(9,937)**
Revaluations	-	3,696	-	-	-	-	-	-	**3,696**
Reclassifications	-	-	-	(7,337)	1,666	-	6,078	11	**418**
Disposals / derecognition	(9,415)	(3,479)	-	(246)	(5,210)	(8)	-	(300)	**(18,658)**
Valuation/gross cost at 31 March 2019	**125,596**	**1,094,956**	**3,990**	**24,138**	**173,232**	**162**	**47,427**	**736**	**1,470,237**
Accumulated depreciation at 1 April 2018 - B/F	**-**	**-**	**-**	**-**	**99,113**	**167**	**26,776**	**585**	**126,641**
Provided during the year	-	29,370	359	-	16,541	3	4,680	69	**51,022**
Impairments	-	293	-	-	-	-	-	-	**293**
Disposals / derecognition	-	(138)	-	-	(5,023)	(8)	-	(300)	**(5,469)**
Depreciation / Accumulated depreciation at 31 March 2019	**-**	**29,525**	**359**	**-**	**110,631**	**162**	**31,456**	**354**	**172,487**
Net book value at 31 March 2019	**125,596**	**1,065,431**	**3,631**	**24,138**	**62,601**	**-**	**15,971**	**382**	**1,297,750**
Net book value at 1 April 2018	**135,011**	**1,091,747**	**3,987**	**7,737**	**67,121**	**3**	**12,794**	**440**	**1,318,840**

6.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - B/F Restated	**134,092**	**999,931**	**3,958**	**5,572**	**153,262**	**170**	**38,266**	**1,025**	**1,336,276**
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	-	**-**
Reclassifications for Accumulated Depreciation	-	(28,896)	(349)	-	(1,693)	-	(6,434)	-	**(37,372)**
Valuation/gross cost at 31 March 2018	**135,011**	**1,091,747**	**3,987**	**7,737**	**166,234**	**170**	**39,570**	**1,025**	**1,445,481**
Accumulated depreciation at 1 April 2017 - B/F Restated	**-**	**-**	**-**	**-**	**84,312**	**159**	**28,177**	**516**	**113,164**
Provided during the year	-	27,166	349	-	16,423	8	5,033	69	**49,048**
Impairments	-	1,730	-	-	-	-	-	-	**1,730**
Reclassifications for Accumulated Depreciation	-	(28,896)	(349)	-	(1,622)	-	(6,434)	-	**(37,301)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**99,113**	**167**	**26,776**	**585**	**126,641**
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**

16.2 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	125,596	307,838	2,984	22,718	51,838	-	15,401	373	**526,748**
Finance leased	-	5,618	217	-	-	-	-	-	**5,835**
On-SoFP PFI contracts and other service concession arrangements	-	719,238	-	-	-	-	-	-	**719,238**
Owned - government granted	-	504	-	-	-	-	-	-	**504**
Owned - donated	-	32,233	430	1,420	10,763	-	570	9	**45,425**
NBV total at 31 March 2019	**125,596**	**1,065,431**	**3,631**	**24,138**	**62,601**	**-**	**15,971**	**382**	**1,297,750**

16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£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**

17 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	10,254	11,289
Consumables	13,757	15,753
Energy	387	366
Total inventories	**24,398**	**27,408**
Of which:		
Held at fair value less costs to sell	24,398	27,408

Inventories recognised in expenses for the year were £237,589k (2017/18: £238,130k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

18 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	142,355	
Trade receivables*		158,621
Accrued income*		38,194
Allowance for impaired contract receivables / assets*	(26,026)	
Allowance for other impaired receivables	(65)	(20,873)
Prepayments (non-PFI)	1,006	8,200
Prepayments - PFI	33,400	14,119
Prepayments - PFI lifecycle	100	100
VAT receivable	11,381	14,741
Other receivables	1,023	877
Total current trade and other receivables	**163,174**	**213,979**
Non-current		
Contract receivables*	4,322	
Trade receivables*		2,062
PFI lifecycle prepayments	2,809	2,909
Total non-current trade and other receivables	**7,131**	**4,971**
Of which receivables from NHS and DHSC group bodies:		
Current	69,328	135,386

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

18.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**-**	**20,873**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	20,808	(20,808)
New allowances arising	8,482	0
Changes in existing allowances	1,544	0
Reversals of allowances	(2,934)	-
Utilisation of allowances (write offs)	(1,874)	-
Allowances as at 31 Mar 2019	**26,026**	**65**

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**20,556**
Increase in provision	8,344
Amounts utilised	(1,936)
Unused amounts reversed	(6,091)
Allowances as at 31 Mar 2018	**20,873**

18.3 Exposure to credit risk

Ageing of non-NHS impaired financial assets, using invoice date	31 March 2019 Trade and other receivables £000	31 March 2018 Trade and Other Receivables £000
0 - 30 days	672	981
30-60 Days	1,107	594
60-90 days	484	572
90- 180 days	1,673	1,413
Over 180 days	22,155	17,313
Total	**26,091**	**20,873**
Ageing of non-NHS, non-impaired, financial assets, using invoice date		
0 - 30 days	6,933	9,759
30-60 Days	6,678	2,320
60-90 days	1,003	1,656
90- 180 days	3,644	4,331
Over 180 days	24,327	20,617
Total	**42,585**	**38,683**

19 Cash and cash equivalents movements

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

	2018/19 £000	2017/18 £000
At 1 April	**3,024**	**3,316**
Net change in year	169	(292)
At 31 March	**3,193**	**3,024**
Broken down into:		
Cash at commercial banks and in hand	72	57
Cash with the Government Banking Service	3,121	2,967
Total cash and cash equivalents as in SoFP	**3,193**	**3,024**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**3,193**	**3,024**

19.1 Third party assets held by the trust

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

	31 March 2019 £000	31 March 2018 £000
Bank balances	78	76
Monies on deposit	-	-
Total third party assets	**78**	**76**

20 Trade and other payables

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Trade payables	91,545	117,210
Capital payables	3,700	4,288
Accruals	51,607	14,770
Social security costs	13,480	10,715
Accrued interest on loans*	-	1,611
Other payables**	11,601	10,138
Total current trade and other payables	**171,933**	**158,732**
Of which, payables from NHS and DHSC group bodies:		
Current	32,535	23,012

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within Note 23. IFRS 9 is applied without restatement therefore comparatives have not been restated.
** The majority of this balance relates to the Trust's payover to NHS Pensions.

20.1 Early retirements in "Other payables" above

There are nil amounts included in payables to buy out the liability for early retirements (nil in 2017/18).

21 Other financial liabilities

There were nil "other financial liabilities" at the 31st March 2019 (nil at 31st March 2018).

22 Other liabilities

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Deferred income: contract liabilities	19,634	18,009
Total other current liabilities	**19,634**	**18,009**

23 Borrowings

	31 March 2019	31 March 2018
Current	**£000**	**£000**
Loans from the Department of Health and Social Care	124,011	118,062
Obligations under finance leases	1,892	1,650
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	23,056	24,534
Total current borrowings	**148,959**	**144,246**
Non-current		
Loans from the Department of Health and Social Care	327,766	310,933
Obligations under finance leases	3,698	4,441
Obligations under PFI, LIFT or other service concession	989,774	1,012,830
Total non-current borrowings	**1,321,238**	**1,328,204**

23.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	**£000**	**£000**	**£000**
Carrying value at 1 April 2018	**428,995**	**6,091**	**1,037,364**	**1,472,450**
Cash movements:				
Financing cash flows - payments and receipts of principal	20,999	(1,826)	(24,534)	**(5,361)**
Financing cash flows - payments of interest	(12,592)	(252)	(35,752)	**(48,596)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	1,611	0	0	**1,611**
Additions	-	1,325	-	**1,325**
Application of effective interest rate	12,764	252	35,752	**48,768**
Carrying value at 31 March 2019	**451,777**	**5,590**	**1,012,830**	**1,470,197**

24 Finance leases

24.1 Barts Health NHS Trust as a lessee

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

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**5,936**	**6,544**
Of which liabilities are due:		
- not later than one year;	2,072	1,852
- later than one year and not later than five years;	3,864	4,692
Finance charges allocated to future periods	(346)	(453)
Net lease liabilities	**5,590**	**6,091**
- not later than one year;	1,892	1,650
- later than one year and not later than five years;	3,698	4,441

25 Provisions for liabilities and charges

	Total	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Redundancy	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**17,563**	**11,917**	**4,100**	**837**	**96**	**613**
Change in the discount rate	**(220)**	(142)	(78)	-	-	-
Arising during the year	**1,219**	531	164	524	-	-
Utilised during the year	**(1,933)**	(1,074)	(216)	(26)	(96)	(521)
Reversed unused	**(1,008)**	(51)	(202)	(663)	-	(92)
Unwinding of discount	**16**	12	4	-	-	-
At 31 March 2019	**15,637**	**11,193**	**3,772**	**672**	**0**	**0**
Expected timing of cash flows:						
- not later than one year;	**2,030**	1,139	219	672	0	0
- later than one year and not later than five years;	**5,413**	4,556	857	0	0	0
- later than five years.	**8,194**	5,498	2,696	0	0	0
Total	**15,637**	**11,193**	**3,772**	**672**	**0**	**0**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

The majority of the Trust's provisions (£11.2m) relate to NHS Pensions early departure costs. Expected future cash flows have been discounted using the real discount rate of 0.29% (2017/18: 0.10%) (set by HM Treasury) to determine the full liability.

26 Clinical negligence liabilities

At 31 March 2019, £800,086k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Barts Health NHS Trust (31 March 2018: £647,867k).

27 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(222)	(165)
Other*	(3,000)	-
Gross value of contingent liabilities	**(3,222)**	**(165)**
Net value of contingent liabilities	**(3,222)**	**(165)**

* Relates to Vacant Possession works

28 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	10,948	3,055
Total	**10,948**	**3,055**

The 2018/19 capital commitments relate largely to reconfiguration, refurbishment and building works across Trust sites and an element of the e-prescribing ICT project.

29 On-SoFP PFI arrangements

Historically, private finance initiative (PFI) schemes have been a way for public sector bodies to create "public–private partnerships" (PPPs), where private firms are contracted to complete and manage public projects.

At the St Bartholomew's and Royal London sites, the Trust 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. Construction completed in 2016.

Working with our partner, John Laing (Healthcare Support Newham Limited - HSNL), the Newham Hospital scheme was completed in 2006, with an initial construction cost of £35m.

29.1 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 schemes:

	Both Sites 31 March 2019 £000	Barts & RLH 31 March 2019 £000	Newham 31 March 2019 £000	Both Sites 31 March 2018 £000
Gross PFI	**1,597,993**	**1,528,341**	**69,652**	**1,658,279**
Of which liabilities are due:				
- not later than one year;	**57,977**	54,021	3,956	60,286
- later than one year and not later than five years;	**231,564**	216,927	14,637	232,111
- later than five years.	**1,308,452**	1,257,393	51,059	1,365,882
Finance charges allocated to future periods	**(585,163)**	(544,268)	(40,895)	(620,915)
Net PFI obligation	**1,012,830**	**984,073**	**28,757**	**1,037,364**
- not later than one year;	**23,056**	22,213	843	24,534
- later than one year and not later than five years;	**100,356**	97,293	3,063	97,460
- later than five years.	**889,418**	864,567	24,851	915,370

29.2 Total on-SoFP PFI commitments

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

	Both Sites 31 March 2019 £000	Barts & RLH 31 March 2019 £000	Newham 31 March 2019 £000	Both Sites 31 March 2018 £000
Total future payments committed in respect of PFI schemes	**4,937,106**	**4,732,845**	**204,261**	**5,015,136**
Of which liabilities are due:				
- not later than one year;	**120,758**	112,681	8,077	117,221
- later than one year and not later than five years;	**513,990**	479,609	34,381	498,930
- later than five years.	**4,302,358**	4,140,555	161,803	4,398,985

29.3 Analysis of amounts payable to service concession operators

This note provides an analysis of the unitary payments made to the service concession operator during the financial year:

	Both Sites 2018/19 £000	Barts & RLH 2018/19 £000	Newham 2018/19 £000	Both Sites 2017/18 £000
Unitary payment payable to service concession operator	**117,836**	**109,953**	**7,883**	**118,716**
Consisting of:				
- Interest charge	**35,752**	32,570	3,182	36,588
- Repayment of finance lease liability	**24,534**	23,967	567	24,522
- Service element and other charges to operating expenditure	**26,025**	24,023	2,002	30,253
- Capital lifecycle maintenance	**5,207**	4,687	520	3,847
- Contingent rent	**26,318**	24,706	1,612	23,506
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	**4,402**	4,402	-	4,181
Total amount paid to service concession operator	**122,238**	**114,355**	**7,883**	**122,897**

29.4 Barts and The Royal London Hospitals PFI Schemes

Under the PFI contract, which ends on 25th April 2048, the Trust's PFI provider has constructed two new hospitals and provides 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 3.28% (excluding contingent rent) or 7.5% (including estimated contingent rent in the note below).

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.

Barts and the Royal London: Committed future charges: services and building maintenance

Lifecycle replacement costs are a contractual payment that the Trust makes to the PFI partner for the maintenance of the buildings:

	Total	Lifecycle Replacement	Services Received
	£000	£000	£000
Within One Year	**32,867**	8,932	23,935
Between One and Five Years	**138,761**	35,552	103,209
Later than Five Years	**1,292,476**	406,186	886,290
Total	**1,464,104**	**450,670**	**1,013,434**

Barts and the Royal London Hospitals PFI Schemes: committed future charges: provision of buildings

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).

	Total	Repayment of Borrowings	Interest	Contingent Rent
	£000	£000	£000	£000
Within One Year	**79,814**	22,213	31,808	25,793
Between One and Five Years	**340,848**	97,293	119,634	123,921
Later than Five Years	**2,848,079**	864,568	392,826	1,590,685
Total	**3,268,741**	**984,074**	**544,268**	**1,740,399**

29.5 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 the note below).

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

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

	Total	Lifecycle Replacement	Services Received
	£000	£000	£000
Within One Year	**2,281**	264	2,017
Between One and Five Years	**11,582**	2,779	8,803
Later than Five Years	**60,578**	19,487	41,091
Total	**74,441**	**22,530**	**51,911**

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

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).

	Total	Repayment of borrowings	Interest	Contingent Rent
	£000	£000	£000	£000
Within One Year	**5,796**	843	3,112	1,841
Between One and Five Years	**22,799**	3,062	11,574	8,163
Later than Five Years	**101,225**	24,851	26,209	50,165
Total	**129,820**	**28,756**	**40,895**	**60,169**

30 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 Social 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 2019 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 30.1 and 30.2, 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.

30.1 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	117,287	**117,287**
Cash and cash equivalents at bank and in hand	3,193	**3,193**
Total at 31 March 2019	**120,480**	**120,480**

	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£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**

30.2 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
	£000	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	451,777	**451,777**
Obligations under finance leases	5,590	**5,590**
Obligations under PFI, LIFT and other service concession contracts	1,012,830	**1,012,830**
Trade and other payables excluding non financial liabilities	158,432	**158,432**
Total at 31 March 2019	**1,628,629**	**1,628,629**

	Other financial liabilities	Total book value
	£000	**£000**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	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**

30.3 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	**£000**
In one year or less	307,391	282,230
In more than one year but not more than two years	338,143	323,719
In more than two years but not more than five years	86,982	81,165
In more than five years	896,113	923,320
Total	**1,628,629**	**1,610,434**

31 Losses and special payments

	2018/19 Total number of cases Number	2018/19 Total value of cases £000		2017/18 Total number of cases Number	2017/18 Total value of cases £000
Losses					
Cash losses	59	221		63	92
Fruitless payments	1	520	*	-	-
Bad debts and claims abandoned	107	1,662		279	1,944
Stores losses and damage to property	-	-		1	1
Total losses	**167**	**2,403**		**343**	**2,037**
Special payments					
Ex-gratia payments	59	25		78	47
Total special payments	**59**	**25**		**78**	**47**
Total losses and special payments	**226**	**2,428**		**421**	**2,084**

* The "fruitless" payment of £520k relates to a payment made to HMRC for backdated salary sacrifice obligations.

32 Gifts

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

33 Application of New Accounting Standards in 2018/19

33.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £1,611k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was -£18,438k.

33.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

34 Related parties

The employees of Barts Health NHS Trust are required to disclose any relevant and material interests they may have in other organisations (related parties). This is recorded in the Register of Interests.

The transactions listed below are payments made to the related parties declared by Barts Health NHS Trust's Board members:

	Payments to Related Party	Amounts owed to Related Party	Receipts from Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Barts Charity	0	0	4,680	1,831
Deloitte (declared by Prof A Chesser)	468	44	0	0
Frimley Health NHS Foundation Trust (declared by Dr T Swage)	20	7	21	7
Glaxo Smith Kline (declared by Prof S Thornton)	0	0	10	46
Hologic (declared by Prof S Thornton)	67	4	0	0
Isle of Wight NHS Trust (declared by Dr T Peachey)	3	0	0	0
Medical Schools Council (declared by Prof S Thornton)	4	0	0	0
Monash University (declared by Prof S Thornton)	0	0	4	0
Queen Mary University of London (declared by Prof S Thornton)	14,765	1,062	3,249	428
Royal College of Obstetricians & Gynaecologists (declared by Prof S Thornton)	2	1	0	0
William Harvey Research Foundation (declared by Prof S Thornton)	26	0	2	0
Wolseley UK (declared by Mr M Higson)	0.02	0	0	0

During 2018/19 and 2017/18, Barts Health NHS Trust has had a significant number of material transactions (income or expenditure more than £1m) with the Department of Health and Social Care (DHSC), and with other entities for which DHSC is regarded as the parent department, and with other Whole of Government Account bodies. These organisations are listed below:

Barking, Havering & Redbridge University Hospitals NHST
Care Quality Commission
Central and North West London NHSFT
Common Council of the City of London
Community Health Partnerships
East London NHSFT
Great Ormond Street Hospital for Children NHSFT
Health Education England
Homerton University Hospital NHSFT
Mid Essex Hospital Services NHST
Newham London Borough Council
NHS Barking and Dagenham CCG
NHS Barnet CCG
NHS Basildon and Brentwood CCG
NHS Bexley CCG
NHS Blood and Transplant
NHS Brent CCG
NHS Bromley CCG
NHS Camden CCG
NHS Castle Point and Rochford CCG
NHS Central London (Westminster) CCG
NHS City and Hackney CCG
NHS East and North Hertfordshire CCG
NHS Enfield CCG
NHS Greenwich CCG
NHS Hammersmith and Fulham CCG
NHS Haringey CCG
NHS Havering CCG
NHS Herts Valleys CCG
NHS Islington CCG
NHS Lambeth CCG
NHS Lewisham CCG
NHS Mid Essex CCG
NHS Newham CCG
NHS North East Essex CCG
NHS Property Services
NHS Redbridge CCG
NHS Southend CCG
NHS Southwark CCG
NHS Thurrock CCG
NHS Tower Hamlets CCG
NHS Waltham Forest CCG
NHS West Essex CCG
Royal Free London NHSFT
Tower Hamlets London Borough Council
University College London Hospitals NHSFT
Waltham Forest London Borough Council
Department of Health and Social Care
HM Revenue & Customs
NHS East Berkshire CCG
NHS England
NHS Improvement
NHS Pensions
NHS Resolution

35 Events after the reporting date

Events after the end of the reporting period are events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the financial statements are authorised. The events can be adjusting or non adjusting.

There have been no such events after the end of the reporting period for Barts Health NHS Trust.

36 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	175,360	997,250	184,464	927,402
Total non-NHS trade invoices paid within target	118,382	850,473	121,871	764,919
Percentage of non-NHS trade invoices paid within target	**67.5%**	**85.3%**	**66.1%**	**82.5%**
NHS Payables				
Total NHS trade invoices paid in the year	5,159	275,240	4,616	264,063
Total NHS trade invoices paid within target	2,168	233,853	2,235	236,892
Percentage of NHS trade invoices paid within target	**42.0%**	**85.0%**	**48.4%**	**89.7%**

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

37 External Financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	4,305	115,237
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	**4,305**	**115,237**
External financing limit (EFL)	4,305	115,814
Under / (over) spend against EFL	**0**	**577**

38 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	49,246	36,263
Less: Disposals	(13,189)	(71)
Less: Donated and granted capital additions	(2,316)	(6,795)
Charge against Capital Resource Limit	**33,741**	**29,397**
Capital Resource Limit	34,228	33,196
Under / (over) spend against CRL	**487**	**3,799**

39 Breakeven duty financial performance

	2018/19 £000	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(84,243)	(108,782)
Add back income for impact of 2016/17 post-accounts STF reallocation	-	419
Breakeven duty financial performance surplus / (deficit)	**(84,243)**	**(108,363)**

39.1 Breakeven duty rolling assessment

	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance	409	(38,270)	(79,642)	(134,881)	(69,481)	(108,363)	(84,243)
Breakeven duty cumulative position	409	(37,861)	(117,503)	(252,384)	(321,865)	(430,228)	(514,471)
Operating income	1,324,338	1,288,172	1,319,964	1,342,594	1,488,833	1,512,726	1,526,645
Cumulative breakeven position as a percentage of operating income	0.0%	(2.9%)	(8.9%)	(18.8%)	(21.6%)	(28.4%)	(33.7%)

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty should be 2009/10. Barts Health NHS Trust was established on the 1st April 2012.

Notes

Adult services

So much of the vital work we do in caring for our patients would simply not be possible without community support.

Barts Charity is the dedicated charity for our hospitals, funding state of the art equipment, research leading to medical breakthroughs, and innovative projects that improve care and outcomes for our patients here and now. You can be a source for change by supporting our hospitals' charity. (or by supporting our hospitals' charity you could be a source for change) Please visit **bartscharity.org.uk**, call **020 7618 1720** or email **appeals@bartscharity.org.uk** to see the ways you can get involved.

Barts Charity is the dedicated charity for all of the hospitals of Barts Health NHS Trust, funding projects above and beyond standard NHS funding. Reg no 212563.

Children services

So much of the vital work we do in caring for sick children and their families would simply not be possible without community support.

BARTS CHARITY

Large print and other languages

For this leaflet in large print, please speak to your clinical team.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. For more information, speak to your clinical team.

এই তথ্যগুলো সহজে পড়া যায় অথবা বৃহৎ প্রিন্টের মত বিকল্প ফরম্যাটে পাওয়া যাবে, এবং অনুরোধে অন্য ভাষায়ও পাওয়া যেতে পারে। আরো তথ্যের জন্য আপনার ক্লিনিক্যাল টিমের সাথে কথা বলুন।

Na żądanie te informacje mogą zostać udostępnione w innych formatach, takich jak zapis większą czcionką lub łatwą do czytania, a także w innych językach. Aby uzyskać więcej informacji, porozmawiaj ze swoim zespołem specjalistów.

Macluumaadkaan waxaa loo heli karaa qaab kale, sida ugu akhrinta ugu fudud, ama far waa weyn, waxana laga yabaa in lagu heli luuqaado Kale, haddii la codsado. Wixii macluumaad dheeraad ah, kala hadal kooxda xarunta caafimaadka.

Bu bilgi, kolay okunurluk veya büyük baskılar gibi alternatif biçimlerde sunulabilir, ve talep üzerine Alternatif Dillerde sunulabilir. Daha fazla bilgi için klinik ekibinizle irtibata geçin.

یہ معلومات متبادل فارمیٹس میں دستیاب کی جا سکتی ہیں، جیسا کہ پڑھنے میں آسان یا بڑا پرنٹ اور درخواست پر متبادل زبانوں میں بھی دستیاب ہو سکتی ہیں۔ مزید معلومات کے لیے، اپنی کلینکل ٹیم سے بات کریں۔

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