WeCare
Our vision, values and behaviours

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Annual Report and Annual Accounts

2019 - 2020

For the year ended 31 March 2020


Dr. Martin Thomas
Consultant Cardiologist

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Group CEO foreword

As 2019-20 drew to a close and the coronavirus pandemic was declared, the NHS faced the greatest public health and operational challenge in its history. The staff and volunteers of the Barts Health group of hospitals, and our patients and families, responded magnificently, as the numbers of cases of Covid-19 grew throughout March and we reshaped our services to treat and care for them. The full story will be covered in next year's annual report. This one reflects on the bulk of the year before the pandemic, during which we pursued our ambition to become an outstanding group of hospitals.

Our vision for the group has guided us on a journey of continued and sustained progress since our original 'safe and compassionate' improvement plan in 2015. We began 2019/20 having just lifted ourselves out of special measures, and we used that achievement as a springboard for a step change in our approach. We set ourselves three strategic goals: to become an excellent provider of patient safety, to deliver the best possible patient experience; and to become an outstanding place to work. These were set out in our quality strategy in November, and have informed every aspect of our work ever since.

Evidence that we were on the right track came early when The Royal London was rated 'good' by the Care Quality Commission in April, and two-thirds of all our core services were recognised as 'good' or 'outstanding'. We demonstrated an improved safety culture during the year, by both increasing the numbers of incidents reported and reducing the amount of harm they caused to patients. Compared to our peers, we now are among the best for combining safe practices with a positive learning culture. Meanwhile, our staff survey showed the proportion of staff recommending Barts Health as a place to work is at its highest point in five years.

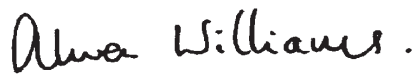
These milestones were achieved while we continued to face a steady increase in demand for services. During the last year, we saw over 2.4m patients across our services, an increase of nearly 130,000 from just two years ago. Despite this considerable increase of patients, we exceeded some of our national performance standards, in particular for cancer waiting times.

Like many trusts, our A&E services have found it challenging to meet the 4-hour wait standard, and we also had challenges delivering diagnostic 6-week waits, largely as a result of capacity issues for MRI scans. However, we performed strongly against the nine cancer standards.

Against this operational backdrop, we worked with our partners across North East London on implementing the principles of the NHS long-term plan to create a more seamless healthcare system for the future. With clinical commissioners in our three local boroughs we set out initial proposals to transform the shape of surgery services, by creating specialist centres of excellence in our hospitals. We further developed our plans with Queen Mary University of London to create a life sciences campus in Whitechapel. And the detailed design and planning of a brand new hospital at Whipps Cross is now underway following the Prime Minister's announcement that it would be in the first wave of a £2.7bn building programme.

So we believe our future is bright. While we plan for potential further pandemic peaks in the year ahead, we do so with confidence in what we've already achieved. Our breadth in leadership enabled us to take on the running of a temporary hospital, at NHS Nightingale London, deliver critical care training to hundreds of staff, and double our own numbers of intensive care beds – all in a matter of weeks. We also recently fitted out two floors of The Royal London that were previously empty to create six permanent new critical care wards. This additional capacity will be with us for the long term to support our east London community – and the wider London population – at a time when it is needed.

We couldn't have achieved this without the support of our people, our partners, and our public. I would especially like to thank our dedicated staff, who go above and beyond to provide quality care to our patients. I'd also like to thank Barts Charity for their unstinting support, which helps us offer extraordinary healthcare to the people of east London and look after the wellbeing of TeamBartsHealth. Last year marked the start of a new fundraising campaign to strengthen the Barts Charity presence at all the hospitals in the group. We are grateful to our other partner charities for their continued support, too, and I must pay particular tribute to the incredible generosity of a large number of local and national organisations who have helped support our teams throughout the pandemic. Together, we can confidently look forward to the year ahead.



Alwen Williams CBE,
Group Chief Executive

17 June 2020

Performance overview

The purpose of this section is to outline the framework for delivering high quality care, comprising details of structures, performance reporting tools and performance management mechanisms.

Details of Trust performance during 2019/20 is provided separately via the Integrated Performance Report held on the Trust website under the section 'about us/our board/board papers'. Details of the risks and issues to delivery are detailed in subsequent sections (the accountability report and annual governance statement) and the going concern statement is contained in the annual accounts.

Clinical and organisational strategy

The Trust's clinical and organisational strategy provides a framework within which the Trust Board seeks to deliver its immediate and long-term operational priorities.

The Trust's vision is to establish a high-performing group of NHS hospitals, renowned for excellence and innovation, and providing safe and compassionate care to our patients in east London and beyond. We aspire to achieve this in everything we do, by living our We Care values of being welcoming, engaging, collaborative, accountable, respectful and equitable.

As medicine advances, health needs change, and society develops, the NHS has responded with an ambitious national programme to future-proof our health care system over the next decade. The Barts Health group of hospitals is playing a major part in that long-term transformation by working with local partners to identify and meet the needs of a growing and diverse population in north east London.

We are guided by the five principles outlined in our five year clinical and organisational strategy, Sustaining Safe and Compassionate Care:

- Tailoring services to the needs of our growing and diverse population, to reduce health inequalities.
- Changing services to prioritise prevention, and put patients first.
- Reducing variation, to improve quality and productivity.
- Networking services, to drive higher standards of care.
- Pursuing clinical and academic excellence at all times.

In support of our vision we have set three strategic goals: to be a provider of excellent patient safety, to offer the best possible patient experience, and to be an outstanding place to work. These are set out in our quality strategy, setting out how we will achieve our ambition to deliver outstanding patient care.

As we evolve our group operating model, and its network of advisory clinical boards, we are constantly reviewing our strategy for developing services and sites to sustain high standards. The outcome is an emerging suite of strategic delivery plans setting out our mission and medium-term goals in eight areas that are critical to the provision of modern healthcare – quality, people, finance, transformation, informatics, estates, inclusion, and research. Each of these acts as a bridge between our over-arching group strategy and our annual integrated operating plan.

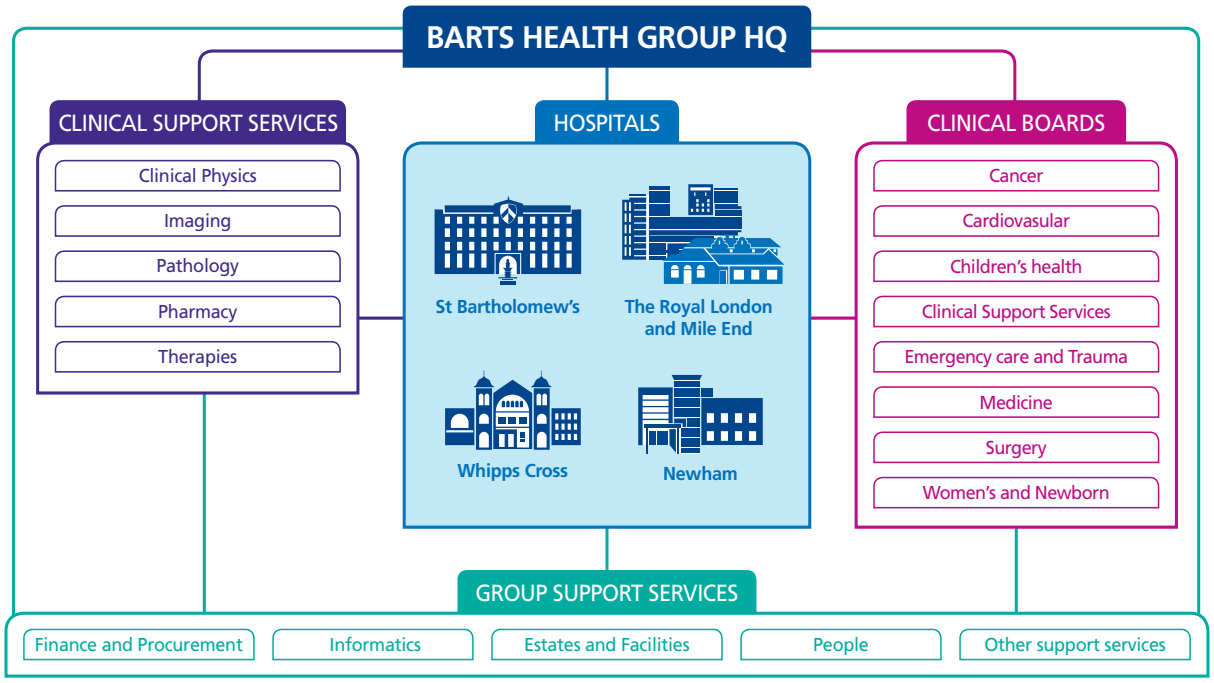
Group model

Barts Health NHS Trust is an acute provider of clinical services to populations based in north east London and beyond and is based on a group structure. An operating model with supporting accountability framework sets out the respective roles of the component elements involved in delivery of healthcare services:

- Group Leadership (HQ): Comprises the Group Executive, led by the Group Chief Executive, and its direct support - core functions include communication and engagement, strategy and planning, improvement, developing leadership and commissioning Group Support Services (GSS).
- Hospitals: Led by a hospital Chief Executive who reports to the Group Chief Executive and supported by a Hospital Executive Board. Each hospital has a divisional structure based on clinical specialties. The hospitals are responsible for the oversight and delivery of services and the bulk of the group's staff and resources are managed by the hospitals.
- Clinical Boards: Clinical boards, led by a chair, have a trustwide role for the specialities within their remit on devising strategy and vision, overseeing standards and minimising variation, collaboration, research and innovation.

- Clinical Support Services (CSS), led by a Managing Director, provide a group of clinical services and networks supporting front line delivery.
- Group Support Services (GSS), led by a Management Board and consisting of corporate services.

Fig 1. Our group model



Performance management – structure and tools

To support and assure on delivery of its strategic objectives, the Trust's performance management approach comprises performance review and quality deep dive governance mechanisms supported by robust management information. The Trust's Business Intelligence Unit leads on production of the Trust's integrated performance report (IPR), a key resource published monthly on the website, reporting on a suite of key metrics – including constitutional standards and locally agreed priorities - at group level (for the Trust Board and executive review) and at hospital or divisional level where greater granularity is required. The IPR is replicated at hospital and divisional level and is the principal tool for each of the component of the group structure to assess progress on operational delivery. Associated details of hospital level performance and activities in support of delivery of the Trust's WeCare vision and values are held within the Quality Account.

Monthly performance reviews of hospitals and Clinical Support Services are held by Group Leadership, supported by regular separate quality and finance deep dives; with a quarterly review of Group Support Services by the Group Chief Executive with hospital representation.

Quarterly assurance meetings are held with each clinical board. External oversight has been conducted jointly by NHS London and the East London Health and Care Partnership.

Performance – management information

The Trust has recently re-structured its Business Intelligence offering to improve its analytics capability in response to key lines of enquiry generated by clinical teams. Internal reporting includes a variety of QlikView reports reporting on patient care and outcome metrics, including the Board's integrated performance report, hospital integrated performance reports, quality governance dashboards and an operational efficiency dashboard.

The above include national patient access performance dashboards and automated patient tracking lists, including RTT, A&E, Cancer Waiting Times and Diagnostic Waiting Times.

Analysis within this covers patient feedback from a range of sources including Friends and Family Test, Patient and Staff Annual Survey, Datix risk and incident reporting and social media to draw out themes and specific areas that require improvement, while a Clinical Effectiveness Unit provides a discrete clinical audit, patient safety and clinical quality function across the trust.

Steps have been taken during the year to integrate risk management into the Trust's performance management mechanisms at every level.

Performance management information data quality

- Methodology

  In order to ensure the consistency and accuracy of data production the corporate performance team have constructed a catalogue which lists key performance indicators and corresponding data source, data supplier, data owner, executive owner and peer reviewers. Once data is produced against an indicator the results are peer reviewed by an independent analytical reviewer and subsequently sent to the data owner and executive owner for review and challenge. An externally commissioned well-led review in 2019 supported previous internal audit reports in providing significant assurance rating regarding the production of the Trust's Integrated Performance Report in terms of its design, content and use.

- Next steps on data quality and refining performance management information

  The Trust's Well-Led plan includes recommendations to refine data quality through centralising and standardising information in a data warehouse with single data sources for key data feeds reflecting operations, finance, workforce, quality and safety performance supporting consistent reporting across departments, the group and externally.

The corporate performance team are undertaking a streamlining project, scheduled to complete by March 2021. The resulting performance database will contain high level and lower level disaggregated information which will enable analysts and data-users to drill down into the detail.
This performance database is still in the process of being developed, further enhanced by transitioning reporting from QlikView to the next generation reporting layer, Qlik Sense. A rigorous and automated process of consistency will be applied to key data feeds and a `kite-marking` process is being designed assessing each data-item against key data-quality domains (including completeness, timeliness, accuracy and consistency).

Going concern basis

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. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust submitted a financial plan for 2020/21 to NHS England and NHS Improvement (NHSE/I) which would deliver a breakeven position supported by £92.9m Financial Recovery Fund (FRF) income in line with the financial trajectory notified by NHSE/I in February 2020. NHSE/I confirmed FRF funding of £92.9m for 2020/21 in February 2020. Further details are provided in the annual accounts section.

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Corporate governance report

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

The Chief Executive of NHS England/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, other items of comprehensive income and cash flows for the year.

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

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.

Signed:

Alwen Williams.

Alwen Williams CBE,
Group Chief Executive

Date: 17 June 2020

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Group Chief Finance Officer's Foreword to the Annual Report and Accounts

Coming into the financial year 2019/20 we faced a large challenge to achieve our planned deficit position of £65m, which is after receiving support of £53m from the Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and a level of Marginal Rate Emergency Tariff (MRET). By working with our partners in North East London to deliver our collective financial target we have been able to secure the full value of £53m support funding as planned. The Trust reported position for 2019/20 post PSF, FRF & MRET is a deficit of £73m which is £8m away from our original plan (or we delivered our financial plan within 0.5%).The successful achievement of our overall financial plan was based on achieving savings, through a cost improvement programme, of over £50m whilst continuing to improve the quality of services. Each element of the programme went through an assessment process to ensure that there were no adverse impacts on the quality of services delivered.

For the £1.7bn spend we made on delivering our services we continue to face challenges in relation to managing our rate of spend and meeting our ambitious saving plans. By looking at every area of spend we have made good progress, but there is more to do. We recognise that we have long standing commitments such as payments for our Private Finance Initiative (PFI) estate and we look forward to changes in the financing regime to transfer our loan debt to Public Dividend Capital. This will give us a stronger balance sheet and help to drive better value for each pound we spend whilst improving patient care.

We invested over £60m in our capital infrastructure and equipment to support the delivery of services. The capital investment programme was funded through various sources including, loans from the Department of Health & Social Care, internal resources and through kind donations from Barts Charity. We welcomed the announcement during the year for approval to redevelop the Whipps Cross Hospital. Such a significant investment will have long term benefits for the population we serve.

Both capital and revenue spend were impacted by the Covid-19 pandemic; however the Trust was reimbursed for costs incurred. Looking ahead the pandemic has dramatically changed the financial framework planned for the NHS during the first part of 2020/21. The Trust had originally set a plan for 2020/21 to achieve a break-even position supported by £93m FRF; however formal planning submissions for the year have been suspended. We continue to work with partners and stakeholders to ensure we maintain financial control through our governance structure during the pandemic.

Signed:

Hardev Virdee
Group Chief Finance Officer

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 three other executive directors who attend board meetings in a non-voting capacity. The number of NEDs is one higher than most NHS trusts, reflecting the size and complexity of Barts Health's agenda as the busiest trust in England. As at 1 April 2020, 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 under-represented groups). During 2019/20, one former NExT director (Kim Kinnaird) was successfully appointed as a Barts Health NED.

The Trust Board has overall 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 and board terms of reference reviewed and approved in 2019/20). The Trust Board meet regularly in public to discharge its duties (the board met 6 times in public during 2019/20, excluding the annual general meeting).

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 England/Improvement to identify the skills and experience required for any new appointments to NED positions.

Independence of NEDs

One of the NEDs (Professor Steve Thornton) 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 further terms of office.

Board members –biographies of board members (as at 1 April 2020)

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 (group chief executive) has been a manager in the NHS since 1980, working in primary care, community and acute services, commissioning and joint planning. On 1 June 2015, Alwen moved to Barts Health NHS Trust as interim chief executive and became substantive chief executive on 21 October 2015. 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 London region director of delivery and development for the NHS Trust Development Authority.

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 the recently appointed chair of 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 Kathy McLean (non-executive director) joined Barts Health in December 2019. A former medical director of NHS Improvement, Dr Kathy McLean, chairs the quality assurance committee of the Trust Board that oversees quality governance arrangements from ward to board across the group. Dr McLean's work has focused on improving quality by building in clinical leadership and expertise across the NHS. Prior to NHS Improvement, Dr McLean was the Medical Director at the NHS Trust Development Authority and the Clinical Transitions Director working with Sir Bruce Keogh building the NHS Commissioning Board, now NHS England.

Ms Kim Kinnaird (non-executive director) was appointed to her current role in February 2020 having previously served as an associate non executive director and NExT director on the board. As the Banking and Trade Delivery Director for the Commercial Bank at Lloyd Banking Group, Kim is responsible for leading the servicing teams that look after the Commercial Banking clients. Prior to her current position, Kim has undertaken a number of roles within the Commercial Bank spanning strategy and development, to leading large scale servicing teams within the SME Bank. Prior to joining Lloyds Banking Group she was a restructuring and insolvency lawyer at Berwin Leighton Paisner LLP advising large corporates, banks and funds on solvent and insolvent debt restructurings. Kim has experience of leading large scale transformational change in complex and regulated environments, including the implementation of segmentation strategies, skills development, and cultural change programmes. Kim graduated from Warwick, before undertaking post graduate studies at Nottingham.

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 Mary's 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.

Mr Hardev Virdee (chief finance officer) joined Barts Health in November 2019 and has worked in the NHS for many years, including most recently a successful three-year spell as CFO at Central and North West London NHS Foundation Trust.

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.

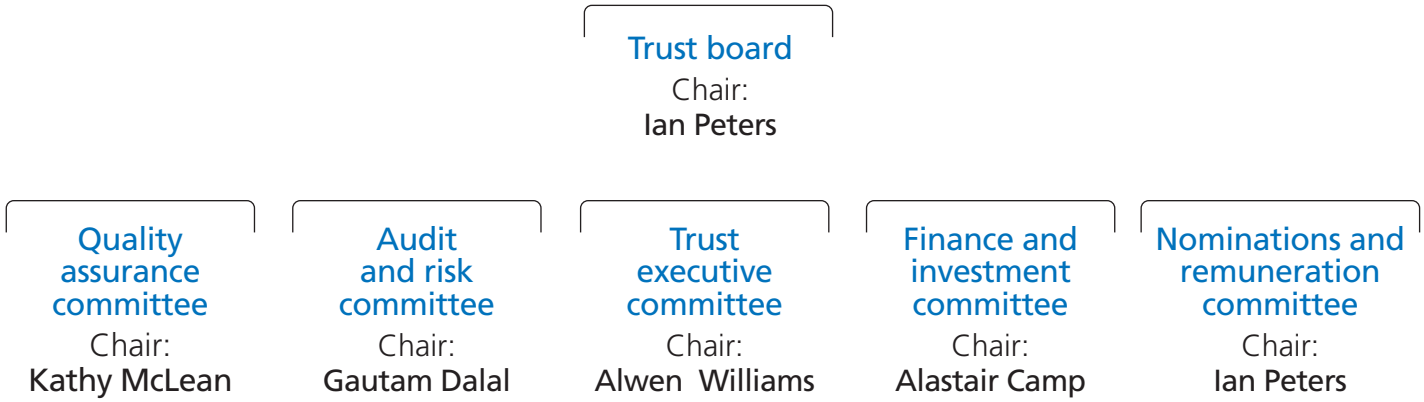
Mr Ralph Coulbeck (director of strategy) was appointed director of strategy for the Trust in April 2016. He began his career on the NHS Management Training Scheme and has worked in the NHS, parliament and government. He was previously director of strategy at the NHS Trust Development Authority and also 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 2020 are shown below in Chart 1.

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

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. Terms of reference for the Trust Board, board committees, executive boards and hospital governance structures are published on the Trust's website as part of a corporate governance manual approved by the Board in January 2020.



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. In November 2019 the Trust Board approved the audit and risk committee annual report, which confirmed compliance with the above key duties in its terms of reference (summary ToR last approved in January 2020) and identifying areas requiring further assurance.

Membership: 4 non executive directors (Mr Gautam Dalal – chair, Ms Margaret Exley, Ms Kim Kinnaird, Dr Kathy McLean).

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

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 2019/20, the quality assurance committee included a specific focus on implementation of the quality improvement plan and progress against CQC and external agency assurance findings. Exception reports were provided to the trust board (based on use of a standard proforma reporting template) following each meeting. At its meeting in October 2019, the audit and risk committee reviewed the quality assurance committee's annual report, which confirmed compliance with key duties set out in its terms of reference (summary ToR approved by the Trust Board on 22 January 2020).

Membership: 4 non executive directors (Dr Kathy McLean – chair, Ms Margaret Exley, Prof Steve Thornton and Mr Alastair Camp) chief executive and/or deputy chief executive, chief medical officer, chief nurse, director of corporate development 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. The trust board last approved revised summary terms of reference for the committee in January 2020.

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 in line with the key duties set in its terms of reference. The trust board last approved summary terms of reference for the committee in January 2020.

Membership: Four non executive directors (Mr Alastair Camp – chair, Ms Natalie Howard, Mr Gautam Dalal, Ms Kim Kinnaird), chief executive, deputy chief executive, chief finance officer, director of people, director of transformation and efficiency.

Group executive board (executive committee)

While not a Board committee chaired by a NED, the group executive board, 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 to perform an enhanced oversight but reduced operational role (supported by a series of executive group boards).

Membership: executive directors (voting and non-voting), hospital chief executives, CSS managing director, director of communications and engagement.

Attendance by members of board committees, 2019-20

*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%)	6/7 (86%)			4/4 (100%)	
Gautam Dalal	5/6 (83%)	5/7 (71%)	3/3 (100%)		4/4 (100%)	9/11 (82%)
Thoreya Swage	4/4 (100%)	5/5 (100%)	2/2 (100%)	4/4 (100%)	3/3 (100%)	
Alastair Camp	5/6 (83%)	5/6 (83%)			4/4 (100%)	10/11 (91%)
Steve Thornton	4/6 (67%)	4/6 (67%)		4/6 (67%)	3/4 (75%)	
Mark Higson	3/3 (100%)	2/3 (67%)	0/1 (0%)		2/3 (67%)	7/7 (100%)
Natalie Howard	5/6 (83%)	5/6 (83%)			4/4 (100%)	8/11 (73%)
Margaret Exley	6/6 (100%)	6/6 (100%)		4/6 (67%)	4/4 (100%)	
Kim Kinnaird	2/2 (100%)	2/2 (100%)	0/1 (0%)		0/1 (0%)	
Kathy McLean	2/2 (100%)	2/2 (100%)	1/1 (100%)	2/2 (100%)	1/1 (100%)	
Alwen Williams	5/6 (83%)	7/7 (100%)				9/11 (82%)
Chrisha Alagaratnam						0/1 (0%)
Caroline Alexander	5/6 (83%)	5/6 (83%)		5/6 (83%)		
Alistair Chesser	6/6 (100%)	6/6 (100%)		5/6 (83%)		
Hardev Virdee	3/3 (100%)	3/3 (100%)	1/1* (100%)			5/5 (100%)
Shane DeGaris	6/6 (100%)	6/6 (100%)	3/3* (100%)	5/6 (83%)		11/11 (100%)
Michael Pantlin	6/6 (100%)	6/6 (100%)				10/11 (91%)
Ralph Coulbeck	6/6 (100%)	6/6 (100%)				
Andrew Hines	5/6 (83%)	5/6 (83%)	3/3* (100%)	6/6 (100%)		
Bill Boa (acting CFO)	4/4 (100%)	5/5 (100%)	2/2* (100%)			7/7 (100%)

* In attendance

Board effectiveness

During 2019/20, 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, Well Led self-assessment was commenced ahead of a formal CQC Well Led assessment (which was scheduled but subsequently postponed). The implementation of a Trust well-led improvement plan, linked with the development of Trustwide quality improvement programme and senior leadership development work reflect the organisation's wider system leadership role and contribution. As part of this work, a Trust Board awayday focusing on board development, effectiveness and visioning was conducted in 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, typically during quarter one each year. Appraisals of non-executive director performance for 2019/20 were completed by the end of May 2020. Appraisals of the executives by the CEO are due for completion by the end of Quarter 1 2020. 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.

cDisclosure 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).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts; that, as far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware; that they have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the entity's auditors are aware of that information.

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'.

Anchor institution

Anchor institutions are influential private and public sector employers which play a lead role in creating growth in the areas that they serve in a more inclusive and sustainable way. The role of acute trusts as anchors was explored in The NHS Long Term Plan, with NHS England committing to develop this work. Barts Health has an ideal opportunity to improve local residents' health through the way we interact with local communities and our local economy. There are opportunities to consciously adopt anchor principles so that they become a valued part of how Barts Health functions. As a major employer of local east London residents (with around 42% of staff drawn from this population) and a large procurer of services and goods, the Trust can play a role in supporting business in the local economy as well as consider our employment offer to residents. An effective Green Plan can help target action for minimising air pollution from health-related transport, travel and logistics, and have a direct impact on the health and wellbeing of local residents. Exploring equity and equality issues through our clinical work streams will also inform and improve our approach to reducing health inequalities for patients accessing our services across east London.

There are a range of anchor activities already taking place across Barts Health that provide a foundation to develop a more comprehensive trustwide approach:

- Strategy. The anchor institution concept is set out as one of five key themes for the Trust's new 5-10 year strategy and cross referenced in the 2020 sustainable development management plan.
- Employment and careers. Over 850 young people engaged with the Trust through summer schools, insight days and health career events to support local employment. 660 students undertook placements in work experience, 120 young people trained ready for NHS apprenticeship jobs and 33 east London schools participated in a 'Healthcare Horizons' scheme, developed in partnership with JP Morgan Foundation and Barts Charity. The trust has been ranked in the top 100 employers for social mobility, with 119 local candidates trained in pre-employment skills, over 40 internships identified for Working Start (Tower Hamlets women in work candidates) and 50 Project Search internships (for learning disabilities candidates).
- Community events and working with partner organisations. A successful Barts Health Community Awards event was held in 2019. Important initiatives have been developed with Newham College to develop a Barts Health learning centre; education, careers and employment services work with colleagues in London Boroughs of Tower Hamlets, Newham, Waltham Forest, Hackney and with Poplar Housing and Regeneration Community Association.
- Procurement. Work is underway to identify Small and Medium sized Enterprises (SMEs) – which typically include greater local business representation. 80% of the Trust's suppliers are SMEs and they accounted for 22% of non-pay expenditure in 2018/19. The Trust's ambition is to meet the Government target of 33% of spend through SMEs by 2022. Trust contractors are being asked if they are buying locally and if their procurement processes help in this respect. Procurement documentation has been amended to provide additional emphasis on the Equality Act, Modern Slavery, recruiting and developing local talent, payment of the London Living Wage and steps being taken to reduce any negative impact on the environment.

System development and integrated care

During 2019/20, the trust continued to engage in important work with system partners at borough, multi-borough, Integrated Care System (ICS), Academic Health Sciences Network (AHSN) and pan-London level. This work included the following elements:

- At borough level, our hospitals work closely with primary, community and social care partners in our boroughs. 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. These partnerships are focusing on improving how health and social care work together in integrated care systems. They are working to improve population health by equipping local people to manage their own health and wellbeing, and to access the health and care services which best meet their needs, as close to home as possible. The work of borough urgent care groups (reporting into a regional emergency care delivery board) reflects an increasingly system-based approach to improving patient care pathways.
- At multi-borough level, the trust is a key partner in the Waltham Forest and East London (WEL) collaborative. Priorities for improvement at this level include our outpatient transformation strategy to improve experience and reduce the need for face-to-face appointments, same day emergency care standards, our surgical strategy to create centres of expertise across our hospitals and developing a strategy for medicine across the East London system.
- At north east London level, the trust is a member of the East London Health and Care Partnership ICS and clinical senate which together oversee the wider system and support a range of priorities, including improvements to cancer services, end of life care, maternity provision, mental health, work to prevent ill health, primary care and urgent and emergency care.
- The trust is a member of the UCLP Academic Health Science Network and the UCLH cancer collaborative, both of which operate across north east and north central London. The AHSN focuses on collaborative clinical research and the adoption of innovation. The trust is the second highest patient recruiter to trials in the North Thames Clinical Research Network's portfolio.
- The trust has a leading role in a number of pan-London partnerships, including the north east London cancer alliance (established to improve survival and earlier diagnosis), the East London maternity system (set up to reduce still births and maternal mortality and improve continuity of care), an integrated Stroke Delivery Network across east London, a north London specialised children's services network, and an emerging pathology network serving east and south east London.

- The government announced in September 2019 that it will invest in a brand new hospital at Whipps Cross. Barts Health is working on the Whipps Cross redevelopment programme in partnership with patient and stakeholder representative groups, East London Health and Care Partnership, London Borough of Waltham Forest, North East London NHS Foundation Trust and neighbouring Clinical Commissioning Groups.

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. There has been considerable work in 2019/20 to strengthen risk management and the following highlights are noted:

- Implementation of the group's Accountability Framework and publication of a Corporate Governance Manual setting out arrangements for risk management (and wider context of governance structures and terms of reference).
- Introduction of a group wide approach for the development and reporting of Hospital and CSS assurance frameworks.
- Introduction of a risk appetite approach, used in shadow form by executive and board assurance committees.
- A rapid response to developing a risk tracking mechanism for Covid-19 risks and a risk register/risk appetite statement for the newly-created Nightingale Hospital (serving as a support function to London's critical care capacity surge response).
- Creation of a trust wide Risk Review Group to support Hospitals, Group Support Services and Clinical Support Services in implementing the risk management policy consistently across the group.
- Appointment of a substantive Head of Risk and agreed funding to strengthen the centralised risk management function in 2020/21.
- A 'significant' assurance internal audit opinion on the Board Assurance Framework's design, content and application.
- A 2019 independent Deloitte review of risk management findings indicating that the Trust's Risk Management Board benchmarks well with other NHS organisations.

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 2020-21.

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 board, chaired by the group director of corporate development, 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 BAF 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 2019/20 including those relating to quality of services (with assurance provided through improving CQC ratings). 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 2020/21.

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 well embedded at a hospital-level and group level, with the Trust commissioning further assurances on this during 2019/20. The development of the group model and enhanced site-based leadership has contributed to improved risk management maturity, reflected in an overall CQC Well Led domain rating of 'good'.

The trust risk management board has met monthly throughout the year and maintains corporate oversight of risk in the organisation, reporting regularly to the Group Executive Board on its work. At each meeting the committee reviews the trust's highest risks and reviews quarterly progress on key risk reporting metrics. A risk management strategy, approved in 2018, has been supported by the development of a draft risk management policy during 2019/20.

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.

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 as well as emerging Covid-19 risks.

Alwen Williams.

Alwen Williams
Group Chief Executive
17 June 2020

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.

2. The purpose of the system of internal control

The Trust's 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 2020 and up to the date of approval of the annual report and accounts.

2019/20 was a year of progress for Barts Health, including the achievement of further improvements in CQC ratings for hospital services (with no 'inadequate' rated core services and the majority of core services rated 'good' or 'outstanding' across the group). Diagnostic imaging services at Newham improved its Well Led domain rating from 'inadequate' to 'good'. Following inspection of maternity services at Whipps Cross Hospital the rating in the Safe domain improved from 'requires improvement' to 'good'. Overall ratings also improved following reinspections of maternity and end of life care services at The Royal London Hospital. Progress was made on financial resilience, with key year end financial targets met and the financial outlook for 2020/21 more positive. The Trust's overall group model governance structure was strengthened. Each hospital executive board established a supporting suite of committees that mirror those supporting the group executive board. Divisional structures supporting operational leadership at hospital level were standardised across the group. And an accountability framework was refined to clarify the respective roles of each element of the group's structures. The Trust's strategy framework was refined with some key elements approved by the Trust Board during 2019/20 including the quality strategy, patient experience strategy, people strategy, inclusion strategy and surgery strategy. Similarly progress was made on some key strategic developments, including Whitechapel lifesciences, pathology network development, roll out of WeConnect nursing documentation and the welcome confirmation of significant central funding to support the redevelopment of Whipps Cross University Hospital.

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 have been three change to the Board's voting membership during 2019/20 with Hardev Virdee joining the Board as Group Chief Finance Officer, following the retirement of Chrisha Alagaratnam; and Kathy McLean and Kim Kinnaird joining as NEDs following the completion of terms by Thoreya Swage and Mark Higson.

There were no Trust Board vacancies at the end of the financial year.

A 'Well Led' inspection in October 2018 provided assurance on progress on this domain, with the Trust securing a 'good' rating overall. A self-assessment process commenced in 2019/20 ahead of an anticipated Well Led CQC re-inspection in Spring 2020 (which was subsequently stood down in light of the Covid-19 national incident).

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 Group Executive Board (executive committee). Details of the roles of these committees are provided in the accountability section of this 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 sharing of Minutes and exception reports to each Board meeting held in public; with assurance committees providing annual reports on compliance with terms of reference.

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 2019/20, the Audit and Risk Committee focused on the effectiveness of controls in relation to risk management, information governance, stock control arrangements, salary sacrifice incentives, CIPs and financial controls. The Committee also reported to the Trust Board on its assurance review of the BAF and high risks (including emerging site assurance frameworks), waiver processes, information 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, with a planned review in early 2020 deferred due to the Covid-19 pandemic.

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. A revised timetable for the Quality Account in 2019/20 has indicated a deferred deadline for submission of 15 December 2020 (in light of the Covid-19 national incident).

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 2018/19 Quality Account including a deep dive review of selected quality indicators and the findings were reported to the Quality Assurance Committee, indicating no significant issues. The Trust Board approved the 2018/19 Quality Account in June 2019, 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 2019/20, 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 and high risks relating to quality and safety. 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 Board, which is chaired by the Group Director of Corporate Development, provides executive oversight of risk management, reporting into the Group Executive Board. The Risk Management Board 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 Board 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 Board at each meeting. 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 Board 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 or Director of Operations (as determined by the Hospital CEO) 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 Executive Boards have responsibility for monitoring, managing and where necessary escalating risks on their risk registers via Hospital Risk Management Committees. 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.
- Performance review mechanisms for hospitals and CSS have been enhanced in 2019/20 to incorporate standing reviews of risks scored 16 and above.
- The Group 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 Board 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 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 2019/20 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 2019/20, are included on the Board Assurance Framework and relate to:

- Failure to address patient flow and capacity issues impacts on emergency care access and patient experience (risk score 5x4=20).
- Risks on learning from never events, SIs and complaints; 18 Weeks RTT trajectory compliance; PFI excess costs; and capital investment on fire safety improvement and medical equipment (all risk scored at 4x4=16)

New BAF entries have been developed in relation to the Covid-19 incident and Nightingale hospital arrangements for Board consideration in early 2020/21.

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 BAF is further supported by each hospital's development of equivalent Site Assurance Frameworks which reflects on their key strategic risks. The 2019/20 Internal Audit report on the Board Assurance Framework, in draft at the time of producing this Annual Governance Statement, indicated a significant assurance rating on the design and use of the BAF to manage risk across the organisation. Action will be taken by the Executive to address recommendations for refinements identified in the audit report.

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.

External assurance

The Care Quality Commission's reports following their re-inspections of the Trust (including its Well Led review in 2018/19) and outputs from Internal Audit reviews demonstrate progress in embedding risk management systems and processes and the use of risk registers and assurance frameworks. 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.
- Specific public engagement activities held as part of the Whipps Cross redevelopment programme.

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. The number of staff recommending the Trust as a place to work is the highest recorded in the last five years.

Partners

- Regular performance discussions with commissioners, local partner provider organisations and NHS England/Improvement (NHSE/I).
- Board-approved stakeholder management plan and regular reports on impact to the Board.
- Joint working groups for emergency care, critical care and RTT and sector work as part of the NEL ISC.
- Membership of joint programme boards, 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

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.

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 on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) 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.

Sustainability

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 Green Plan supports the NHS England and NHS Improvement 'For a Greener NHS' initiative and adopts the vision originally established in the Sustainable Development Unit's Sustainable Development Strategy 2014-2020 'Sustainable, Resilient, Healthy People & Place' for the NHS, Public Health England (PHE) and Social Care system: 'A sustainable health and care service that works within the available environmental and social resources protecting & improving health now and for future generations'. This includes considering how services are best delivered, resources managed and the application of sustainable goals. The Green Plan is written in the context of the NHS Long-Term Plan, the urgent need to support efforts to address the climate emergency and the transition to 'net zero' carbon emissions. It also reflects the need to support the transition to a circular economy, protect scarce natural resources, improve local air quality and the resilience of our estate, while addressing social inequalities within east London and ethical sourcing of goods and services. It is aligned with Trust strategies and initiatives that focus on efficiency, clinical and care models and social improvement in our community.

Details of the Trust's role and responsibilities as an anchor institution are included earlier in this annual report. As an anchor institution in east London, the Trust has a vision to advance the welfare of our community. This includes working closely with local partners, using buildings and space to support communities, purchasing locally and for social benefit, widening access to quality work and reducing our environmental impact, while complying with all relevant legislation. The Plan therefore adopts the following objectives, which include the potential for innovative solutions:

- Sustainable Trust and Estate. Using resources efficiently and responsibly within energy, water, waste, travel, procurement, and buildings while adapting to climate change, in conjunction with our workforce, community, suppliers and strategic partners.
- Sustainable Healthcare. Deliver health care that reflects financial, social and environmental return on investment, including adapting how services are delivered, health promotion, more prevention and developing more sustainable models of care. Helping people lead more healthy lives also reduces pressure on resources.

This Plan details the extent and nature of impacts, good practice examples and intended actions, within the following topics, including the role of staff, patients, visitors, the community and strategic partners.

The Trust has set the following targets:

- 25% reduction in CORE emissions by 2030, from the 2018 level.
- 30% reduction in energy and water emissions by 2030, from the 2018 level.
- 20% reduction in emissions from business and patient transport by 2030, from the 2018 level.
- 20% reduction in emissions from waste by 2030, from the 2018 level.
- 45% reduction in emissions from anaesthetic agents/gases by 2030, from the 2018 level, including reduce proportion of desflurane to sevoflurane used in surgery to less than 20% by volume by end March 2021 (in accordance with the NHS goal).

These targets are challenging and progress against them will be monitored and reported to the Board. The Plan is supported by a set of measurable actions, which will be managed and adjusted as necessary during the lifetime of the Green Plan.

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 Group 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 Quality Board 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's Data Security and Protection toolkit submission for 2019/20 was postponed. In light of events NHSX recognised that it would be difficult for many organisations to fully complete the toolkit without impacting on their Covid-19 response and amended the final deadline for submissions to 30 September 2020. The annual Internal Audit review of the Data Security and Protection toolkit received a draft 'reasonable' assurance rating, which remained subject to confirmation at the time of drafting this report.

In 2019-20 there were three serious incidents involving a breach of personal-identifiable data which were investigated and reported to the Information Commissioner's Office (ICO) in accordance with national guidance:

- The loss of a bag containing a list of approximately 50 patients with some limited clinical information on each patient. Following a full investigation, steps were taken to address the issues and no enforcement action was taken.
- A letter confirming the freezing of embryos and the future funding of the storage sent to a patient in error. The ICO noted that this had included limited personal data and prompt action was taken by the Trust following the incident on checking procedures and GDPR training for staff.
- A confidential whistleblowing report was shared with staff without redacting names. Following a full investigation, the ICO were content with actions taken through root cause analysis, a review of relevant procedures and training for staff.

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 March 2020, 85% of 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 and each month receives an integrated report reporting against the plan.

As a part of the annual planning process for 2019/2020 the Trust Board agreed nursing and midwifery and allied health professional safer staffing workforce plans presented by the Chief Nurse. The nursing and midwifery safe staffing plans are developed at ward, hospital and then Group level. The monthly integrated performance report details ward-level safer staffing metrics including fill rates and care hours per patient day. The Trust Board also received a report from the Guardian of Safe Working providing assurance that doctors in training working hours are safe and compliant with their terms and conditions of service.

We continue to develop a process for clinical groups that aligns with the established nursing midwifery safe staffing practice. We have focussed on developing the process for allied health professionals and medical staff in line with 'Developing Workforce Safeguards' published in October 2018.

Covid-19 arrangements

During March 2019, the Trust faced unprecedented demand for services arising from the Covid-19 pandemic, which affected all NHS trusts and more acutely those in London during this period. The following section sets out a few of the steps taken to respond in governance terms to the pandemic.

- Governance structures and risk

From the outset of the incident, the Trust's business-as-usual governance structures were adapted to respond to the need for a 'command and control' approach, rapid reporting, decision-making and data sharing. A revised executive governance structure, with clinical and operational workshops spanning workforce, procurement and other key areas reported into a pandemic executive group meeting daily, with Trust Board meetings converted to 'virtual' weekly briefing meetings. These groups oversaw design and delivery of a trustwide pandemic peak operating plan and subsequent second phase plan, supported by a daily Covid-19 dashboard to track progress with patient treatment.

- Critical care capacity

The pandemic placed an immediate pressure on hospital critical care requirements. A trust response to patient admissions and the national modelling on capacity required to manage peaks included the repurposing of Trust resources to support increased intensive care capacity, group and sector mutual aid to direct resources to the most appropriate setting, the establishment and hosting of the Nightingale Hospital, London as 'surge' capacity to treat excess patients, the retraining of over 2600 clinicians in critical care skills, and the fit out of additional floors at The Royal London to support long term critical care capacity requirements for NE London.

- Equipment

A widely acknowledged pressure point for NHS trusts from the outset of the pandemic was the provision of suitable equipment to support safety for staff and patients. The Trust introduced measures to respond rapidly to emerging national guidance on infection control and took steps to supplement NHS Supply Chain provision of equipment (from ventilators through to Personal Protective Equipment such as masks). The provision of consumables, whether oxygen supply, filtration equipment, or reagents to support testing remained a key focus during the period.

- Workforce, safe staffing, and health and wellbeing

As the Trust entered the Covid-19 activity peak and the Nightingale Hospital became operational, it quickly redeployed staff, trainees and students both within the Barts Health Group and from across London, expanding our staff bank numbers to ensure that services to care for Covid-19 patients were staffed appropriately. A Memorandum of Understanding (MoU) was put in place across NHS Trusts in London to enable the free movement of staff between employers. This provided assurance that the employment checks and statutory and mandatory training for redeployed member of staff was up to date and set out appropriate governance arrangements. The People Services team developed an on-boarding process to minimise the time for employment checks to be undertaken to expedite the availability of staff to work on the staff Bank to support our services whilst retaining the integrity of the checking process. The Education Academy provided induction and skills training for all new and redeployed staff utilising both online training resource and face to face training to underpin safe practice, with the Trust hosting events at the O2 providing pan-London critical care training for over 2600 staff. The Trust also responded rapidly to national guidance reflecting the service pressures and new modes of care, including revised safe staffing ratios in critical care and infection control requirements. The need for permanent changes to the clinical staffing model was reflected in the establishment of a clinical workforce steering group. Support for staff health and wellbeing during this period included free hotel accommodation, provision of food and temporary parking, while investment made possible by donations were used to sustained basis through improvements to staff facilities, such as lockers and rest rooms.

Elective waiting time data

The Trust has reported on elective waiting times throughout the year, with the adoption of the pilot for measuring and reporting the average week wait, which is a new national reporting metrics (focusing on the size of the overall waiting list).The Trust has also continued 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 rolled out a 'Right Every Time' training programme, which identifies the sources of poor quality data, followed by meaningful intervention designed to address underlying issues including staff training needs. An extensive data quality dashboard has been designed to support staff to manage data quality and track themes in terms of improvement and errors. This is actively used by the corporate and operational teams. The Board Assurance Framework includes a specific entry in relation to waiting list performance and data quality to support Board-level monitoring of the related risks.

Update on significant control issues in 2018/19

The Trust identified the following significant control issues in its Annual Governance Statement for 2018/19 (four of which have been carried forward to appear as significant control issues in 2019/20):

- 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.

The Trust met its principal financial duties and targets this year, although the ongoing underlying financial deficit position is reflected in this being identified as an ongoing significant control issue in 2019/20. Continued high levels of emergency care demand in 2019/20 resulted in non-achievement of emergency care standards; while steady improvement were achieved on waiting list performance and supporting data quality prior to disruption related to the Covid-19 pandemic. The Trust sustained its pattern of improvement on CQC ratings, with improved domain ratings confirmed in 2019/20 for Royal London maternity and end of life care services, Whipps Cross maternity services and Newham diagnostic services following re-inspections. The Trust maintained its focus on Never Events, although there was only moderate improvement in terms of reported numbers of cases in 2019/20. A three year fire safety improvement programme was agreed with the London Fire Brigade to support work on older elements of the Trust's estate. Updates on all other 2019/20 significant control issues are provided in Section 4 (overleaf).

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 The Royal London, Whipps Cross University and Newham University Hospitals by the Care Quality Commission (CQC) as published during 2019/20.
- 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 2019/20 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 risk-based assessment. None of the finalised audit reports contained findings that Internal Audit regard as significant control issues requiring 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 Board 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 comprising operational, financial, quality and workforce elements; through Board and committee reporting on progress against strategic objectives; and oversight of the Board Assurance Framework.
- The Audit and Risk Committee (ARC) has overseen the effectiveness of risk management arrangements and the Board Assurance Framework, supported by an executive Risk Management Board (RMB) undertaking regular reviews of the Trust's risk register and the Board Assurance Framework. ARC and RMB monitored key clinical and non-clinical risks highlighted by hospitals, directorates and other committees. 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 2019/20, with drivers including high levels of emergency demand beyond contracted levels; underachievement of patient treatment income on elective and other planned activity; and underachievement of savings targets for non-pay. The Trust reported achievement of key financial targets (including the system control total and regulatory duties) with a break-even target set for 2020/21. Financial performance will remain a focus due to the ongoing challenge of sustainably improving the Trust's underlying financial position in the context of changing financial and contractual regimes.

National performance standards (emergency care, diagnostic waiting times and elective waiting times)

Emergency department attendances continued to rise significantly during 2019/20 and, despite more patients being seen within the standard

than ever before, the Trust underachieved against the national 4-hour waiting time standard. Barts Health was selected as a pilot site for the transition from existing 18 Weeks referral to Treatment Time standard towards a focus on overall waiting list length – in respect of this the Trust performed relatively well on this for the majority of the year, prior to disruption to planned activity as a result of the Covid-19 pandemic. Significant work will be required in 2019/20 to recover the elective activity, minimise 52 week breaches and reduce the overall waiting list size. Despite historically strong performance in this area, diagnostic waiting time performance was below the national standard in 2019/20. Following disruption due to equipment failures earlier in the year, performance improved during 2019/20 despite rising demand levels and a return to compliance in quarter 4 had been forecast prior to the onset of the pandemic.

External Auditor appointment

Section 7 of the Local Audit and Accountability Act 2014 requires that an NHS trust must appoint an external auditor to audit its accounts by 31 December in the financial year preceding the one to which the audit relates. During 2019/20, the existing External Audit supplier advised that they would not seek reappointment or an extension of existing terms beyond conclusion of the 2019/20 audit. NHSE/I were notified of a likely failure to appoint, as technically required, by 31 December 2019 and it was recommended that this should be recorded in the Annual Governance Statement. Following an open procurement process, Mazars LLP were formally appointed by the Trust Board as the Trust's External Audit partner in March 2020.

Never Events

The Trust reported 13 Never Events during 2019/20 (compared with 13 Never Events having been recorded in 2018/19) although one of these is due to be de-escalated. Three of the never events resulted in moderate harm to the patients involved although the remainder of the cases resulted in no harm. 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 initiatives), nasogastric tube policy review and awareness raising. 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

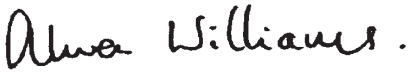
The Trust operated within a constrained capital budget during 2019/20, with an ongoing reliance on capital loan funding approvals. A proportion of available funding was ring-fenced and prioritised, as in recent years, for investment in fire safety improvement works with a focus on addressing improvement notices in place for Whipps Cross and Newham. There has been ongoing monitoring of progress against plans with the London Fire Brigade in-year. The Risk Management Board received regular updates, noting particular progress in year at Whipps Cross to mitigate the risk of regulatory intervention. The Trust Board remains determined to prioritise available capital funding to support and conclude the fire safety improvement work programme.

5. 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).
- External auditor appointment.
- Never events performance.
- Fire safety improvement and capital constraints.

During 2019/20, 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 Ex\cutive
Barts Health NHS Trust

17 June 2020

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

Risk description
1. A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety (A2) (CMO)
2. Failure to sustain or improve CQC ratings for inspected services, or improve systems for early detection and intervention impairs quality of care (A1) (CN)
3. A failure to meet agreed 18 Weeks Referral to Treatment Time trajectories or sustain data quality improvements impacts on patient experience and reputation (A3) (DCEO)
4. Failure to address patient flow and capacity issues impacts on emergency care access and patient experience (A3) (DCEO)
5. Failure to identify deteriorating patients impacts on patient safety (A6) (CMO
6. A failure to address the underlying run rate position over a three year timeframe through delivery of transformational CIPs, while managing operational pressures within the existing cost base impacts on financial sustainability. (B1) (CFO)
7. PFI costs (outside the scope of the Trust's savings programme) over the life of the contract impact on long term financial sustainability. (B1) (CFO)
8. Failure to implement the Trust strategy impacts on sustainability and the development of the group model. (C6) (DS)
9. A failure to deliver outpatients transformation plans in 2019/20 impairs service efficiency, patient experience and referrals. (C1) (DCEO)
10. Delivery of recruitment and retention objectives are impaired by continued high vacancy rates in hard-to-recruit specialties/sites and the impact of Brexit (D6) (DP)
11. A failure to effectively communicate across a large organisation to lead and embed consistent values behaviours and accountability impacts on delivering workforce goals. (D2) (DP)
12. Risk of not delivering workforce and patient equalities and inclusion goals impact on delivery of key objectives (D4) (DP)
13. Capital funding constraints on a) delivery of a resourced ICT strategy and infrastructure remediation plans results in operational disruption and/or non-delivery of national standards (E5) (DS) b) replacement and investment in medical equipment results in operational disruption and/or non-delivery of national standards (E1) (DCEO) c) scheduled fire safety improvement works impacts on regulatory compliance (E1) (DCEO) d) The long-term infrastructure of the Whipps Cross estate results in operational disruption and/or non-delivery of national standards
14. Failure to maximise available resources in the context of reduced national educational funding results in loss of training posts, insufficient recruitment and delivery of workforce targets (F1) (CMO)

Register of Interests - Directors

Name	Organisation	Description	Start Date (if not whole year)	End Date (if not whole year)
Non-Executive Directors				
Mr Ian Peters	Emrgnt Ltd	Shareholding	27/11/2019	
	The Floow	Chairman		
	Switchee Ltd	<1% Shareholding		
	Sagacity Solutions Ltd	Strategic advisor		
	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		
	AgilityEco	Chairman	27-Nov-19	
Ms Natalie Howard	DRC Capital Ltd	Partner		
Ms Margaret Exley	SCT consulting	Director	01-Nov-11	
Mr Alastair Camp	London Institute of Banking & Finance	Chairman, pension fund	12-Feb-14	
	Local Justice Area	Magistrate - South and West Devon Local Area	01-Jun-09	
	China Fleet Trust	Trustee	01-Jan-17	
Dr Thoreya Swage	NEL Clinical Excellence Awards Advisory Cttee	Member		
	Frimley Health NHS Foundation Trust	Non-Executive Director		
	Thoreya Swage	Sole Trader		
Professor Steve Thornton	Royal College of Obstetricians and Gynaecologists	Various roles		
	Ferring Pharmacy	Consultancy advice		
	General Medical Council	Chair, UKMed		
	Glaxo Smith Kline	Consultancy advice		
	GSK	Advisory Board		
	Hologic	Consultancy advice		
	Jannsen	Advisory Board		
	Medcity	Board member		
	Medical Schools Council	Executive		
	Queen Mary University of London	QMUL VP		
	UCLP	Board member		
	Wellbeing for Women	Trustee		
	William Harvey Research Foundation	Member		
	Monash University	Advisory Board		
Mr Gautam Dalal	ZincOx Resources Plc	Chairman		
	National Gallery	Member of Audit and Finance Committees		
	Camellia Plc	Non-Executive Director		
Mr Mark Higson	Wolseley UK	Managing Director		
Dr Kathy McLean	NHS Employers	Chair, national Staff and Associate Specialists Negotiating Committee	01-Dec-19	
	2020 Delivery	Advisor - consultancy	01-Sep-19	13-Dec-19
	Care Quality Commission	Inspection roles	01-Dec-19	
	Derby and Burton University Hospitals NHS FT	Chair	01-Dec-19	
Ms Kim Kinnaird	Lloyds Bank Group	Employment contract	01-Sep-10	
Executive Directors				
Ms Alwen Williams	No Interests Declared			
Professor Alistair Chesser	No Interests Declared			
Ms Caroline Alexander	Buckinghamshire New University	Honorary Visiting Professor		
	Foundation of Nursing Studies (FONS)	Trustee		
Mr Shane DeGaris	No Interests Declared			
Mr Hardev Virdee	Point of Care Foundation	Trustee	20-Nov-19	
	King's Fund	Member, General Advisory Committee	01-Jan-20	
Mr Bill Boa	University Hospital, Plymouth	Associate Non Executive Director	27-Mar-20	
	Arts & Health South West	Trustee and Treasurer		
	Boa & Associates Consultancy Ltd	Director of Financial Improvement role to support the Trust		
Ms Chrisha Alagaratnam	No Interests Declared			
Mr Ralph Coulbeck		Spouse has training placement at Barts Health NHS Trust.		
Mr Andrew Hines	No Interests Declared			
Mr Michael Pantlin	No Interests Declared			

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 Subject to Audit)

Name and title	2019-20					
	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, Group Chief Executive (Note 1)	240 to 245	0	0	0	0	240 to 245
Mr Shane DeGaris, Group Deputy Chief Executive	195 to 200	0	0	0	57.5 to 60	255 to 260
Prof Alistair Chesser, Group Chief Medical Officer	215 to 220	0	0	0	57.5 to 60	275 to 280
Ms Caroline Alexander, Group Chief Nurse	160 to 165	0	0	0	22.5 to 25	185 to 190
Ms Chrisha Alagaratnam, Group Chief Financial Officer (to 30.04.2019) (Note 2)	10 to 15	0	0	0	0	10 to 15
Mr Hardev Virdee, Group Chief Financial Officer (from 04.11.2019)	70 to 75	0	0	0	80 to 82.5	155 to 160
Mr Bill Boa, Finance Improvement Director (to 30.04.2019) Interim Group Chief Financial Officer (from 01.05.2019 to 03.11.2019) (Note 1)	170 to 175	0	0	0	0	170 to 175
Mr Michael Pantlin, Group Director of People	165 to 170	0	0	0	7.5 to 10	175 to 180
Mr Ralph Coulbeck, Group Director of Strategy	125 to 130	0	0	0	32.5 to 35	160 to 165
Mr Andrew Hines, Group Director of Corporate Development	140 to 145	0	0	0	37.5 to 40	180 to 185
Non Executive Directors						
Mr Ian Peters, Chair (Note 3)	45 to 50	34	0	0	0	45 to 50
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 (to 30.11.2019) (Notes 3 and 4)	5 to 10	11	0	0	0	5 to 10
Mr Mark Higson, Non Executive Director (to 09.10.2019)	0 to 5	0	0	0	0	0 to 5
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
Dr Kathy McLean, Non-Executive Director (from 01.12.2019)	0 to 5	0	0	0	0	0 to 5
Ms Kim Kinnaird, Non-Executive Director (from 03.02.2020) (Note 5)	0 to 5	0	0	0	0	0 to 5

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): This member left the Trust and the NHS Pension Scheme in 2019/20, and accrued no further pensionable membership. Hence nil is shown in the "All Pension-Related Benefits" column.

Note (3): Expense payments (taxable benefits) are shown in hundreds, and not thousands, in line with reporting requirements. The respective amounts are £3,410 and £1,107, and relate to travel expenses.

Note (4): Dr Thoreya Swage was an Associate Non-Executive Director (from 01.12.2019 to 02.02.2020)

Note (5): Ms Kim Kinnaird was an Associate Non-Executive Director (from 01.04.2019 to 02.02.2020)

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

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.

There are no entries in respect of pensions for non-executive members, as they do not receive pensionable remuneration.

Alwen Williams

Alwen Williams CBE, Group Chief Executive

17 June 2020

Date

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

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 expenses.

Pensions Table (Information Subject to Audit)

2019/20									
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 2020	Lump sum at pension age related to accrued pension at 31st March 2020	Cash equivalent transfer value at 1st April 2019	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2020	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, Group Deputy Chief Executive	2.5 to 5	0 to 2.5	50 to 55	20 to 25	602	39	684	0
	Prof Alistair Chesser, Group Chief Medical Officer	2.5 to 5	0 to 2.5	80 to 85	200 to 205	1,589	70	1,738	0
	Ms Caroline Alexander, Group Chief Nurse	0 to 2.5	-2.5 to 0	55 to 60	120 to 125	1,033	28	1,110	0
1	Ms Chrisha Alagaratnam, Group Chief Financial Officer (to 30.04.19)	0 to 2.5	0 to 2.5	90 to 95	165 to 170	1,196	0	0	0
	Mr Hardev Virdee, Group Chief Financial Officer (from 04.11.19)	0 to 2.5	0 to 2.5	45 to 50	100 to 105	700	20	793	0
2	Mr Michael Pantlin, Group Director of People	0 to 2.5	0	10 to 15	0	158	6	174	0
2	Mr Ralph Coulbeck, Group Director of Strategy	2.5 to 5	0	10 to 15	0	79	6	106	0
	Mr Andrew Hines, Group Director of Corporate Development	0 to 2.5	-2.5 to 0	50 to 55	115 to 120	842	35	908	0

Notes

1 This officer left the NHS Pension scheme in 2019/20, therefore no CETV is shown for the 31st March 2020.

2 These officers are 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.

There are no entries in respect of pensions for non-executive members, as they do not receive pensionable remuneration.

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.

On 8 August 2019, the method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP). If the individual concerned was entitled to a GMP, this will affect the calculation of the real increase in CETV. This is more likely to affect members in the 1995 Section and the 2008 Section. This does not affect the calculation of the real increase in pension benefits, or the "All Pension-related Benefits" figure in the Salary and Allowances table.

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.

Senior Manager numbers by salary band

Band	Number of senior managers
Less than £5,000	3
£5,000 - £10,000	6
£10,001 - £15,000	1
£45,001 - £50,000	1
£70,000 - £75,000	1
£125,001 - £130,000	1
£140,001 - £145,000	1
£160,001 - £165,000	1
£165,001 - £170,000	1
£170,001 - £175,000	1
£195,001 - £200,000	1
£215,001 - £220,000	1
£240,001 - £245,000	1
Total	**20**

Composition of Senior Managers by Gender

Gender	Headcount	%
Female	8	40%
Male	12	60%
Total	**20**	**100%**

Compensation on early retirement or for loss of office (Information Subject to Audit)

In 2019/20, there were no such payments (none in 2018/19).

Payments to past directors (Information Subject to Audit)

In 2019/20, there were no such payments (none in 2018/19).

Fair Pay (Information Subject to Audit)

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

The banded remuneration of the highest paid Director in Barts Health NHS Trust in the financial year 2019/20 was £240k to £245k (2018/19, £245k to £250k).

This was 6.8 times (2018/19, 6.8) the median remuneration of the workforce, which was £36k (2018/19 £36k).

In 2019/20, no individual received remuneration in excess of the highest paid Director (one in 2018/19*).

Remuneration ranged from the bands £0k-£5k to £240k-£245k (2018/19 £10k-£15k to £305k-£310k*)

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 in 2018/19 was an interim appointment, which has been recruited to substantively in 2019/20.

Staff Costs (Information Subject to Audit)

	2019/20			2018/19		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	**785,679**	785,679	0	**744,218**	744,218	0
Social Security costs	**82,441**	82,441	0	**78,278**	78,278	0
Apprenticeship levy	**3,889**	3,889	0	**3,698**	3,698	0
NHS Pensions Scheme	**117,637**	117,637	0	**79,117**	79,117	0
Pension cost - other	**77**	77	0	**25**	25	0
Termination Benefits	**391**	391	0	**450**	450	0
Temporary staff	**37,939**	0	37,939	**32,103**	0	32,103
Total	**1,028,053**	990,114	37,939	**937,889**	905,786	32,103
Less costs capitalised as part of assets	**4,109**	4,109	0	**934**	934	0
Total	**1,023,944**	986,005	37,939	**936,955**	904,852	32,103

Staff numbers (Information Subject to Audit)

	2019/20			2018/19		
Average staff numbers	Total	Permanently employed	Other Number	Total	Permanently Employed	Other Number
Medical and dental	**2,822**	2,478	344	**2,714**	2,331	383
Administration and estates	**4,072**	3,699	373	**3,931**	3,566	365
Healthcare assistants and other support staff	**2,000**	1,567	433	**1,939**	1,525	414
Nursing, midwifery and health visiting staff	**6,015**	4,909	1,106	**5,849**	4,807	1,042
Scientific, therapeutic and technical staff	**1,901**	1,626	275	**1,816**	1,564	252
Healthcare Science Staff	**649**	618	31	**651**	630	21
Total	**17,459**	14,897	2,562	**16,900**	14,423	2,477
Of the above - staff engaged on capital projects	**63**	54	9	**13**	5	8

Staff composition (as at 31st March 2020)

Gender	Headcount	%
Female	**12,777**	**71%**
Male	**5,110**	**29%**
Total	**17,887**	**100%**

Sickness absence data

In 2019/20, the unprecedented circumstances of COVID-19 make it optional for NHS bodies to disclose sickness absence data.

Further up to date information can be found at this link to the NHS Digital publication series on NHS sickness absence rates: NHS Sickness Absence Rates

Trade Union Facility Time

Entities within the scope of the Trade Union (Facility Time Publication Requirements) Regulations 2017, which took effect from 1 April 2017, are required to publish details in their Annual Report. The Trust's disclosures are shown below.

Relevant Union Officials

Number of employees who were relevant union officials during 2019/20	Full-time equivalent employee number
90	86.6

Percentage of Union Officials time spent on facility time

Percentage of time	Number of Employees
0%	59
1-50%	30
51-99%	0
100%	1

Percentage of pay bill spent on facility time

	Figures
Total cost of facility time	£84,558
Total pay bill	£1,028,053,000
Percentage of the total pay bill spent on facility time	0.008%

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	0.13%

Exit Packages (Information subject to audit)

	2019/20					
	Compulsory Redundancies		Other Departures (see table below)		Total Exit Packages	
Exit package cost band (including any special payment element)	Number	£000	Number	£000	Number	£000
Less than £10,000	1	2	20	73	21	75
£10,000 - £25,000	1	15	5	88	6	103
£25,001 - £50,000			1	29	1	29
£50,001 - £100,000			3	185	3	185
£100,001 - £150,000						
£150,001 - £200,000						
More than £200,000						
Totals	**2**	**17**	**29**	**375**	**31**	**392**

	2018/19					
	Compulsory Redundancies		Other Departures (see table below)		Total Exit Packages	
Exit package cost band (including any special payment element)	Number	£000	Number	£000	Number	£000
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
More than £200,000						
Totals	**36**	**356**	**4**	**200**	**40**	**556**

There were no “Special Payments” in 2019/20 (nil in 2018/19).

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

Analysis of Other Departures

2019/20		
	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*	20	131
Exit payments following Employment Tribunals or court orders	10	244
Non-contractual payments requiring HMT approval**		
Total	**30*** **	**375**

2018/19		
	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**

* Any non-contractual payments in lieu of notice are disclosed under “Non-contractual payments requiring HMT approval” below.

**Includes any non-contractual severance payment made following judicial mediation.

***The total number of payments (30) differs to the figure of 29 in the table above because one of the ex-employees was compensated against 2 elements of the "Other Departure" categories.

Consultancy expenditure

	2019/20	2018/19
Consultancy expenditure charged to operating expenses	**£000s**	**£000s**
Consultancy services	1,056	5,344

Off-payroll Engagements

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	**8**
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	5
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 2019 and March 2020, 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 2019 and 31 March 2020	**5**
Of which…	
No. assessed as within scope of IR35	0
No. assessed as not within scope of IR35	5
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 2019 and 31 March 2020

	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.	20

The off-payroll individual included in the table above was the Trust's Interim Group Chief Financial Officer for the priod from 1st May 2019 to the 3rd November 2019.

Annual Accounts

2019 - 2020

For the year ended
31 March 2020

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, other items of comprehensive income 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.
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

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

17th June 2020

Alwen Williams CBE
Group Chief Executive

17th June 2020

Hardev Virdee
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 2020, 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 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 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 2019 to 2020; 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.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust submitted a financial plan for 2020/21 to NHS England and NHS Improvement (NHSE/I) which delivered a breakeven position supported by £92.9 million Financial Recovery Fund (FRF) income in line with the financial trajectory notified by NHSE/I in February 2020. NHSE/I confirmed FRF funding of £92.9 million for 2020/21 in February 2020.

The underlying financial performance of the Trust within the draft 2020/21 plan was a deficit of £101 million, excluding £93 million FRF funding and £8 million of other non-recurrent benefits. The Trust board recognised that this was a demanding plan, which is subject to a high degree of risk, and dependent upon the full delivery of cost reduction targets, adherence to agreed budgets and delivery of assumptions around the benefits of working with North East London health system partners.

These events or conditions, along with the other matters as set forth in note 1.2, 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

Emphasis of Matter – effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 1.24 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As disclosed in Note 1.24 to the financial statements, the outbreak of Covid-19 has caused uncertainties in the markets. As a result, the Trust's valuer has declared a "material uncertainty" in their valuation report which was carried out in March 2020 with a valuation date of 31 March 2020. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the 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 in April 2015 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 England and 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 2019 to 2020 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.

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(a) of the Local Audit and Accountability Act in relation to the Trust setting a deficit budget for the year ending 31 March 2020.

On 5 June 2020, 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 2020.

- 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 2021 and the resultant ongoing breach of the Trust's breakeven duty for the three-year period ending 31 March 2021.

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

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 April 2020, 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 2020.

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 £73.1million in 2019/20, which was £8 million higher than the target set for it by NHS England and NHS Improvement (NHSE/I). The Trust benefitted from receipt of £53.3 million of Provider Sustainability Funding, Financial Recovery Funding and Marginal Rate Emergency Tariff funding as the wider local health system achieved the financial target set for it by NHSE/I.

- The Trust has initially set a break even budget for 2020/21, which includes delivery of a challenging £49.4 million savings programme and anticipated receipt of £92.9 million of Financial Recovery Funding. The Trust will only receive additional funding if it meets its financial target agreed with NHSE/I. There is a risk that the Trust will not make all of the targeted efficiency savings, which would have a significant impact on the Trust's ability to recover the underlying deficit.

- 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
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 April 2020, 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 2020, and to report by exception where we are not satisfied.
We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

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

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
24 June 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	4	1,455,142	1,359,954
Other operating income	5	242,976	166,691
Operating expenses	7	(1,700,960)	(1,603,421)
Operating surplus/(deficit) from continuing operations		**(2,842)**	**(76,776)**
Finance income	12	475	425
Finance expenses	13	(75,597)	(74,922)
Net finance costs		**(75,122)**	**(74,497)**
Other gains / (losses)	14	1,680	63,958
Surplus / (deficit) for the year from continuing operations		**(76,284)**	**(87,315)**
Surplus / (deficit) for the year		**(76,284)**	**(87,315)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(7,931)	(9,937)
Revaluations	16	89,597	3,696
Total comprehensive income / (expense) for the period		**5,382**	**(93,556)**

The Trust's performance against its Control Total is shown at Note 38 - Break Even Duty Financial Performance.

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	15	100	85
Property, plant and equipment	16	1,389,714	1,297,750
Receivables	18	13,405	7,131
Total non-current assets		**1,403,219**	**1,304,966**
Current assets			
Inventories	17	23,385	24,398
Receivables	18	193,726	163,174
Cash and cash equivalents	19	3,316	3,193
Total current assets		**220,427**	**190,765**
Current liabilities			
Trade and other payables	20	(179,163)	(171,933)
Borrowings	23	(621,669)	(148,959)
Provisions	25	(5,315)	(2,030)
Other liabilities	22	(6,728)	(19,634)
Total current liabilities		**(812,875)**	**(342,556)**
Total assets less current liabilities		**810,771**	**1,153,175**
Non-current liabilities			
Borrowings	23	(968,010)	(1,321,238)
Provisions	25	(13,859)	(13,607)
Total non-current liabilities		**(981,869)**	**(1,334,845)**
Total assets employed		**(171,098)**	**(181,670)**
Financed by			
Public dividend capital		342,075	336,885
Revaluation reserve		338,263	257,997
Income and expenditure reserve		(851,436)	(776,552)
Total taxpayers' equity		**(171,098)**	**(181,670)**

The notes on pages 69 to 97 form part of these accounts.

The financial statements on pages 65 to 97 were approved by the Board on the 17 June 2020 and signed on its behalf by:

17 June 2020

Alwen Williams CBE, Group Chief Executive

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2019 - brought forward	**336,885**	**257,997**	**(776,552)**	**(181,670)**
Surplus/(deficit) for the year	-	-	(76,284)	**(76,284)**
Impairments	-	(7,931)	-	**(7,931)**
Revaluations	-	89,597	-	**89,597**
Transfer to retained earnings on disposal of assets	-	(1,400)	1,400	**0**
Public dividend capital received	5,190	-	-	**5,190**
Taxpayers' equity at 31 March 2020	**342,075**	**338,263**	**(851,436)**	**(171,098)**

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	**0**
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)**

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.

Financial Assets Reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income and expenditure, unless the assets are equity instruments measured at fair vale through other comprehensive income as a result of the irrecoverable election at recognition.

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	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(2,842)	(76,776)
Non-cash income and expense:			
Depreciation and amortisation	7	50,932	51,111
Net impairments	8	1,764	293
Income recognised in respect of capital donations	5	(3,086)	(2,316)
(Increase) / decrease in receivables and other assets	18	(36,673)	48,745
(Increase) / decrease in inventories	17	1,013	3,010
Increase / (decrease) in payables and other liabilities	20	(8,618)	17,025
Increase / (decrease) in provisions	25	3,494	(1,942)
Net cash generated from / (used in) operating activities		**5,984**	**39,150**
Interest received	12	475	425
Purchase of intangible assets		0	(9)
Purchase of property, plant, equipment and investment property		(60,856)	(46,226)
Sales of property, plant, equipment and investment property		6,013	77,269
Net cash generated from / (used in) investing activities		**(54,368)**	**31,459**
Cash flows from financing activities			
Public dividend capital received		5,190	9,835
Movement on loans from the Department of Health and Social Care		143,251	20,999
Capital element of finance lease rental payments		(1,925)	(1,826)
Capital element of PFI, LIFT and other service concession payments		(23,056)	(24,534)
Interest on loans		(13,475)	(12,592)
Other interest		(1)	0
Interest paid on finance lease liabilities		(212)	(252)
Interest paid on PFI, LIFT and other service concession obligations		(61,265)	(62,070)
Net cash generated from / (used in) financing activities		**48,507**	**(70,440)**
Increase / (decrease) in cash and cash equivalents		**123**	**169**
Cash and cash equivalents at 1 April - brought forward		**3,193**	**3,024**
Cash and cash equivalents at 31 March	19	**3,316**	**3,193**

1 Accounting policies and other information

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 2019/20 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.

Accounting convention

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

1.2 Going concern

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 submitted a financial plan for 2020/21 to NHS England and NHS Improvement (NHSE/I) which delivered a breakeven position supported by £92.9m Financial Recovery Fund (FRF) income in line with the financial trajectory notified by NHSE/I in February 2020. NHSE/I confirmed FRF funding of £92.9m for 2020/21 in February 2020.

The underlying financial performance of the Trust within the draft 2020/21 plan was a deficit of £101m, excluding £93m FRF funding and £8m of other non-recurrent benefits.

The Trust board recognised that this was a demanding plan, which is subject to a high degree of risk, and dependent upon the full delivery of cost reduction targets, adherence to agreed budgets and delivery of assumptions around the benefits of working with North East London system partners.

Subsequent to the above, in March 2020, NHSE/I notified the Trust of amended financial arrangements for COVID-19 for the NHS for the period between 1 April and 31 July 2020, which suspended the 2020/21 operational planning process.

Under these COVID-19 arrangements the Trust will be funded at its baseline level of expenditure for April to July 2020, calculated using 2019/20 monthly expenditure data from monthly returns, uplifted for anticipated inflation.

Providers will be funded through a block contract and national top-up payment with reimbursement for any genuinely additional COVID-19 costs as set out in the letter from Sir Simon Stevens, NHS Chief Executive, to system leaders dated 17 March 2020, and subsequent guidance.

During the COVID-19 pandemic, temporary arrangements are in place to ensure all providers have sufficient funding to respond to the crisis, including meeting reasonable additional costs. DHSC revenue support should not be needed during this period but will be available as a safety net, should it be required. Where the need arises revenue support will be provided as PDC. This recognises that any provider with a requirement for revenue support must be facing exceptional financial difficulties and therefore the need and the timeframe for provider recovery plans in the large majority of cases is highly likely to be unknown or uncertain. After the end of the current exceptional financial arrangements due to the COVID-19 outbreak, and given changes to the Financial Recovery Fund set out in the NHS Operational Planning and Contracting Guidance for 2020/21 published in January, the need for longer-term financial support will be rare and should only arise in exceptional circumstances.

The Trust continues to move forward with budget setting and signing off of baseline positions. The Board has been taken through the approach for budget setting which is in line with national guidance, and in accordance with the letter from Simon Stevens referred to above. This will be supported by further national NHSE/I briefings, to be issued shortly, that will outline the new capital regime and allocations, and the financial framework beyond July 2020. The Trust continues to work with system colleagues to align need, demand and capacity (estate, workforce, capital, operating costs and equipment) to best manage the requirements of COVID-19 and non COVID-19 pathways for the next 18 months.

Historic Loans

In order to reset the wider financial architecture and simplify the system, interim revenue debt, working capital loans, and interim capital debts at 31 March 2020 will be repaid with new Public Dividend Capital (PDC) issued by DHSC in 2020/21. Effectively this will extinguish liabilities due to DHSC from providers. Normal course of business loans remain repayable in line with current practice. In the future, valuable cash that would otherwise have been needed to repay past liabilities, will be freed up to maintain vital services and self-finance more capital investment.

This will remove over £596m in loan principal from Barts Health NHS Trust’s balance sheets, including outstanding interest, removing a sizeable hurdle and giving the Trust a head start on the path to financial sustainability. As PDC is to be issued in 2020/21 to match the interim debt, all loan balances as at 31 March 2020 have been reclassified as a current liability (Notes 23 and 33).

DHSC and NHSE/I will carry out a review of the PDC dividend rate as it applies across the NHS financial architecture in 2020/21. This review will consider the impact of lowering the PDC rate against the benefits of doing so, with the intention of making any appropriate changes for 2021/22.

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 2019/20 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.

1.3 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).

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. This accrual is disclosed as a contract receivable, as entitlement to payment for work completed is usually only dependent on the passage of time.

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 do not 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 is received from Health Education England for the training and development of the Trust's workforce, and from a range of NHS organisations for the provision of non-patient care services.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Other Income

The Trust receives revenue for the delivery of a range of services which is disclosed in further detail at Note 5.1.

1.4 Other forms of income

Grants and donations

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. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Disposals

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.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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.

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.

1.6 Expenditure on other goods and services

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

1.7 Property, plant and equipment

1.7.1 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.

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.

1.7.2 Measurement

Valuation

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

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. 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.

Note 1.24 provides further detail of the 2019/20 valuation exercise, carried out by the Valuation Office Agency on behalf of the Trust, in light of the COVID-19 pandemic.

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.

1.7.3 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.

1.7.4 Donated and grant funded assets

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

1.7.5 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 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.

1.7.6 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 life Years	Max life Years
Buildings, excluding dwellings	2	72
Dwellings	3	37
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.

1.8 Intangible assets

1.8.1 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 requirements of IAS 38 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.

1.8.2 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 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.

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.

1.8.3 Useful economic life of intangible assets

	Min life Years	Max life Years
Information technology	5	5
Software licences	3	5

1.9 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.

1.10 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.

1.11 Financial assets and financial liabilities

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.

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, 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.

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.

1.12 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.

1.12.1 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.

1.12.2 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.

1.13 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of *minus* 0.5% in real terms (2018/19: positive 0.29%)

1.14 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.

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.

1.15 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.

1.16 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 and grant 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 2019/20 financial year, the Trust's average net relevant assets was a negative figure, and hence PDC dividends were not payable.

1.17 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.

1.18 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*.

1.19 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.

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.

1.20 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.

1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below.

For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

The Trust established a cross-department Working Group on the 31 July 2019, which has been tasked with ensuring adequate procedures are in place to identify assets leased by the Trust and appropriate accounting treatment under IFRS 16. The Trust is embedding procedures for the review of future contracts and leasing arrangements to identify potential IFRS 16 implications.

During 2020/21, the Trust will continue to identify the impact of IFRS 16 on its financial statements for the 2021/22 financial year.

1.23 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 the London Borough of 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.

1.24 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:

Land and Buildings Valuations – Note 16

Land and Building assets were revalued at 31st March 2020. 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.

Non-Specialised Operational Assets

For those properties where there is market-based evidence to support the use of EUV to arrive at Current Value (e.g. a residence, office or industrial property) the comparative method of valuation has been adopted.

Where a non-specialised property has been valued using the comparative method of valuation, the total value has been apportioned between its residual amount (the land) and depreciable amount (the remainder, effectively the building). Remaining life information has also been provided for the building. It is emphasised that these are informal apportionments produced solely for the purposes of depreciation accounting and do not represent formal valuations of the land and building elements. They should not be relied upon for any other purpose.

Specialised Operational Assets

These assets have been valued under depreciated replacement cost, using the Building Cost Information Service of RICS (BCIS) indices. The BCIS (all price) Tender Price Index (TPI) is based on the BCIS published estimate as at 31st January 2020. BCIS Location Factors are also applied to the national TPI, on a Borough or County specific basis.

The valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation - Global Standards and RICS UK National Supplement, commonly known together as the "Red Book", the valuer has declared a ‘material valuation uncertainty’ in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

The valuer's report notes that:

"a) Specialised In Use (Operational) assets - buildings valued using depreciated replacement cost
There has been no diminution identified in the public sector’s on-going requirement for these operational assets nor reduction in their on-going remaining economic service potential as a result of the incidence of Covid-19. Regarding the BCIS cost indices, BCIS have stated that they consider new construction output is likely to fall in 2020 as a result of the Covid-19 outbreak, as it affects labour availability on sites and delays or leads to cancellation of projects in the pipeline. However, at the present time, BCIS have advised and we agree that it is too early for Covid-19 related issues to impact on BCIS indices published and adopted in our valuations.

b) Non – Specialised In Use (Operational) assets including the land element of the depreciated replacement cost valuation of specialised assets
There has been no diminution identified in the public sector’s ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of Covid-19. Their basis of valuation is however current value in existing use, having regard to comparable market evidence and early commentary as it exists regarding direction of travel tends to suggest and support a downward movement in value. It is too early at this stage in our professional judgement to accurately evidence this impact and it is our opinion at the date of valuation on the information then available that the assessed impact falls within normal valuation tolerances.

The duration of the impact and understanding of likely short, medium to long term effects are hard to predict currently. As further market evidence comes available then the full extent of the Covid-19 impact will become clearer. We therefore strongly recommend that a future impairment review is also undertaken."

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. Whilst the valuer has declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

The valuation report is dated 20 April 2020, and in particular in section 20 refers to the uncertainty created by the COVID-19 Pandemic. The valuations are therefore reported on the basis of ‘material valuation uncertainty’ as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to the valuation than would normally be the case

The valuation report does not provide a potential scale of the uncertainty and includes factors which might lead to a higher as well as lower valuation. The impact of a +/-5% change on the net book value of land and buildings (circa +/- £64m) would have a nil impact on PDC dividends as the Trust has a closing net negative balance sheet as at the 31 March 2020 of £171m, and therefore did not incur PDC interest in 2019/20. The calculation of PDC dividend charge for 2020/21 is still subject to NHSE/I guidance, and at this point it is not possible to estimate the impact of changes in valuation.

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 as 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. The Trust had no individual income generation activity whose full cost exceeded £1m or was otherwise material.

4 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy Note 1.3.

4.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Elective income	177,326	177,072
Non elective income	395,173	366,169
First outpatient income	59,673	57,531
Follow up outpatient income	128,154	127,211
A & E income	69,316	62,641
High cost drugs income from commissioners (excluding pass-through costs)	143,380	120,373
Other NHS clinical income	410,211	397,624
Community services income from CCGs and NHS England	16,212	15,869
Private patient income	5,305	6,372
Agenda for Change pay award central funding*	0	11,327
Additional pension contribution central funding**	35,794	0
Other clinical income	14,598	17,765
Total income from activities	**1,455,142**	**1,359,954**

*The Trust received funding for the additional costs of the Agenda for Change pay reform in 2018/19. From 2019/20, this funding is incorporated into the tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate, with the additional amount (£35.794m) being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

4.2 Income from patient care activities (by source)

	2019/20 £000	2018/19 £000
NHS England	576,833	523,894
Clinical commissioning groups	836,126	782,044
Department of Health and Social Care	0	11,367
Other NHS providers	11,671	8,047
NHS other	601	619
Local authorities	10,008	9,886
Non-NHS: private patients	5,305	6,372
Non-NHS: overseas patients (chargeable to patient)	4,863	10,168
Injury cost recovery scheme	9,725	7,544
Non NHS: other	10	13
Total income from activities	**1,455,142**	**1,359,954**
Of which:		
Related to continuing operations	1,455,142	1,359,954

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

	2019/20 £000	2018/19 £000
Income recognised this year	4,863	10,168
Cash payments received in year	1,596	1,072
Amounts added to provision for impairment of receivables	5,765	5,817
Amounts written off in-year	11,571	1,548

5 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	58,825	0	**58,825**	48,531	0	**48,531**
Education and training	71,182	0	**71,182**	72,077	0	**72,077**
Non-patient care services to other bodies	24,584	0	**24,584**	7,070	0	**7,070**
Provider sustainability fund (PSF)	4,370	0	**4,370**	0	0	**0**
Financial recovery fund (FRF)	39,572	0	**39,572**	0	0	**0**
Marginal rate emergency tariff funding (MRET)	9,360	0	**9,360**	0	0	**0**
Receipt of capital grants and donations	0	3,086	**3,086**	0	2,316	**2,316**
Charitable and other contributions to expenditure	0	436	**436**	0	154	**154**
Rental revenue from operating leases	0	3,207	**3,207**	0	3,279	**3,279**
Other income*	28,354	0	**28,354**	33,264	0	**33,264**
Total other operating income	236,247	6,729	**242,976**	160,942	5,749	**166,691**
Of which:						
Related to continuing operations			**242,976**			**166,691**

*5.1 Other Income is analysed in further detail below:

	2019/20	2018/19
	£000	£000
Car Parking income	2,169	1,131
Catering	244	0
Pharmacy sales	4,769	1,931
Property rental (not lease income)	455	3,490
IT recharges (external)	681	1,004
Clinical tests	1,756	5,232
Clinical excellence awards	2,754	2,729
Grossing up consortium arrangements	509	2,601
Other income not already covered (recognised under IFRS 15)	15,017	15,146
Total "Other" Contract Income	**28,354**	**33,264**

6 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the year that was included within contract liabilities at the previous period end	19,634	18,009

7 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	7,638	9,452
Purchase of healthcare from non-NHS and non-DHSC bodies	9,047	6,689
Staff and executive directors costs	1,023,553	936,504
Remuneration of non-executive directors	110	110
Supplies and services - clinical (excluding drugs costs)	145,252	141,628
Supplies and services - general	87,457	82,725
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	166,948	174,910
Consultancy costs	1,056	5,344
Establishment	10,039	9,778
Premises	62,087	53,229
Transport (including patient travel)	8,464	7,592
Depreciation on property, plant and equipment	50,862	51,022
Amortisation on intangible assets	70	89
Net impairments	1,764	293
Movement in credit loss allowance: contract receivables / contract assets	7,909	7,092
Change in provisions discount rate(s)	884	(220)
Audit services - statutory audit*	131	131
Other auditor remuneration (external auditor only, Note 7.1 below)	0	9
Clinical negligence	43,131	43,563
Legal fees	1,524	1,178
Insurance	1,245	1,333
Research and development	22,077	22,604
Education and training	3,716	4,111
Rentals under operating leases	4,018	4,207
Redundancy	391	450
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	25,659	26,025
Other	15,928	13,573
Total	**1,700,960**	**1,603,421**
Of which:		
Related to continuing operations	1,700,960	1,603,421

7.1 Other auditor remuneration

Other auditor remuneration paid to the external auditor:	2019/20 £000	2018/19 £000
Audit-related assurance services (Audit of Quality Accounts)	0	9
Total	0	**9**

Due to the unprecedented circumstances of the COVID19 pandemic, DHSC has instructed that auditor assurance work on quality accounts and quality reports should cease for 2019/20. Hence, there is nil fee for 2019/20.

7.2 Limitation on auditor's liability

The limitation on auditors liability for external audit work is £2m (2018/19: £2m)

8 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	0	92
Other	1,764	201
Total net impairments charged to operating surplus / deficit	**1,764**	**293**
Impairments charged to the revaluation reserve	7,931	9,937
Total net impairments	**9,695**	**10,230**

When assets are revalued each year, changes in value are charged to the revaluation reserve, where a ring-fenced balance is held for each asset. Downward valuations of an asset result in an “impairment”, which is charged to the ring-fenced balance for that particular asset. As negative ring-fenced balances are not permitted in the revaluation reserve, any excess impairment over and above the balance is charged to the Statement of Comprehensive Income (SOCI).

In 2019/20, two of the Trust’s assets at its Whipps Cross site were impaired by £1.764m over and above their ring-fenced revaluation reserve balances, and this is reflected in the SOCI.
Impairments of £7.931m relating to these and other assets were charged to the available balances in the revaluation reserve.

9 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	785,679	744,218
Social security costs	82,441	78,278
Apprenticeship levy	3,889	3,698
Employer's contributions to NHS pensions*	117,637	79,117
Pension cost - other	77	25
Termination benefits	391	450
Temporary staff (including agency)	37,939	32,103
Total staff costs	**1,028,053**	**937,889**
Of which:		
Costs capitalised as part of assets	4,109	935

*In 2019/20, this includes the additional employer pension contribution of £35.794m (6.3%) which was paid by NHS England on the Trust's behalf.

9.1 Retirements due to ill-health

During 2019/20 there were 6 early retirements from the Trust agreed on the grounds of ill-health (9 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £285k (£603k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 for Health and Social Care 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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 2019/20 was 3% (2018/19: 2%).

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.

	2019/20	2018/19
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	3,207	3,279
Total	**3,207**	**3,279**

	31 March 2020	31 March 2019
Future minimum lease receipts due:	**£000**	**£000**
- not later than one year;	3,070	3,011
- later than one year and not later than five years;	9,834	10,306
- later than five years.	85,516	87,857
Total	**98,420**	**101,174**

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.

	2019/20	2018/19
Operating lease expense	**£000**	**£000**
Minimum lease payments	4,018	4,207
Total	**4,018**	**4,207**

	31 March 2020	31 March 2019
Future minimum lease payments due:	**£000**	**£000**
- not later than one year;	3,578	3,422
- later than one year and not later than five years;	1,882	3,757
- later than five years.	228	257
Total	**5,688**	**7,436**

12 Finance income

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

	2019/20	2018/19
	£000	**£000**
Interest on bank accounts	475	425
Total finance income	**475**	**425**

13 Finance expenses

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

	2019/20	2018/19
	£000	**£000**
Interest expense:		
Loans from the Department of Health and Social Care	14,076	12,572
Finance leases	212	252
Interest on late payment of commercial debt	1	12
Main finance costs on PFI schemes obligations	33,631	35,752
Contingent finance costs on PFI schemes obligations	27,634	26,318
Total interest expense	**75,554**	**74,906**
Unwinding of discount on provisions	43	16
Total finance costs	**75,597**	**74,922**

14 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	1,680	63,958
Total gains / (losses) on disposal of assets	**1,680**	**63,958**

In 2019/20, the Trust disposed of its Steels Lane site, a community health building that was surplus to requirements.
The prior year figure relates to diposal of part of the Trust's Whitechapel site to the Department of Health and Social Care.
The net gain of both disposals is shown above.

15 Intangible assets - 2019/20

	Software licences	IT (internally generated and 3rd party)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - B/F	**1,619**	**670**	**2,289**
Reclassifications	85	-	**85**
Valuation / gross cost at 31 March 2020	**1,704**	**670**	**2,374**
Amortisation at 1 April 2019 - B/F	**1,534**	**670**	**2,204**
Provided during the year	70	-	**70**
Amortisation at 31 March 2020	**1,604**	**670**	**2,274**
Net book value at 31 March 2020	**100**	**-**	**100**
Net book value at 1 April 2019	**85**	**-**	**85**

15.1 Intangible assets - 2018/19

	Software licences	IT (internally generated and 3rd party)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**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 - as previously stated	**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**

16 Property, plant and equipment - 2019/20

	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 2019 - B/F	**125,596**	**1,065,431**	**3,631**	**24,138**	**173,232**	**162**	**47,427**	**736**	**1,440,353**
Additions	-	24,039	611	28,539	11,047	-	1,454	-	**65,690**
Impairments	-	(7,931)	-	-	-	-	-	-	**(7,931)**
Revaluations	645	88,909	43	-	-	-	-	-	**89,597**
Reclassifications	-	11,126	(2,762)	(20,182)	5,481	-	6,252	-	**(85)**
Revaluations (removal of accumulated depreciation)	-	(30,548)	(410)	-	-	-	-	-	**(30,958)**
Disposals / derecognition	(925)	(1,770)	-	-	(3,726)	-	(13,970)	-	**(20,391)**
Valuation/gross cost at 31 March 2020	**125,316**	**1,149,256**	**1,113**	**32,495**	**186,034**	**162**	**41,163**	**736**	**1,536,275**
Accumulated depreciation at 1 April 2019 - B/F	**-**	**-**	**-**	**-**	**110,631**	**162**	**31,456**	**354**	**142,603**
Provided during the year	-	28,798	410	-	16,075	-	5,419	160	**50,862**
Impairments	-	1,764	-	-	-	-	-	-	**1,764**
Disposals / derecognition	-	(14)	-	-	(3,726)	-	(13,970)	-	**(17,710)**
Revaluations (removal of accumulated depreciation)	-	(30,548)	(410)	-	-	-	-	-	**(30,958)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**122,980**	**162**	**22,905**	**514**	**146,561**
Net book value at 31 March 2020	**125,316**	**1,149,256**	**1,113**	**32,495**	**63,054**	**-**	**18,258**	**222**	**1,389,714**
Net book value at 1 April 2019	**125,596**	**1,065,431**	**3,631**	**24,138**	**62,601**	**-**	**15,971**	**382**	**1,297,750**

*The Trust carried out a valuation of its land, buildings and dwellings at 31st March 2020 using the services of the Valuation Office Agency. As a result of this exercise, the in year depreciation for buildings and dwellings totalling £30.958m has been removed in the "Revaluations" line so that the closing accumulated depreciation is shown as nil.

Note 1.24 provides further detail of the 2019/20 valuation exercise, carried out by the Valuation Office Agency on behalf of the Trust, in light of the COVID-19 pandemic.

16.1 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 Restated	**135,011**	**1,062,222**	**3,628**	**7,737**	**166,234**	**170**	**39,570**	**1,025**	**1,415,597**
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**
Reclassifications for Accumulated Depreciation / Disposals	(9,415)	(3,479)	-	(246)	(5,210)	(8)	-	(300)	**(18,658)**
Valuation/gross cost at 31 March 2019	**125,596**	**1,065,431**	**3,631**	**24,138**	**173,232**	**162**	**47,427**	**736**	**1,440,353**
Accumulated depreciation at 1 April 2018 - B/F Restated	**-**	**-**	**-**	**-**	**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**
Reclassifications for Accumulated Depreciation / Disposals	-	(29,663)	(359)	-	(5,023)	(8)	-	(300)	**(35,353)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**110,631**	**162**	**31,456**	**354**	**142,603**
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	1,062,222	3,628	7,737	67,121	3	12,794	440	**1,288,956**

16.2 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	125,316	333,836	532	29,018	54,914	17,833	215	**561,664**
Finance leased	-	3,870	581	-	-	-	-	**4,451**
On-SoFP PFI contracts	-	776,462	-	-	-	-	-	**776,462**
Owned - government granted	-	543	-	-	-	-	-	**543**
Owned - donated	-	34,545	-	3,477	8,140	425	7	**46,594**
NBV total at 31 March 2020	**125,316**	**1,149,256**	**1,113**	**32,495**	**63,054**	**18,258**	**222**	**1,389,714**

16.3 Property, plant and equipment financing - 2018/19

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

17 Inventories

	31 March 2020	31 March 2019
	£000	£000
Drugs	10,259	10,254
Consumables	12,747	13,757
Energy	379	387
Total inventories	**23,385**	**24,398**
Of which:		
Held at fair value less costs to sell	23,385	-

Inventories recognised in expenses for the year were £251,705k (2018/19: £237,589k).

Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

18 Trade receivables and other receivables

	31 March 2020	31 March 2019
	£000	£000
Current		
Contract receivables	169,717	142,355
Allowance for impaired contract receivables / assets	(22,294)	(26,026)
Allowance for other impaired receivables	0	(65)
Prepayments (non-PFI)	4,713	1,006
Prepayments (PFI)	28,592	33,400
PFI lifecycle prepayments	253	100
VAT receivable	8,640	11,381
Other receivables	4,105	1,023
Total current trade and other receivables	**193,726**	**163,174**
Non-current		
Contract assets	6,582	4,322
PFI lifecycle prepayments	6,823	2,809
Total non-current trade and other receivables	**13,405**	**7,131**
Of which receivables from NHS and DHSC group bodies:		
Current	113,522	69,328

18.1 Allowances for credit losses - 2019/20

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2019 - brought forward	**26,026**	**65**
New allowances arising	11,311	0
Reversals of allowances	(3,402)	0
Utilisation of allowances (write offs)	(11,641)	(65)
Allowances as at 31 Mar 2020	**22,294**	**0**

18.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - restated	**0**	**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)	0
Utilisation of allowances (write offs)	(1,874)	0
Allowances as at 31 Mar 2019	**26,026**	**65**

18.3 Exposure to credit risk

The note below shows the ageing of impired and not impaired non-NHS financial assets, using the invoice date as the age range:

	31 March 2020 Trade and other receivables	31 March 2019 Trade and Other Receivables
Non NHS financial assets - Impaired	**£000**	**£000**
0 - 30 days	682	672
30-60 Days	743	1,107
60-90 days	222	484
90- 180 days	1,004	1,673
Over 180 days	19,643	22,155
Total	**22,294**	**26,091**
Non NHS financial assets - Not Impaired		
0 - 30 days	6,654	6,933
30-60 Days	4,028	6,678
60-90 days	861	1,003
90- 180 days	4,723	3,644
Over 180 days	25,882	24,327
Total	**42,148**	**42,585**

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.

	2019/20	2018/19
	£000	**£000**
At 1 April	**3,193**	**3,024**
Net change in year	123	169
At 31 March	**3,316**	**3,193**
Broken down into:		
Cash at commercial banks and in hand	39	72
Cash with the Government Banking Service	3,277	3,121
Total cash and cash equivalents as in SoFP	**3,316**	**3,193**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**3,316**	**3,193**

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 2020	31 March 2019
	£000	**£000**
Bank balances	85	78
Monies on deposit	0	0
Total third party assets	**85**	**78**

20 Trade and other payables

	31 March 2020	31 March 2019
Current	**£000**	**£000**
Trade payables	95,129	91,545
Capital payables	4,990	3,700
Accruals	60,313	51,607
Social security costs	5,095	13,480
Other payables*	13,636	11,601
Total current trade and other payables	**179,163**	**171,933**
Of which, payables from NHS and DHSC group bodies:		
Current	33,761	32,535

* The majority of this balance relates to the Trust's payover of pension contributions 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 2018/19).

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 2020	31 March 2019
Current	**£000**	**£000**
Deferred income: contract liabilities	6,728	19,634
Total other current liabilities	**6,728**	**19,634**

23 Borrowings

	31 March 2020	31 March 2019
Current	**£000**	**£000**
Loans from the Department of Health and Social Care*	595,629	124,011
Obligations under finance leases	1,997	1,892
Obligations under PFI service concession contracts (excl. lifecycle)	24,043	23,056
Total current borrowings	**621,669**	**148,959**
Non-current		
Loans from the Department of Health and Social Care*	0	327,766
Obligations under finance leases	2,279	3,698
Obligations under PFI service concession contracts	965,731	989,774
Total non-current borrowings	**968,010**	**1,321,238**

*The Department of Health and Social Care has announced that interim capital and revenue loans at 31 March 2020 of provider organisations are to be extinguished via conversion to Public Dividend Capital (PDC) in 2020/21. This provides evidence that the classification of this debt at 31 March 2020 should be disclosed as a current liability, rather than split between current and non-current, as the liability will be repayable within 12 months of the SoFP date.

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 2019 - brought forward	**451,777**	**5,590**	**1,012,830**	**1,470,197**
Cash movements:				
Financing cash flows - payments and receipts of principal	143,251	(1,925)	(23,056)	**118,270**
Financing cash flows - payments of interest	(13,475)	(212)	(33,631)	**(47,318)**
Non-cash movements:				
Additions	0	611	0	**611**
Application of effective interest rate	14,076	212	33,631	**47,919**
Carrying value at 31 March 2020	**595,629**	**4,276**	**989,774**	**1,589,679**

	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**
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)**
Impact of implementing IFRS 9 on 1 April 2018	1,611	0	0	**1,611**
Additions	0	1,325	0	**1,325**
Application of effective interest rate	12,764	252	35,752	**48,768**
Carrying value at 31 March 2019 - carried forward	**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 2020 £000	31 March 2019 £000
Gross lease liabilities	**4,474**	**5,936**
Of which liabilities are due:		
- not later than one year;	2,128	2,072
- later than one year and not later than five years;	2,346	3,864
Finance charges allocated to future periods	(198)	(346)
Net lease liabilities	**4,276**	**5,590**
- not later than one year	1,997	1,892
- later than one year and not later than five years	2,279	3,698

25 Provisions for liabilities and charges analysis

	Total	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Clinicians' pension tax
	£000	£000	£000	£000	£000
At 1 April 2019	**15,637**	**11,193**	**3,772**	**672**	**0**
Change in the discount rate	**884**	563	321	0	0
Arising during the year	**4,430**	604	156	482	3,188
Utilised during the year	**(1,375)**	(1,033)	(213)	(129)	0
Reversed unused	**(445)**	(97)	(84)	(264)	0
Unwinding of discount	**43**	32	11	0	0
At 31 March 2020	**19,174**	**11,262**	**3,963**	**761**	**3,188**
Expected timing of cash flows:					
- not later than one year;	**5,315**	1,151	215	761	3,188
- later than one year and not later than five years;	**5,464**	4,604	860	0	0
- later than five years.	**8,395**	5,507	2,888	0	0
Total	**19,174**	**11,262**	**3,963**	**761**	**3,188**

The majority of the Trust's provisions (£11.3m) relate to NHS Pensions early departure costs. Expected future cash flows have been discounted using the real discount rate of -0.5% (2018/19: 0.29%) (set by HM Treasury) to determine the full liability.

The "Other" newly arising provision of £3.2m relates to clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in this tax year (2019/20), face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. The Trust wil meet this charge, for which it will be re-imbursed by NHS England.

26 Clinical negligence liabilities

At 31 March 2020, £806.225m was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of Barts Health NHS Trust (31 March 2019: £800.086m).

27 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(270)	(222)
Other*	0	(3,000)
Gross value of contingent liabilities	**(270)**	**(3,222)**
Net value of contingent liabilities	**(270)**	**(3,222)**

* In 2018/19, related to the Whitechapel site vacant possession works.

28 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	19,379	10,948
Total	**19,379**	**10,948**

Approximately half of the 2019/20 capital commitments relate to clinical equipment and building works required to increase clinical ITU capacity to treat COVID-19 patients. The funding stream for this is via the extra-ordinary arrangements put in place by DHSC to support NHS providers.
The balance relates to similar commitments as previous years relating to reconfiguration, refurbishment and building works across Trust sites as well as clinical equipment purchases.

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 on the SoFP

	Both Sites 31 March 2020	Barts & RLH 31 March 2020	Newham 31 March 2020	Both Sites 31 March 2019
	£000	£000	£000	£000
Gross PFI Obligation	**1,540,016**	**1,474,320**	**65,696**	**1,597,993**
Of which liabilities are due:				
- not later than one year;	**58,139**	54,385	3,754	57,977
- later than one year and not later than five years;	**229,706**	215,317	14,389	231,564
- later than five years.	**1,252,171**	1,204,618	47,553	1,308,452
Finance charges allocated to future periods	**(550,242)**	(512,459)	(37,783)	(585,163)
Net PFI obligation:	**989,774**	**961,861**	**27,913**	**1,012,830**
Of which liabilities are due:				
- not later than one year;	***24,043***	*23,309*	*731*	*23,056*
- later than one year and not later than five years;	***102,006***	*98,857*	*3,151*	*100,356*
- later than five years.	***863,725***	*839,695*	*24,031*	*889,418*

29.2 Total futue PFI payments

	Both Sites 31 March 2020	Barts & RLH 31 March 2020	Newham 31 March 2020	Both Sites 31 March 2019
	£000	£000	£000	£000
Total future payments committed in respect of PFI schemes	**4,802,354**	**4,606,377**	**195,977**	**4,937,106**
Of which liabilities are due:				
- not later than one year;	***123,425***	*115,154*	*8,271*	*120,758*
- later than one year and not later than five years;	***525,337***	*490,132*	*35,205*	*513,990*
- later than five years.	***4,153,592***	*4,001,091*	*152,501*	*4,302,358*

29.3 Analysis of amounts paid and payable to service concession operators

	Both Sites 2019/20	Barts & RLH 2019/20	Newham 2019/20	Both Sites 2018/19
	£000	£000	£000	£000
Unitary payment payable to service concession operator, consisting of:				
- Interest charge	33,631	30,518	3,113	35,752
- Repayment of finance lease liability	23,056	22,213	843	24,534
- Service element and other charges to operating expenditure	25,659	23,647	2,012	26,025
- Capital lifecycle maintenance	9,196	8,932	264	5,207
- Contingent rent	27,634	25,793	1,841	26,318
- Addition to lifecycle prepayment	-			-
	119,176	**111,103**	**8,073**	**117,836**
Other amounts paid to operator due to a commitment under the service concession contract, but not part of the unitary payment	4,611	4,611	-	4,402
Total amount paid to service concession operator	**123,787**	**115,714**	**8,073**	**122,238**

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	**32,895**	8,161	24,734
Between One and Five Years	**143,413**	39,070	104,343
Later than Five Years	**1,242,684**	394,306	848,378
Total	**1,418,992**	**441,537**	**977,455**

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	**82,259**	23,309	31,076	27,874
Between One and Five Years	**346,719**	98,857	116,460	131,402
Later than Five Years	**2,758,407**	839,695	364,923	1,553,789
Total	**3,187,385**	**961,861**	**512,459**	**1,713,065**

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	**2,635**	538	2,097
Between One and Five Years	**12,240**	3,197	9,043
Later than Five Years	**57,131**	18,522	38,609
Total	**72,006**	**22,257**	**49,749**

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	**5,636**	731	3,023	1,882
Between One and Five Years	**22,965**	3,151	11,238	8,576
Later than Five Years	**95,370**	24,031	23,522	47,817
Total	**123,971**	**27,913**	**37,783**	**58,275**

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 Trust has with its commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. 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 Englnd and 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 England and 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 2020 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

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	148,340	**148,340**
Cash and cash equivalents at bank and in hand	3,316	**3,316**
Total at 31 March 2020	**151,656**	**151,656**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost £000	Total book value £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**

30.2 Carrying value of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care*	595,629	**595,629**
Obligations under finance leases	4,276	**4,276**
Obligations under PFI, LIFT and other service concession contracts	989,774	**989,774**
Trade and other payables excluding non financial liabilities	168,679	**168,679**
Total at 31 March 2020	**1,758,358**	**1,758,358**

*In 2020/21, the loans that the Trust holds with DHSC will be converted to Public Dividend Capital. Note 33 provides further information.

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost £000	Total book value £000
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**

30.3 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	790,345	307,391
In more than one year but not more than two years	26,773	338,143
In more than two years but not more than five years	77,514	86,982
In more than five years	863,726	896,113
Total at 31 March	**1,758,358**	**1,628,629**

31 Losses and special payments

	2019/20		2018/19	
	Number of cases	Value of cases	Number of cases	Value of cases
	Number	£000	Number	£000
Losses				
Cash losses	56	81	59	221
Fruitless payments*	0	0	1	520
Bad debts and claims abandoned	2,860	11,630	107	1,662
Total losses	**2,916**	**11,712**	**167**	**2,403**
Special payments				
Ex-gratia payments	72	26	59	25
Total special payments	**72**	**26**	**59**	**25**
Total losses and special payments	**2,988**	**11,738**	**226**	**2,428**

* The fruitless payment of £520k in 2018/19 related to payment 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.
No such gifts were received in 2019/20 (2018/19: nil)

33 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.

Historic Loan Conversion

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £596m as at 31 March 2020 in these financial statements have been classified as current liabilities as they will be repayable within 12 months.

Nightingale Hospital

As part of the national response to the COVID- 19 pandemic, the NHS has been asked to establish a number of specific facilities namely “Nightingale Hospitals” to support and deliver care to the most critically ill patients.

The Board of Barts Health NHS Trust agreed to a request from NHS England and NHS Improvement (London Region) to host the new hospital being built for Covid-19 patients at the ExCeL exhibition centre in Newham.

This facility came under the direct control of the Trust on the 1st April 2020, with the Trust taking formal legal responsibility for the operation and governance of the NHS Nightingale Hospital London, working closely with NHSE/I.

The facility has been specially built to provide the best possible care for patients who have already been intubated and ventilated at a London hospital and require further intensive care treatment for COVID-19.

Based at the ExCeL conference centre in east London, the hospital could provide up to 4,000 beds, fully equipped with ventilators and oxygen. These are a mixture of intensive care and recovery beds. At present the operating model and requirement for these beds is still being determined and the number of beds will be flexed and defined by demand, and as such the costs and budgets will be modeled accordingly. It is important to note that that the reasonable costs relating to COVID-19 are reimbursed as appropriate by DHSC.

The NHS Nightingale Hospital London not only provides vital critical care services to patients, but also helps other London hospitals free up bed space.

Future Funding Arrangements

The UK Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2020/21, and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year.

Providers can therefore expect NHS funding to flow at similar levels to that previously provided, where services are reasonably still expected to be commissioned. Whilst mechanisms for contracting and payment are not definitively in place, it is clear that government financial support is available. For the period April 2020 to June 2020, the Trust is receiving income via block contract lump sums.

34 Related parties

During 2019/20 and 2018/19, Barts Health NHS Trust has had a significant number of material transactions (income and expenditure, outstanding balances including commitments over £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:

Provider Organisations

Barking, Havering & Redbridge University Hospitals NHST
Central and North West London NHSFT
East London NHSFT
Great Ormond Street Hospital for Children NHSFT
Homerton University Hospital NHSFT
Mid Essex Hospital Services NHST
North East London NHSFT
Royal Free London NHSFT
University College London Hospitals NHSFT

Other

Care Quality Commission
Common Council of the City of London
Community Health Partnerships
Department of Health and Social Care
East of England Regional Office
Health Education England
HM Revenue & Customs
Newham London Borough Council
NHS Blood and Transplant
NHS England
NHS Improvement
NHS Pensions
NHS Property Services
NHS Resolution
Tower Hamlets London Borough Council
Waltham Forest London Borough Council

Clinical Commissioning Groups

Barking and Dagenham CCG
Barnet CCG
Basildon and Brentwood CCG
Bexley CCG
Brent CCG
Bromley CCG
Camden CCG
Castle Point and Rochford CCG
Central London (Westminster) CCG
City and Hackney CCG
East and North Hertfordshire CCG
East Berkshire CCG
Enfield CCG
Greenwich CCG
Hammersmith and Fulham CCG
Haringey CCG
Havering CCG
Herts Valleys CCG
Islington CCG
Lambeth CCG
Lewisham CCG
Mid Essex CCG
Newham CCG
North East Essex CCG
Redbridge CCG
Southend CCG
Southwark CCG
Thurrock CCG
Tower Hamlets CCG
Waltham Forest CCG
West Essex CCG

35 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	179,331	1,049,390	175,360	997,250
Total non-NHS trade invoices paid within target	89,823	812,434	118,382	850,473
% of non-NHS trade invoices paid within target	**50.1%**	**77.4%**	**67.5%**	**85.3%**
NHS Payables				
Total NHS trade invoices paid in the year	4,528	240,254	5,159	275,240
Total NHS trade invoices paid within target	1,882	210,022	2,168	233,853
% of NHS trade invoices paid within target	**41.6%**	**87.4%**	**42.0%**	**85.0%**

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.

36 External Financing

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

	2019/20 £000	2018/19 £000
Cash flow financing	123,337	4,305
External financing requirement	**123,337**	**4,305**
External financing limit (EFL)	123,337	4,305
Under / (over) spend against EFL	**0**	**0**

37 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	65,690	49,246
Less: Disposals	(2,681)	(13,189)
Less: Donated and granted capital additions	(3,086)	(2,316)
Charge against Capital Resource Limit	**59,923**	**33,741**
Capital Resource Limit	60,857	34,228
Under / (over) spend against CRL	**934**	**487**

38 Breakeven duty financial performance

	2019/20 £000	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(73,119)	(84,243)
Breakeven duty financial performance surplus/(deficit)*	**(73,119)**	**(84,243)**

*The Trust's performance against its Control Total is set out in further detail below:

	Note	2019/20 £000	2018/19 £000
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(76,284)	(87,315)
Remove net impairments not scoring to the Departmental expenditure limit	8 &16	1,764	293
Remove I&E impact of capital grants and donations		1,401	2,779
Adjusted financial performance surplus / (deficit)		**(73,119)**	**(84,243)**

38.1 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	2019/20 £000
Breakeven duty in-year financial performance	409	(38,270)	(79,642)	(134,881)	(69,481)	(108,363)	(84,243)	(73,119)
Breakeven duty cumulative position	409	(37,861)	(117,503)	(252,384)	(321,865)	(430,228)	(514,471)	(587,590)
Operating income	1,324,338	1,288,172	1,319,964	1,342,594	1,488,833	1,512,726	1,526,645	1,698,118
Cumulative breakeven position as a percentage of operating income	**0.0%**	**(2.9%)**	**(8.9%)**	**(18.8%)**	**(21.6%)**	**(28.4%)**	**(33.7%)**	**(34.6%)**

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, hence the note discloses performance from the 2012/13 financial year.


NHS

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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 ای 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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