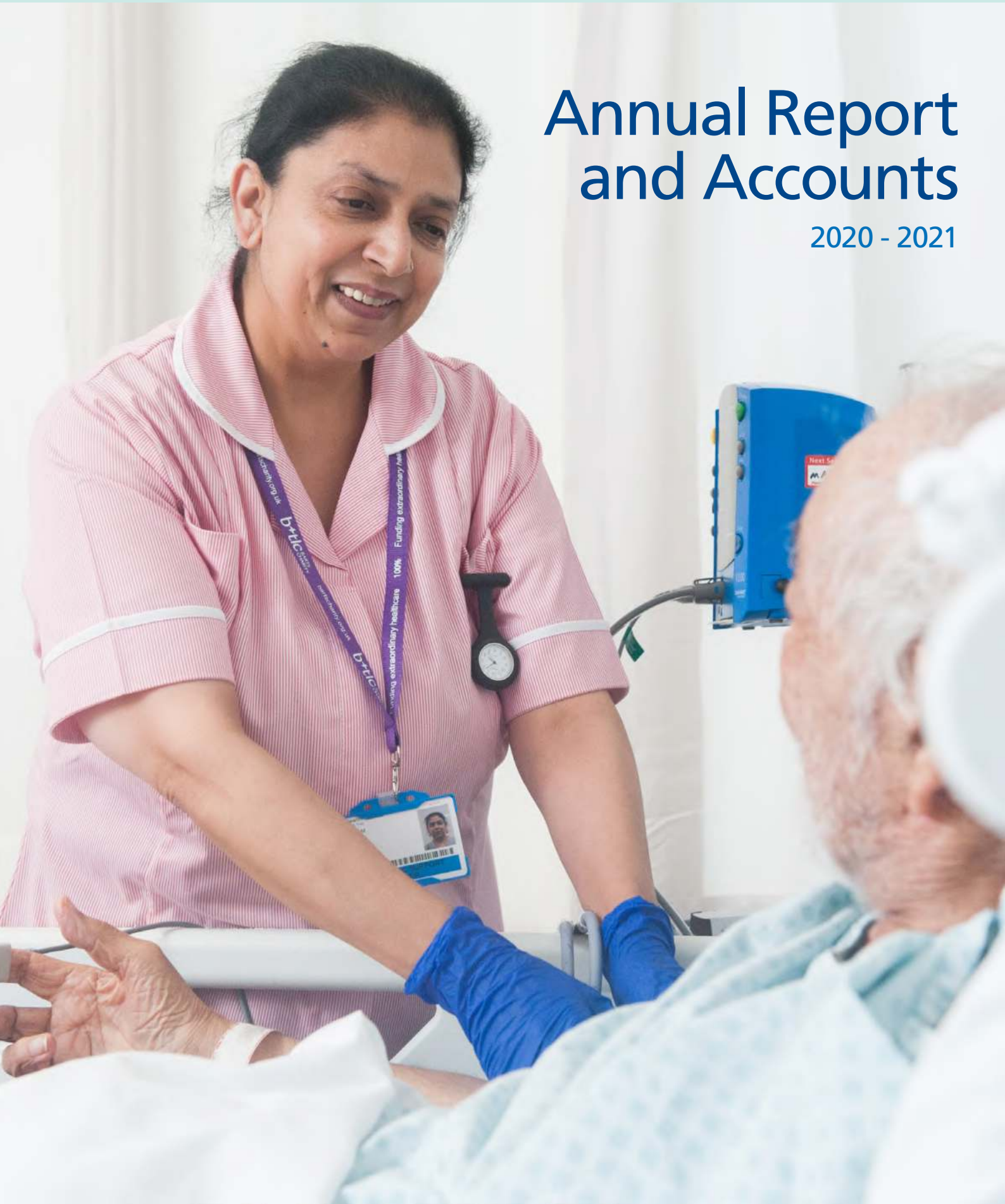
WeCare
Our vision, values and behaviours

NHS
Barts Health
NHS Trust



# Annual Report and Accounts

2020 - 2021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# Group CEO foreword

2020/21 represented a year dominated by the coronavirus Covid-19 pandemic. This previously unknown disease took lives and had far reaching effects across the world. The impact on the NHS has been profound and is likely to continue for some time, as the process of safely restoring services progresses. During the year the Trust dealt with more than 12,000 coronavirus cases. Many thousands of patients have now recovered from Covid-19 thanks to the skill and compassion of our hospital staff. Our hospitals have transformed in adapting to the new clinical circumstances and our staff have responded with patience, professionalism and pride in their work. Evidence of Trust staff exemplifying the organisation's WeCare values has been provided by widespread recognition in local communities, the media and in national honours. The Trust has among the most diverse catchment populations in the country. Covid-19 also shone a spotlight on health inequalities through its disproportionate impact on BAME communities.

The first wave of the pandemic between March and May 2020 provided a shock to healthcare systems in the UK and worldwide. The second wave of the pandemic during the winter of 2020/21 lasted longer than the first, and its peak was higher for a longer period. This was particularly true of the experience in north east London, with our hospitals treating more than double the number of Covid-19 patients than in the first wave. While we plan for potential further pandemic peaks in the winter ahead, we take confidence from what we've already achieved. Our leadership enabled us to take on the running of the temporary hospital at NHS Nightingale London, to deliver critical care training to hundreds of staff, and to double our own numbers of intensive care beds. This included fitting out two floors of The Royal London that were previously empty to create six permanent new wards and embracing innovative approaches such as the creation of the north east london critical care transport and retrieval service (NECCTAR) .

In 2020/21 we streamlined our approach to focus on three strategic objectives directly linked to pandemic priorities: to create an inclusive organisation by taking a systematic Trust-wide approach to eliminating discrimination and racial inequality; to restart and transform clinical services to provide equitable access, high quality outcomes and a focus on population health;and to make progress on our longer term strategic priorities. This report, in conjunction with the Quality Account, confirms the progress made against these objectives.

Against the backdrop of such severe challenges, the Trust worked more closely than ever before with our partners across North East London on implementing the principles of the NHS long-term plan to create a more seamless and integrated healthcare system for the future.

As the pandemic stretched clinical teams to face new challenges, innovative approaches were embraced and have since been retained in plans for new patient pathways and the roles of multiple agencies, guided by principles of supporting care closer to home where possible while concentrating excellence in hubs that will deliver improved outcomes. This integrated approach will be ever more important as the Trust restores its elective services and minimises long waiting times. The Trust also took on the management of the Nightingale Hospital based at the ExCel Centre, initially serving as a critical care facility for the Covid peak and subsequently as a vaccination hub, providing much needed support for East London's population. Barts Health has played a key role in the widely-celebrated success of the coronavirus vaccination programme, with a key role in hosting research trials, delivering 1,620 vaccinations in hospital hubs, and a further 51,683 at the ExCeL.

Despite the pandemic, progress continued on some key strategic developments, including the establishment of a pathology network (in partnership with Homerton University Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust); visible progress being made on the redevelopment of Whipps Cross University Hospital, accompanied by significant engagement with stakeholders and the local community on its design and planning; major investment in refurbishment and fire safety improvement works at Newham Hospital; and further progress towards realising the Whitechapel lifesciences vision. 2020/21 was also a notable year for Barts Health in terms of financial sustainability, with confirmation in December 2020 that the Trust had exited financial special measures and the Trust reporting an unaudited breakeven position for the financial year. This financial stability was accompanied by significant investment in the Trust's infrastructure, with approximately double the capital spend of 2019/20.

Barts Health can, therefore, look back on 2020/21 with some pride in its achievements but also embrace the great potential of the year ahead, building on the confidence gained from its handling of the seismic challenges of coronavirus. Perhaps symbolically, the Trust enters 2021/22 contemplating preparations for the 900 year anniversary celebration of St Bartholomew's Hospital's existence, with its origins in the founder Rahere's desire to provide care for all including the poorest inhabitants of London. We couldn't have achieved so much this year without the support of our people, our partners, and our public. I would especially like to thank local businesses and charities, including Barts Charity for their unstinting support, which helps us offer extraordinary healthcare to the people of east London and look after the wellbeing of our staff.

**Dame Alwen Williams, DBE,**
Group Chief Executive Officer

28 June 2021

# 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 2020/21 is provided separately via the monthly Integrated Performance Report published 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 of this annual report (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 WeCare 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 equip our local 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. Some specific themes that have been identified during the pandemic have included the need to expand critical care capacity; to ensure hospital design is flexible to deliver required infection prevention and control standards (supporting the need for hospital redevelopment); and to support digitally enabled care closer to home (outside the hospital setting, whether through virtual outpatients clinics or outreach services).

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 objectives for 2021/22 relating to the following themes: creating an inclusive organisation; effective restoration of clinical services as the Trust emerges from the pandemic; and delivering longer term strategic transformation ambitions. This builds on a similar approach taken in terms of scale and focus to objective setting in 2020/21.

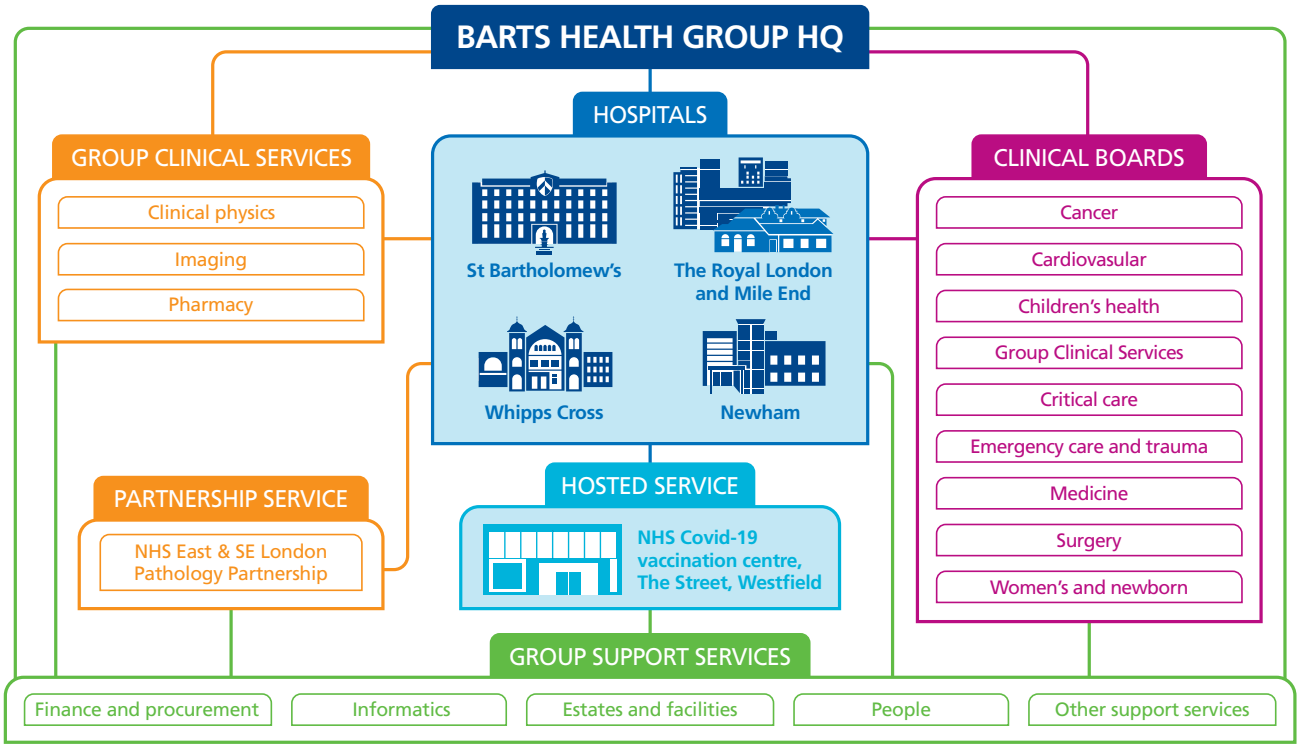
As we evolve our group operating model, the role of clinical boards plays an increasingly crucial role, constantly reviewing our strategy for developing services (incorporating the role of system partners in this transformation) while retaining the principles of sustaining consistent and high standards of care across the group and sector. The trust has developed a 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. These act as a bridge between our over-arching group strategy and our annual business plan.

## Group model

Barts Health NHS Trust is an acute provider of clinical services to populations based in north east London and beyond. The Trust's organisational model 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 their respective clinical services; accordingly the majority of Barts Health's staff and resources are managed by the hospitals.
- Clinical Boards: clinical boards, led by a chair, have a trustwide role for specialities within their remit – this focuses on devising strategy and vision for their specific service across the group, setting standards and minimising variation, supporting group collaboration, with input to research and innovation.
- Group Clinical Services (GCS), 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 comprising all corporate directorates.

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 provides 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 key clinical activities are routinely reported in the quality dashboard and annually in the Quality Account.

Monthly performance reviews of hospitals and Group Clinical 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 alongside hospital representation. Quarterly assurance meetings are held with each clinical board.

Performance review meetings have continued throughout 2020/21, with only minimal interruption to these as a result of the pandemic.

External oversight has been provided jointly by NHS London and the East London Health and Care Partnership.

## Performance – management information

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

Analysis within the IPR 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 and business planning methodology.

In 2020/21 the IPR has been extended to incorporate the key metrics used by the Trust to monitor and manage the pandemic. These have included staff vaccination rates, Covid-19 caseloads with acuity breakdowns, oxygen supply data and staffing absences associated with Covid-19.

Recognising the focus on recovering elective activity during 2021/22, a dedicated elective activity tracker has been established and a specific weekly Group Executive Board meeting arranged to monitor progress on boosting activity and minimising long waits.

## 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 successfully launched the next generation reporting platform called 'WeInform' in March 2021, using Qlik Sense as the tool. The platform additionally enables users to access the data and dashboards from the 'Weinform' platform on mobile devices and can alert users to a specific metric and data point. The data feeding the WeInform platform is sourced from the reporting database in the Data Warehouse, which is validated for data accuracy and consistency. The reporting database is continuously improved and being built with more datasets. The next step in the journey, is to migrate all the QlikView dashboards into the modern WeInform platform and build additional clinical and operational dashboards, including predictive analytics such as demand and capacity modelling. Additionally, the WeInform team are collaborating with Quality Governance colleagues to advance the actionable insight agenda and continue to democratise the trusts wealth of data and knowledge.

## 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. NHS Planning Guidance, along with associated North East London system level financial allocations and details of the financial arrangements to operate April-September 2021, were published on 25 March 2021. The Trust will engage with system partners to validate system envelope funding assumptions, and to align with the wider NHS planning process the April-September budget will be submitted for approval by the Trust Board in June 2021. Further details are provided in the annual accounts section.

Barts Health
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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:

**Dame Alwen Williams, DBE,**
Group Chief Executive Officer

28 June 2021

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

Entering the financial year 2020/21, we faced a monumental challenge due to the uncertainties of the COVID19 pandemic, and a national lockdown which seriously impacted on our staff, our external partners and the treatment of our patients.

Despite these challenges, we worked with our partners in the North East London Sustainability and Transformation Partnership to deliver our collective financial target, and we successfully achieved a small surplus of £0.1m. This is a significant achievement for the Trust given the historic period of financial challenge. In recognition of the period of the sustained improvement in delivery of financial sustainability and planning the Trust received the welcome news of being removed from Financial Special Measures by the healthcare regulators. The achievement marks another step for the Trust towards financial sustainability and recognises the hard work from our staff and the Board.It also highlights the significant contribution and leadership of the Trust in the development of the East London Health & Care Partnership (ELHCP) and in working with the London Region.

Our balance sheet has been strengthened by the recent changes in the financing regime, which transferred our loan debt to Public Dividend Capital. This has placed us in a strong position to help drive better value for each pound we spend whilst improving patient care. We invested over £138m in our capital infrastructure and equipment to support the delivery of services and to respond to the COVID19 pandemic. This is more than double the amount we have historically spent and was largely as a result of responding to the severe impact from the pandemic. We invested in expanding our Critical Care capacity as well as a large investment in improving our staff facilities as part of our health and wellbeing offering. The capital programme was funded through various sources, including Public Dividend Capital funding and donated loan equipment from the Department of Health & Social Care, internal resources and through kind donations from the Barts Charity. Our exciting Whipps Cross Hospital development programme has started. This significant investment will have long term benefits for the population we serve.

Both capital and revenue spend was impacted by the COVID19 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 2021/22. We recognise that we have long-standing commitments such as payments for our Private Finance Initiative (PFI) estate, which places a significant financial burden on the Trust. Our future total net PFI liability at the end of the financial year was £966m, and our unitary charge payments to our PFI providers in the year were £126m. The PFI schemes for Barts and the Royal London, and Newham Hospital, run to 2048 and 2039 respectively, and will require sustained central support given their contractual terms. (Notes 22 and 28 of the annual accounts provide further detail). Given the structural nature of the financial commitments for the initiative, we will need to mitigate the PFI excess costs, and will continue to work with our NHS partners to place ourselves on a stronger financial platform.

We continue to work with partners and stakeholders to ensure we maintain financial control through our governance structure as we start to emerge from the pandemic. The financial achievements in 2020/21 have been driven by a set of unique circumstances however our positive response has allowed us to build a strong financial foundation for the future.

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 31 March 2021, there were no executive or non-executive vacancies. The Trust Board seeks to reflect the local population it serves and, as part of succession planning, includes an additional associate non executive director and a NExT director. The Trust has participated in the national NExT director programme in recent years, which is designed to identify the next generation of non-executive directors from under-represented groups (with one current NED successfully transitioning from a NExT director role into a substantive NED position). Looking ahead, the Trust Board will look to appoint substantively to its chair and director of people positions following announced departures.

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 group chief executive to the group 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 last reviewed and approved in 2019/20). The Trust Board meet regularly in public to discharge its duties (the board met 5 times in public during 2020/21, 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. Other NEDs are appointed in an independent capacity, generally for an initial four-year term, with the potential for reappointment of NEDs for further terms of office (within a maximum length of service of ten years). The Trust Chairman leads on monitoring the composition of the board, ensuring that it provides an appropriate balance of skills, experience and knowledge.

## Board members –biographies of board members (as at 1 April 2021)

*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. Ian also chairs a number of small technology companies, and is Vice Chair of Peabody Housing Association where he chairs their Development Committee. He had formerly served as a Non Executive Director at Central and North West London NHS Foundation Trust. Ian announced his appointment as chair of the recently established UK Health Security Agency and will hand over his Barts Health chairmanship following the identification of a successor.

*Dame Alwen Williams, DBE (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.

Previously, Alwen had served as 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. In 2009, she was made a CBE and in 2021, she was made a Dame, recognising her services to healthcare in London.

***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 director of Camellia plc and Moxico Resources plc. He is a member of the finance and audit committees of the National Gallery, having previously been a trustee and chair of these committees. He has also been a founder board member of the UK India business council and the international board of AMREF Health Africa, the chair of the audit committee of The Law Society, 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.

***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, OBE (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 her NHS Improvement role, 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. In addition to her Barts Health role, Dr McLean is chair of Nottingham and Nottinghamshire Integrated Care System as well as chairing Derby and Burton University Hospitals NHS Foundation Trust.

***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 University, before undertaking post graduate studies at Nottingham.

*Natalie Howard (non-executive director)* joined Barts Health NHS Trust in December 2017. Natalie joined Schroders in 2020 as a head of department. Previously Natalie had been appointed at 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.

*Margaret Exley (non-executive director)* joined Barts Health NHS Trust in January 2018. Margaret has a first degree in Economics from Manchester University and a master's degree in business from Warwick Business School. In 2001 she was awarded a CBE in the Queen's Birthday Honours List for services to management in the public sector. She has held a variety of non-executive and public service roles including at HM Treasury, St Mary's NHS Trust and the Field Group plc. Margaret has extensive experience of consulting and advisory work on organisation change, leadership, and organisation design in significant organisations in the public and private sectors.

*Clyde Williams (associate non-executive director)* has a long history of working in East London, having previously served on the board at East London NHS Foundation Trust and as a director at the London Hospital in Whitechapel before it became The Royal London Hospital. He is currently a director of ShoNet, a cloud computing technology business based in London and New Delhi which helps implement digital systems for health organisations.Clyde has extensive experience working across Europe, Africa and the Middle East as a technology consultant for IBM to determine how modern technology can improve the quality of services they deliver for customers. He has also partnered with the Academy of Medical Sciences to overhaul their data infrastructure.He will help the Trust inform its engagement with local communities, and also bring insights from his support to young entrepreneurs in Tottenham and leading a digital skills project to address the underrepresentation of particular groups in the technology sector

*Tajinder Rehal (trainee on the NHS NExT Director scheme to develop future non-executive Board members)* is the commercial director responsible for marketing a portfolio of HIV medicines internationally at ViiV Healthcare, which is majority owned by GSK. She joined the pharma giant's selective leadership programme in 2014 and has held a number of senior roles at local, regional and global level. Before that, most of Tajinder's career was spent in the NHS. After training as a clinical pharmacist she worked at St Mary's Hospital in Paddington, and subsequently she moved into pharmacy management at Barking, Havering and Redbridge NHS Trust. She was Assistant Chief Pharmacist there for a period and subsequently a general manager responsible for the operational management of two acute hospitals. During this time she completed an executive MBA and was mentored by the Chief Executive of Moorfield's Eye Hospital. Tajinder feels a strong connection to the NHS, and is passionate about the delivery of great care to our patients. She combines the perspective of a clinician and NHS manager with experience from the commercial world and strong local roots. She was born and brought up in East London and now lives in Woodford. As a local resident she has personal experience of Whipps Cross Hospital, The Royal London (where her second son was born) and St Bartholomew's Hospital, where her husband trained.

*Shane DeGaris (group 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 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.

*Caroline Alexander, CBE (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. In 2020, Caroline received a CBE in recognition of her services to healthcare.

*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.

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.

*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 Pantlin confirmed his departure to join Surrey and Sussex Heartlands Integrated Care System in April 2021.

*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.

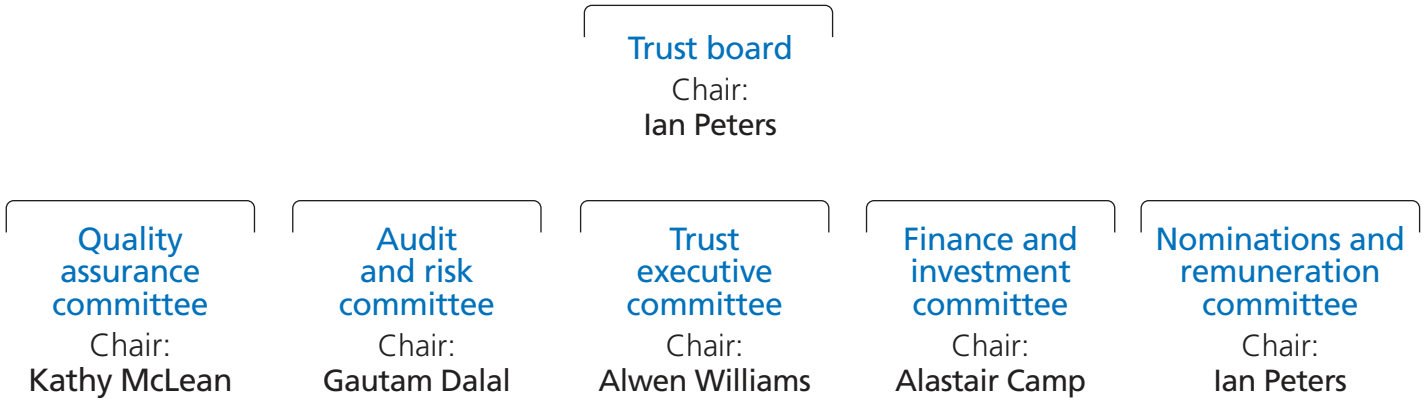
*Ralph Coulbeck (director of strategy)* was appointed director of strategy for the Trust in April 2016. He began his career on the NHS management training scheme and has worked in the NHS, parliament and government. He was previously director of strategy at the NHS Trust Development Authority and also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

## Trust Board and board committees

The membership of 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 2021 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.




## 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 consists only of NEDs, in line with good practice recommendations. Exception reports are provided to the trust board (based on use of a standard proforma reporting template) following each meeting. On 4 November 2020 the Trust Board approved the committee's annual report, which confirmed compliance with the above key duties in its terms of reference; and its revised ToR.

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

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

## Quality assurance committee

The quality assurance committee is a standing assurance committee of the trust board 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 complements 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. 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 2020/21, the quality assurance committee included a specific focus on implementation of quality objectives, pandemic-related quality and safety issues and operational targets. Exception reports were provided to the trust board (based on use of a standard proforma reporting template) following each meeting. On 5 May 2021 the Trust Board approved the most recently revised ToR for the Committee. The committee's annual report, which confirmed compliance with the key duties in its terms of reference was approved by the audit and risk committee in October 2020.

Membership: 4 non executive directors (Dr Kathy McLean – chair, Margaret Exley, Prof Steve Thornton and Alastair Camp), group 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. On 4 November 2020 the Trust Board approved the committee's annual report, which confirmed compliance with the above key duties in its terms of reference; and also approved its revised ToR.

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. In attendance: group chief executive, trust secretary, director of people

## 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. On 4 November 2020 the trust board approved the committee's annual report, which confirmed compliance with the above key duties in its terms of reference; and also approved its revised ToR.

Membership: Four non executive directors (Alastair Camp – chair, Natalie Howard, Gautam Dalal, Kim Kinnaird), group chief executive, group deputy chief executive, chief finance officer, director of people, director of strategy.

## Group executive board (executive committee)

While not a Board committee chaired by a NED, the group executive board, chaired by the group chief executive, is the Trust's 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 will evolve to perform an enhanced oversight but reduced operational role (supported by other executive group boards).

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

## Board committee effectiveness

During March-April 2021 the members of the principal board committees – the Audit and Risk Committee, Quality Assurance Committee and Finance and Investment Committee undertook a 34 point self-assessment survey (with the same questionnaire used in order to provide a basis for comparison across the committees). The scores, comparators and comments were reviewed by the respective committees during April and June 2021. The Finance and Investment Committee recognised positive results across the range of questions. The Audit and Risk Committee concluded similarly that the results reflected good working arrangements with emerging plans to strengthen Internal Audit arrangements providing further scope for improvement.

## Attendance by members of board committees, 2020-21

*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 | 5/5 (100%) | 5/5 (100%) | | | 3/3 (100%) | |
| Gautam Dalal | 5/5 (100%) | 5/5 (100%) | 4/4 (100%) | | 3/3 (100%) | 10/10 (100%) |
| Alastair Camp | 5/5 (100%) | 5/5 (100%) | | | 3/3 (100%) | 10/10 (100%) |
| Steve Thornton | 3/5 (60%) | 5/5 (100%) | | 3/6 (50%) | 2/3 (67%) | |
| Clyde Williams | 1/1 (100%) | 5/5 (100%) | | | 1/1 (100%) | |
| Natalie Howard | 2/5 (40%) | 2/5 (40%) | | | 3/3 (100%) | 8/10 (80%) |
| Margaret Exley | 4/5 (80%) | 4/5 (80%) | 4/4 (100%) | 4/6 (67%) | 3/3 (100%) | |
| Kim Kinnaird | 5/5 (100%) | 5/5 (100%) | 4/4 (100%) | | 2/3 (67%) | 7/10 (70%) |
| Kathy McLean | 5/5 (100%) | 5/5 (100%) | 4/4 (100%) | 6/6 (100%) | 3/3 (100%) | |
| Alwen Williams | 5/5 (100%) | 5/5 (100%) | | | | 5/10 (50%) |
| Caroline Alexander | 4/5 (80%) | 4/5 (80%) | | 6/6 (100%) | | |
| Alistair Chesser | 5/5 (100%) | 4/5 (80%) | | 6/6 (100%) | | |
| Hardev Virdee | 5/5 (100%) | 5/5 (100%) | 4/4* (100%) | | | 10/10 (100%) |
| Shane DeGaris | 5/5 (100%) | 5/5 (100%) | 3/4* (75%) | 6/6 (100%) | | 7/10 (70%) |
| Michael Pantlin | 5/5 (100%) | 5/5 (100%) | | | | 1/10 (10%) |
| Ralph Coulbeck | 5/5 (100%) | 5/5 (100%) | | | | |
| Andrew Hines | 5/5 (100%) | 5/5 (100%) | 2/4* (50%) | 5/6 (83%) | | |

* In attendance

## Board effectiveness

During 2020/21, substantive appointments and reappointments have been made to non-executive roles to strengthen and consolidate the effectiveness of the trust board and in support of the group model. In line with best practice, the Trust has been in process of implementing a well-led improvement plan, based on the findings of an independent external assessment. This links with the development of Trustwide quality improvement programme, leadership development initiatives and equalities and inclusion plans. These plans reflect the organisation's wider system leadership role and incorporate a collaborative working approach. There is a commitment to incorporate a focus on board development and effectiveness as part of the 2021/22 board seminar programme (as pandemic pressures ease).

## Trust board appraisals

The process for appraisals has been established with the chair and regional director of NHS Improvement responsible for overseeing appraisals of the trust chairman; the 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 2020/21 were completed by the end of May 2021. Appraisals of the executives by the CEO are due for completion by the end of Quarter 1 2021/22. 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 completed annually in line with national fit and proper persons regulations and the Trust SOP (which sets out the scope and application of the regulations within the Trust). 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.
- Evidence of disclosure and barring service status checks.
- Confirmation of a central check against register of individuals subject to bankruptcy restrictions, sequestration or debt relief orders.
- Confirmation of professional qualifications and professional registration (for clinicans or relevant others).

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

The annual accounts includes a summary of non-executive director and executive director expenses claimed (which are reviewed 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 large and influential 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 approach.

Barts Health has agreed an outline framework for its Anchor Institution development as part of its overall programme for diversity and inclusion. This entails sustaining it work as a local employer through its Community Works for Health programme which ringfences Band 2 and 3 roles for initial recruitment from a talent pool of local residents. This talent pool is managed to assess on functional skills and suitability and includes pre-employment training and work placements when feasible. The pool is supplied though partnerships with Local Authorities and Housing Associations. Over 80 local people gained work through this route last year, including some in the vaccination campaign.

Other local employment initiatives include the Women into Health programme which provides placements for community candidates sources by LB Tower Hamlets at the Royal London and Mile End

hospitals, and the Project Search placement scheme which has been restored at Whipps Cross Hospital. Project Search generates placements and job opportunities for young people with learning disabilities, including those who are autistic and has a track record of 50% + employment following placement. A follow on coaching approach has been trialled successfully during a the last difficult year which has helped retain the 50 + Project Search candidates who now work across the Trust. In the next 6 months the Trust will seek to restore Project Search supported employment at Newham Hospital and advance planning for a Project Search cohort at Barts Hospital in the City

This work is complemented by the Healthcare Horizons' scheme offering advice and guidance to school and college students. This has helped over 1000 students in 37 schools and colleges and its widening participation approach will help over 100 students enter a health related degree course. In addition over 80 young people have started an apprenticeship or job in the NHS since the scheme commenced in 2018. Due to COVID 19 an online programme of "work experience" has been developed and this innovative approach is being developed as a bespoke platform(with the help of the JP Morgan Force for Good programme) at present.

Thanks to funding from Barts Charity and the Princes Trust, Healthcare Horizons Phase II will commence in July 2021, and will extend its reach to Years 10 and 11 to sharpen the approach to addressing inequalities by working upstream with less advantages and connected students. The Trust's Education Academy continues to work closely with the Mulberry UTC with its health and care curriculum and the Volunteer Service will continue its work with St John's Ambulance on the cadet scheme for young volunteers.

The Barts Health Futures Centre is due to launch at Newham College, Stratford - an anchor institution approach working with a further education College. Inspired by the emerging Lifesciences programme at Whitechapel, the Centre (funded by the GLA) will offer a route into health careers though a dedicated Get into Health programme and a careers practice area equipped to a hospital specification.

To capture all of this work (plus other importance activity on promoting community health (ELOPE) and violence reduction (the Violence Reduction nurse led outreach scheme),a Youth and Community Opportunities Board will be established in 2021, which will focus work on youth unemployment and educational disruption.

The Trust will continue working across NEL on its health and care careers programme, joining the dots across the health and care economy and

## Barts Health anchor framework

## System development and integrated care

During 2020/21, the Trust continued to engage in important work with system partners at borough, multi-borough, Integrated Care System (ICS), Academic Health Sciences Network and pan-London level. The publication of the health and social care White Paper Integration and Innovation in February 2021 cemented the principles for closer integration of healthcare services and underpinned developments in the following areas:

- At north east London level, the Trust is a member of the East London Health and Care Partnership ICS and its clinical senate which 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. Building on the work of the NEL Acute Alliance of hospital providers in the sector, Homerton University NHS Foundation Trust, Barking Havering and Redbridge University Hospitals NHS Trust and the Barts Health group worked together more closely than ever before to co-ordinate care for critically ill Covid-19 patients during 2020/21. Under the umbrella of the NEL ICS, proposals are now being drawn up to develop a provider collaborative arrangement across the Barking Havering and Redbridge University Hospitals NHS Trust hospitals and the Barts Health group. This closer coordination will support plans to transform healthcare services for the benefit of patients, staff and communities, while the two organisations will remain separate statutory bodies.
- At multi-borough level, the Trust is a key partner in TNW – Tower Hamlets, Newham, and Waltham Forest (formerly known as Waltham Forest and East London or WEL). 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 this footprint.
- 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) during the pandemic epitomises the increasingly system-based approach to improving patient care pathways.
- 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.
- Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust are jointly working to set up a shared pathology service from May 2021. The NHS East and South East London Pathology Partnership will be hosted by Barts Health NHS Trust, and its purpose is to provide patients and clinicians with a high-quality, cost-effective service that ensures the long-term sustainability of NHS pathology services. NHS pathology staff from Homerton and Lewisham and Greenwich will TUPE transfer to Barts Health, and existing Barts Health pathology staff will remain employed by the Trust. The Partnership will have an operating budget of c. £123m per annum, with a workforce establishment of c.900 WTE. Over the next four years, the Pathology Partnership will move to a hub and Essential Service Laboratory structure across the three Trusts.
- The new hospital redevelopment at Whipps Cross is part of first wave of the national HIP1 (Hospital Improvement Programme). Barts Health is working on next stage of business case development for 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.

- The Trust is a member of the UCLP Academic Health Science Network (AHSN) 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 development of a Lifesciences campus at Whitechapel represents a highly significant opportunity to bring together leading health, research and commercial partners in the capital and this will increasingly be a focus of the Trust's strategic plans.

## 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 2020/21 to strengthen risk management and the following highlights are noted:

- Further development of the board assurance framework with the introduction of a risk appetite domain. Used in shadow form by executive and board assurance committees, the approach to risk appetite was approved by the Board in March 2021, and will be developed further in 2021/22.
- Implementation of a dedicated risk tracking mechanism for Covid-19 risks and a dedicated risk register/risk appetite statement for the time-limited Nightingale Hospital (during its service as a support function to London's critical care capacity surge response).
- A 'substantial' assurance internal audit opinion on the Board Assurance Framework (and Covid-19 risk management arrangements) in terms of design, content and application. This assessment is supported by the 2019 independent Deloitte review of the Trust's risk management arrangements, indicating that the Trust's Risk Management Board benchmarks well with other NHS organisations.
- Publication of an updated Corporate Governance Manual setting out arrangements for risk management (in the wider context of Trust governance structures and terms of reference).
- The work of a trust wide Risk Review Group to support Hospitals, Group Support Services and Group Clinical Services in implementing the risk management policy consistently across the group. Appointment to an additional Risk Manager post during the year will better support the central function's role.

### 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 2021-22.

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 only moderate success in mitigating board assurance framework risk scores downwards during 2020/21, with the BAF reflecting the emergence of a number of high risks associated with the pandemic in the short and longer term. Assurance was however provided on the quality of services by a consistent trend of improving CQC ratings, the Trust exiting financial special measures in December 2020 and the aggregated findings of other regulatory reviews. The year-end BAF risk scores reflected continuing operational risks despite progress identified internally and by external stakeholders and regulators in managing these. Inevitably, the pandemic dominated the Trust's assessment of principal risks during the year. In March 2021, the Trust Board endorsed the incorporation of a risk appetite dimension to the Board Assurance Framework. In doing so, the Trust Board recognised the potential for this to be developed further, with plans to build on this risk appetite assessment with risk triggers to support effective escalation. Steps are also in place to more closely align the process of assessing key risks with the Trust's business planning processes (identifying priorities for action and tracking progress against these during the year).

## 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. An Internal Audit review commissioned by the risk team, extended the scope of the yearly audit of the BAF to consider the effectiveness of the Trust's arrangements for Covid-specific risk management. The overall rating for this review reflected the highest available 'substantial' assurance rating.

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 (in addition to standing items on risk management at Audit and Risk Committee and Quality Assurance Committee meetings). At each meeting the risk management board 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 an approved risk management policy.

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.

**Dame Alwen Williams, DBE,**
Group Chief Executive Officer

28 June 2021

# Annual Governance Statement 2020/21

## 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 2021 and up to the date of approval of the annual report and accounts.

2020/21 was a year of progress for Barts Health, including the confirmation in December 2020 that the Trust had exited financial special measures and the Trust reporting an unaudited breakeven position reported for the financial year. Given this pleasing progress on financial resilience, the financial outlook for 2021/22 appears positive. This positive outlook should, however, recognise that the national financial framework for the NHS beyond quarters 1 and 2 has yet to be confirmed. There has been no CQC inspection activity, and therefore no changes to ratings, in 2020/21. The Well-led inspection, for which the pre-inspection activity commenced in early 2020 and which was due to take place in the spring, was cancelled because of the COVID-19 pandemic. During the pandemic period the Commission have adopted a Transitional Monitoring Approach (TMA). This approach involved an information request and, following review of the submission and other information held, the Commission held a virtual conversation with key trust stakeholders to assess a particular service or area of interest. These are not inspections and cannot result in a change of rating. In 2020/21 monitoring calls were undertaken in respect of infection control and the Newham NHS COVID-19 vaccination centre at the ExCeL conference centre. Barts Health also participated in one of eight Provider Collaboration Reviews which took place across the country. This review looked at urgent and emergency care and aimed to show the best of innovation across systems under pressure, and to drive system, regional and national learning and improvement. While all of these activities could not result in a change of rating, the trust received extremely positive feedback following all of the reviews.

The Trust's overall group model governance structure was consolidated, with each hospital executive board supported by committees mirroring those supporting the group executive board at group level. Divisional structures supporting operational leadership at hospital level have been standardised across the group, with an accountability framework in place to clarify the respective roles of each element of the group's structures. The Barts Health group was extended during 2020/21 to incorporate the Nightingale Hospital based at the ExCel Centre, initially serving as a critical care facility for the Covid peak and subsequently as a vaccination hub, providing much needed support for East London's population.

### 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 were no change to the Board's voting membership during 2020/21. The desire to strengthen the Board's non-voting membership was reflected in the appointment of Clyde Williams as an associate non-executive director and Tajinder Rehal as a NExT Director (part of a programme to support NED succession planning and widen representation). There were no Trust Board vacancies at the end of the financial year; however, the Trust would be looking to recruit following the departure of Michael Pantlin in April and the confirmation that Ian Peters and Natalie Howard would be stepping down from their respective chair and NED roles in early 2021/22.

The Trust's last '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 concluded in 2019/20 ahead of an anticipated Well Led CQC re-inspection (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 and undertaking self-assessment reviews of their effectiveness.

## 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 2020/21, the Audit and Risk Committee departed from some of its historic focus, reflecting a curtailed audit programme in light of the pandemic; instead focusing on the effectiveness of risk management and its arrangements for Internal and External Audit provision (with a new External Audit partner, Mazars LLP in place and proposals for a new Internal Audit partnering arrangement considered). Standing items and assurances were received on the board assurance framework and risk management; CQC regulations, data protection and security toolkit; salary overpayments; staff engagement; LIMS systems; and budgets, income, treasury and financial reporting – with some Covid-specific reviews of Nightingale arrangements, expenditure and procurement. 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. The Trust's efficiency builds on a CQC and NHS Improvement 'Use of Resources' review during 2018 which identified strong productivity and procurement performance. Pending a return to a normalised inspection regime, the Trust remains at a 'requires improvement' CQC rating overall for its quality of services.

## 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 for 2020/21 indicated a revised target for publication of 30 June 2021.

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 arrangements for a deep dive review of selected quality indicators by external auditors was suspended for 2019/20 and 2020/21.

## 3. The risk and control framework and risk assessment

As designated Accountable Officer, I have overall accountability for risk management in the Trust. During 2020/21, 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 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 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 Trust's caldicott guardian, the SIRO has been responsible for taking ownership of information risk at Board level and advising the group 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 board assurance framework are assigned both a lead director and a lead trust board committee. The respective committees review at each of their meetings progress against those risks assigned to the committee (or a deep dive review of one of these identified principal risks).

The principal risks on the Trust's board assurance framework as approved by the board at the end of 2020/21 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 board assurance framework is updated through both a 'top down' assessment by executive 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 2020/21 internal audit report on the board assurance framework, in draft at the time of producing this Annual Governance Statement, indicated a substantial assurance rating on the design and use of the BAF (and the Trust's Covid-19 risk register and risk management arrangements) 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 investigation service (counter fraud) 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 Head of Investigations 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. The development of a more cohesive approach to identifying and use of survey themes was led by a new Director of Insight post.
- Specific public engagement activities held as part of the Whipps Cross redevelopment programme.

### Staff

- The application of a WeImprove quality improvement approach to sustaining and driving innovation in the context of the pandemic.
- A strong focus on encouraging staff to raise concerns through Guardian of Safe Working and Freedom to Speak Up 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, local negotiating committee and staff partnership forum engagement with clinicians and staff representatives.
- Monitoring of national staff survey findings. 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. An increasingly sector-led approach to planning and performance management was a key feature of the NE London response to Covid-19 and the restoration of elective services subsequently. This includes joint working groups for emergency care, critical care and outpatients transformation as part of the NEL Integrated Care System (ELHCP).
- oint 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 past year has been unlike any other year in sustainability terms at Barts Health. The Trust's response to the Covid-19 pandemic has generated both swift progress but also regression in certain areas of our sustainability programme. For example, the roll out of remote working for office based staff and ability to hold virtual meetings has reduced staff travel and the associated vehicle miles and emissions. Additionally, establishing new virtual clinics for some outpatient's appointments has also eliminated significant patient travel. Covid-19 was a catalyst for introducing these ICT advances at the Trust and these new ways of working should continue to bring benefits in travel emission reductions for the future.

The report published in October 2020 'Delivering a Net Zero National Health Service' reflected that 'In the NHS, early estimates suggest that moving outpatient appointments online could have avoided 58,000,000 miles over three months.' However, a temporary staff benefit of free parking for staff has saw an increase in people travelling by car to the hospitals. Alongside with increased car use, active travel increased, as staff moved away from public transport to reduce public contact. Supporting staff cycling to work became a primary wellbeing priority over the past year, as staff needed to stay safe for themselves, their patients and their families using their commute to best personal advantage during the pandemic. 'Wheels for heroes' was mobilised at the Trust with free use of Brompton bikes. Cycle maintenance days specifically for Brompton bikes were held at the hospital sites to check over bikes to make sure they were fixed and safe. Weekly cycle maintenance days have taken place for all bikes at alternate hospitals to support people cycling in. New changing facilities with showers and extra lockers were built to support these active commutes. Additional secure and sheltered cycle storage was built at Newham hospital, a new hub for 50 cycle spaces. Cycle company's and local borough councils helped with temporary cycle storage solutions for staff. Further plans for larger scale cycle storage across our hospitals are in motion; this is a longer term project which should be finished this year. We continued to support staff through the tax-free cycle purchase schemes and increased the loan limit on these. Now that many of our staff has switched to active methods of transport, the Trust's Green and Active Travel Plan aims to support our staff to continue to travel actively.

The NHS report 'Delivering a Net Zero National Health Service' set two key targets for the NHS as a whole to achieve that Barts Health will need to make a full contribution to delivering, these are:

- For the emissions the NHS controls directly (the NHS carbon footprint), net zero by 2040 with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS carbon footprint plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The Trust is part of the Breathe London Network for air quality monitoring at our hospitals sites. The Trust is also signed up to the 'Clean Air Hospital Framework', which aims to work on ways to reduce local air pollution and protect our patients, staff and local community from the health problems associated with exposure to air pollution. We have worked with the patient transport team to ensure all hospital sites are no idling zones in line with each borough councils zero idling regulations, additional aspects are embedded training air quality into patient transport training and the transport team renewing their fleet with hybrid vehicles to comply with Ultra Low Emission Zone (ULEZ) expansion due to come into effect in October 2021. Clean Air Day 2020 reinforced the important zero idling messaging. We have set up an air quality steering group to work toward being a clean air hospital and also developed a dashboard where we can monitor progress and share with our air quality steering group.

The increase in single use waste such as PPE and clinical waste resulting from the pandemic posed a challenge to the Trust to manage over the past year. With encouragement of the Green at Barts group (a staff group working to make everything we do in caring for our patients better for the planet) reusable surgical masks are being trialled to combat this increase in waste in non-clinical areas at the Royal London Dental Hospital. Additionally, the Trust is planning to procure a new waste contract to make further improvements to recycling and waste management such as making the switch to reusable sharps containers. The Trust sustainability team held their first staff green staff liaison meeting with Green at Barts to work closer together towards delivering the Green Plan targets:

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 that is yet to be confirmed).

The COVID-19 pandemic did show what the Trust was capable of in an emergency. Climate change is a health emergency we need to react with similar urgency. We will be publishing our Green Plan once considered by board for approval. Unfortunately COVID- 19 has delayed publishing the plan. However good work has carried on in the background such as the examples above and also implementing various energy saving initiatives such as the installation of efficient LED lighting across sections of our estate and advancement on the plans for redevelopment of Whipps Cross Hospital which aims to be one of the first Net Zero Carbon Hospitals in the UK.

The Trust also has a board level lead responsible for supporting and promoting our net zero journey and the broader green NHS agenda at Barts Health. The Green 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 NHS Digital data security and protection toolkit for 2020/21 was given a later deadline for submission, 30 June 2021, than had been historically the case (linked to the postponement of the 2019/20 submission). The Trust met the standards in full with one exception – achieving the standard of 95% of staff having received annual training (reporting achievement of 91% compliance at its peak). This area of non-compliance was linked in part to the Trust having been under particularly high pressure arising from the Covid-19 pandemic, diverting attention from training initiatives. The Trust will develop an improvement plan for this standard.

The annual Internal Audit review of the Data Security and Protection toolkit received a 'reasonable' assurance rating.

In 2020-21 there were six 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:

- A clinically detailed post was circulated on social media written as if by a member of Trust staff.
- A transport provider employee filmed a patient and posted the video on social media.
- A patient received multiple appointment letters for other patients together with their own letter.
- «A supplier delivering medication left the package with the building concierge with the types of medicine visible through the bag.
- An audit of a patient record showed inappropriate access by staff not within the care team.
- Email correspondence from a patient detailing their HIV status was forwarded incorrectly to another patient instead of to an internal colleague.

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.

## 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 2020/21 the Trust Board agreed nursing and midwifery and allied health professional safer staffing workforce plans presented by the Chief Nurse with plans for 2021/22 scheduled for the July Trust Board meeting. 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

From March 2020 onwards, 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 2019/20

TThe Trust identified the following significant control issues in its Annual Governance Statement for 2019/20 (three of which have been carried forward to appear as significant control issues in 2020/21 – for which narrative appears in the relevant later section):

- Financial performance.
- Performance against standards for emergency care and elective waiting time standards.
- Never events performance.
- Fire safety improvement and capital constraints.
- Covid-19 – required changes to governance arrangements.
- External auditor appointment delays.

The Trust met its principal financial duties and targets this year and exited financial special measures; although the underlying financial deficit position is likely to remain an ongoing challenge in 2021/22, this significant overall performance improvement is reflected in this not being identified as a significant control issue in 2020/21. No further issues were identified following the successful appointment of Mazars LLP as the trusts external audit partner; while the rapid changes to governance arrangements to take account of the pandemic results in these specific historic issues not reappearing as control issues in 2020/21. Updates on all other 2019/20 significant control issues are provided in Section 4 below.

## 4. Review of effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review has been informed by:

- Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of risk management and internal control.
- Performance against national and local standards and segmentation under the Single Oversight Framework.
- The Trust's ongoing self-assessment of compliance with the CQC's Essential Standards of Quality and Safety and the findings of inspections of services at 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 2020/21 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.

### Covid-19 - requirement to amend controls environment

This report reflects the context of a particularly high level of Covid-19 cases in NE London compared to many regions. Examples of the significant impact of the pandemic for the organisation include nine staff deaths directly attributed to Covid-19 (with some meeting criteria for RIDDOR reporting); a highly stretched critical care service provision; a high risk of nosocomial infections (where the virus is transmitted by staff or other patients); and a disproportionate impact of the virus on BAME individuals. These outcomes reflected the significance and urgency of changes to the Trust's controls environment. The Trust's response included physical environment changes (including Nightingale opening and expansion of additional critical care facilities), infection control-led cohorting and zoning of hospitals; and risk-based changes to safeguard staff working in hospital environments and their patients (including a risk assessment process, redeployment and shielding arrangements for more vulnerable individuals, and widespread PPE provision and social distancing).

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

The trend of high and rising levels of emergency care demand in the previous year was temporarily constrained during the pandemic, albeit that acuity and infection control zoning requirements continued to impair achievement of emergency care standards during 2020/21. The suspension of elective activity during the pandemic had a significant impact on the Trust's overall waiting list size. The number of those on the waiting list waiting for over 52 weeks rose to 61,310 by month 12. Safely reducing the volume of long waiters will be the highest priority for performance management during 2021/22.

### Never Events

The Trust continued to see similar levels of never events during 2020/21 to previous years, with 11 never events reported overall (compared with 12 reported in 2016/20). This was despite close monitoring of performance by the quality assurance committee and in part reflects a strong reporting culture at Barts Health. Improving this run rate remains a key area of focus heading into 2021/22.

### Fire safety remediation and capital constraints

years, for investment in fire safety improvement works with a focus on addressing improvement notices in place for Whipps Cross and Newham. The scale of investment in fire safety works has been higher than ever during 2020/21. However, concerns were expressed in year by new London Fire Brigade inspectors about the pace of improvements at Newham leading to amendments to the original fire improvement works schedule. A trust-commissioned independent review will report its findings to assure on the related governance arrangements for fire safety improvement plans and oversight.

### CQC regulations compliance

Although the Trust's CQC ratings for quality of services has trended strongly upwards in the last three years, the CQC issued the Trust with a Section 29A Warning Notice under the Health and Social Care Act 2008 on 28 May 2021. This required the Trust to set out its plans to improve safety, leadership and governance in Diagnostic Imaging services at The Royal London Hospital and Whipps Cross Hospital. The Trust's group clinical services directorate subsequently set out proposals to assure on the service's out of hours cover, rota management and compliance and daily escalation arrangements in the event of any staffing shortages. Further communications are planned with the CQC and other regulators to provide ongoing assurance on actions being taken and evidencing improvements.

## 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:

- Covid-19 – requirement to amend the controls environment.
- Performance against standards for emergency care and elective waiting time standards.
- Never events performance.
- Fire safety improvement.
- CQC regulations compliance (in relation to diagnostic imaging services at The Royal London Hospital and Whipps Cross Hospital)

During 2020/21, 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.

**Dame Alwen Williams, DBE,**
Group Chief Executive Officer

28 June 2021

## Appendix 1: Board assurance framework – principal risks at 31 March 2021

| Risk description |
|---|
| 1. Failure to deliver agreed inclusion commitments impairs improvements in: organisational culture, staff experience, development of all talent, morale, recruitment and retention of staff and organisational performance. Risk score: 12 |
| 2. Failure to identify healthcare inequalities and to secure equity of access and community connectivity impairs delivery of high quality, equitable healthcare outcomes. Risk score: 16 |
| 3. Failure to implement infection control compliant plans (capturing learning from the pandemic peak and a Quality Improvement approach) impacts on quality of care, staff safety and community prevalence. Risk score: 15 |
| 4. Failure to address CQC, London Fire Brigade and other regulatory body requirements and improve associated systems for early intervention impairs quality of care and the health and safety of staff. Risk score: 12 |
| 5. Failure to restore planned care to restated capacity requirements (through elective activity plans, implementation of surgical hubs and outpatients transformation) at a pace consistent with staff recovery impacts on quality of care. Risk score: 16 |
| 6. Failure to restore non elective care to restated capacity requirements (through transforming urgent and emergency care pathways, critical care expansion and managing winter pressures) at a pace consistent with staff recovery impacts on quality of care. Risk score: 16 |
| 7. Delays to the progress of a robust business case, supported by stakeholders, impairs Whipps Cross redevelopment and delivering the vision of excellent integrated care Risk score: 16 |
| 8. Failure to progress strategic plans, networks and partnerships for surgery pathology and medicine impacts on the Trust's pandemic response and developing centres of excellence. Risk score: 12 |
| 9. Failure to respond to the emerging financial framework, deliver productivity improvements and tackle structural financial issues impacts on medium term financial sustainability, the underlying run rate and strategic investment. Risk score: 16 |
| 10. Capital funding constraints impairs the provision of safe, digitally-enabled clinical environments impacting on quality and safety. Risk score: 16 |
| 11. Capital funding constraints impairs investment in infrastructure and equipment impacting on quality and safety. Risk score: 16 |
| 12. Failure to deliver research and education strategic improvement plans maximising available resources adversely affects, income, reputation and delivery of workforce targets. Risk score: 12 |

Risk scores are determined by application and validation of a 5x5 (consequence x likelihood) rating – in line with the risk scoring approach adopted by most NHS Trusts. In this scoring system, 1 represents the lowest and 5 the highest, such that a 4x4 consequence x likelihood rating produces an overall risk score of 16.

## 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)

| Note | Name and title | 2020-21 | | | | | |
|---|---|---|---|---|---|---|---|
| | | 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** | | | | | | |
| 1 | Dame Alwen Williams DBE, Group Chief Executive | 255 to 260 | 0 | 0 | 0 | 0 | 255 to 260 |
| | Shane DeGaris, Group Deputy Chief Executive | 205 to 210 | 0 | 0 | 0 | 37.5 to 40 | 245 to 250 |
| | Prof Alistair Chesser, Group Chief Medical Officer | 220 to 225 | 0 | 0 | 0 | 70 to 72.5 | 290 to 295 |
| | Caroline Alexander, Group Chief Nurse | 170 to 175 | 0 | 0 | 0 | 50 to 52.5 | 220 to 225 |
| | Hardev Virdee, Group Chief Financial Officer | 175 to 180 | 0 | 0 | 0 | 90 to 92.5 | 265 to 270 |
| | Michael Pantlin, Group Director of People | 175 to 180 | 0 | 0 | 0 | 35 to 37.5 | 210 to 215 |
| | Ralph Coulbeck, Group Director of Strategy | 150 to 155 | 0 | 0 | 0 | 35 to 37.5 | 185 to 190 |
| 2 | Andrew Hines, Group Director of Corporate Development | 155 to 160 | 0 | 0 | 0 | 0 | 155 to 160 |
| | **Non Executive Directors** | | | | | | |
| 3 | Ian Peters, Chair | 45 to 50 | 13 | 0 | 0 | 0 | 45 to 50 |
| | Gautam Dalal, Non-Executive Director and Vice Chair | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| | Alastair Camp, Non Executive Director | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| | Prof Steve Thornton, Non Executive Director | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| | Natalie Howard, Non-Executive Director | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| | Margaret Exley, Non-Executive Director | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| 3 | Dr Kathy McLean, Non-Executive Director | 10 to 15 | 5 | 0 | 0 | 0 | 10 to 15 |
| | Kim Kinnaird, Non-Executive Director | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| | Clyde Williams, Associate Non Executive Director (from 11.11.20) | 0 to 5 | 0 | 0 | 0 | 0 | 0 to 5 |
| 4 | Tajinder Rehal, Associate Non Executive Director (from 29.07.20) | 0 | 0 | 0 | 0 | 0 | 0 |

**Note (1)**: The Pensions Related Benefits figures for this Executive Director is nil, as they do not currently contribute to the NHS Pensions Scheme.

**Note (2)**: This Executive Director's pay includes a one-off pension adjustment, approved under the Trust's Employers Contribution Pension Recycle Policy. Where the Pensions Related Benefits calculation results in a negative figure, a nil figure is reported, which is the case for this director.

**Note (3)**: Expense payments (taxable benefits) are shown in hundreds, and not thousands, in line with reporting requirements. The respective amounts are £1,268 and £477 and relate to travel expenses.

**Note (4)**: Tajinder Rehal is an unpaid Associate Non Executive Director.

*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.

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

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

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

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

**Dame Alwen Williams DBE, Group Chief Executive**

28 June 2021

**Date**

| 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** | | | | | | |
| Dame Alwen Williams, Group Chief Executive (Note 1) | 240 to 245 | 0 | 0 | 0 | 0 | 240 to 245 |
| 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 |
| Caroline Alexander, Group Chief Nurse | 160 to 165 | 0 | 0 | 0 | 22.5 to 25 | 185 to 190 |
| Chrisha Alagaratnam, Group Chief Financial Officer (to 30.04.2019) (Note 2) | 10 to 15 | 0 | 0 | 0 | 0 | 10 to 15 |
| Hardev Virdee, Group Chief Financial Officer (from 04.11.2019) | 70 to 75 | 0 | 0 | 0 | 80 to 82.5 | 155 to 160 |
| Bill Boa, Finance Improvement Director (to 30.04.2019)<br>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 |
| Michael Pantlin, Group Director of People | 165 to 170 | 0 | 0 | 0 | 7.5 to 10 | 175 to 180 |
| Ralph Coulbeck, Group Director of Strategy | 125 to 130 | 0 | 0 | 0 | 32.5 to 35 | 160 to 165 |
| Andrew Hines, Group Director of Corporate Development | 140 to 145 | 0 | 0 | 0 | 37.5 to 40 | 180 to 185 |
| | | | | | | |
| **Non Executive Directors** | | | | | | |
| Ian Peters, Chair (Note 3) | 45 to 50 | 34 | 0 | 0 | 0 | 45 to 50 |
| Gautam Dalal, Non-Executive Director and Vice Chair | 5 to 10 | 0 | 0 | 0 | 0 | 5 to 10 |
| 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 |
| Thoreya Swage, Non Executive Director (to 30.11.2019) (Notes 3 and 4) | 5 to 10 | 11 | 0 | 0 | 0 | 5 to 10 |
| Mark Higson, Non Executive Director (to 09.10.2019) | 0 to 5 | 0 | 0 | 0 | 0 | 0 to 5 |
| Natalie Howard, Non-Executive Director | 5 to 10 | 0 | 0 | 0 | 0 | 5 to 10 |
| 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 |
| 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)**: Kim Kinnaird was an Associate Non-Executive Director (from 01.04.2019 to 02.02.2020)

## Pensions Table (Information Subject to Audit)

| 2020/21 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 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 2021 | Lump sum at pension age related to accrued pension at 31st March 2021 | Cash equivalent transfer value at 1st April 2020 | Real increase in cash equivalent transfer value | Cash equivalent transfer value at 31st March 2021 | 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 |
| | Shane DeGaris, Group Deputy Chief Executive | 2.5 to 5 | -2.5 to 0 | 50 to 55 | 20 to 25 | 684 | 28 | 752 | 0 |
| | Prof Alistair Chesser, Group Chief Medical Officer | 5 to 7.5 | 2.5 to 5 | 90 to 95 | 205 to 210 | 1,738 | 85 | 1,896 | 0 |
| | Caroline Alexander, Group Chief Nurse | 2.5 to 5 | 0 to 2.5 | 60 to 65 | 125 to 130 | 1,110 | 56 | 1,209 | 0 |
| | Hardev Virdee, Group Chief Financial Officer | 5 to 7.5 | 5 to 7.5 | 50 to 55 | 110 to 115 | 793 | 73 | 905 | 0 |
| 1 | Michael Pantlin, Group Director of People | 2.5 to 5 | 0 | 15 to 20 | 0 | 174 | 15 | 216 | 0 |
| 1 | Ralph Coulbeck, Group Director of Strategy | 2.5 to 5 | 0 | 10 to 15 | 0 | 106 | 8 | 137 | 0 |
| | Andrew Hines, Group Director of Corporate Development | 0 to 2.5 | -2.5 to 0 | 50 to 55 | 115 to 120 | 908 | 8 | 944 | 0 |

**Notes**

1 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.

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

**Cash Equivalent Transfer Values**

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

**Real Increase in CETV**

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

| 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 |
| | 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 |
| | 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 | 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 |
| | 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 | Michael Pantlin, Group Director of People | 0 to 2.5 | 0 | 10 to 15 | 0 | 158 | 6 | 174 | 0 |
| 2 | Ralph Coulbeck, Group Director of Strategy | 2.5 to 5 | 0 | 10 to 15 | 0 | 79 | 6 | 106 | 0 |
| | 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.

## Register of Interests - Directors

| Name | Organisation | Description | Start Date (if not whole year) | End Date (if not whole year) |
|---|---|---|---|---|
| **Non-Executive Directors** | | | | |
| Ian Peters | Emrgnt Ltd | <2% Shareholding | | |
| | The Floow | Chairman | | |
| | Switchee Ltd | <1% Shareholding | | |
| | Sagacity Solutions Ltd | Strategic advisor | | |
| | Tock Insurance | Chairman | | 31/12/2020 |
| | 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 | | |
| | Engie UK | Strategic advisor | 01/09/2020 | |
| | Agility Impact Holdings | Chairman | | |
| | UK Health Security Agency | Chairman (designate) | 31/03/2021 | |
| Natalie Howard | DRC Capital Ltd | Partner | | 31/01/2020 |
| | Schroders | Head of Dept - employment contract | 01/02/2020 | |
| Margaret Exley | SCT consulting | Director | | |
| Alastair Camp | London Institute of Banking & Finance | Chairman, pension fund | | |
| | University Hospitals Plymouth | Non Executive Director (designate) | 31/03/2021 | |
| | Local Justice Area | Magistrate - South and West Devon Local Area | 01/06/2009 | |
| | China Fleet Trust | Trustee | 01/01/2017 | |
| Tajinder Rehal | Viiv Healthcare | Director | | |
| Professor Steve Thornton | Royal College of Obstetricians and Gynaecologists | Trustee | 01/02/2021 | |
| | General Medical Council | Chair, UKMed | | |
| | Medcity | Board member | | |
| | Pulsenmore | Consultancy advice | 27/05/2020 | |
| | Medical Schools Council | Executive | | |
| | Queen Mary University of London | QMUL VP | | |
| | UCLP | Board member | | |
| | William Harvey Research Foundation | Member | | |
| | Health Data Research | Board member | | |
| Gautam Dalal | ZincOx Resources Plc | Non-Executive Director | | 09/11/2020 |
| | National Gallery | Member of Audit and Finance Committees | | |
| | Moxico Resources PLC | Non-Executive Director and Chair, Audit Committee | 01/02/2021 | |
| | Camellia Plc | Non-Executive Director and Member of the Audit Committee | | |
| Clyde Williams | Shonet Ltd | Director | | |
| Dr Kathy McLean | NHS Employers | Chair, national Staff and Associate Specialists Negotiating Committee | | |
| | Nottingham and Nottinghamshire Integrated Care System | Chair | 01/02/2021 | |
| | Care Quality Commission | Inspection lead roles | | |
| | Derby and Burton University Hospitals NHS FT | Chair | | |
| Kim Kinnaird | Lloyds Bank Group | Employment contract | | |
| **Executive Directors** | | | | |
| Dame Alwen Williams | No Interests Declared | | | |
| Professor Alistair Chesser | No Interests Declared | | | |
| Caroline Alexander | Buckinghamshire New University | Honorary Visiting Professor | | |
| | Foundation of Nursing Studies (FONS) | Trustee | | |
| Shane DeGaris | No Interests Declared | | | |
| Hardev Virdee | Point of Care Foundation | Trustee | | |
| | NEL Integrated Care System | Interim Finance Director | 01/02/2021 | |
| | King's Fund | Member, General Advisory Committee | | |
| Ralph Coulbeck | Barts Health NHS Trust | Spouse is Barts Health employee | 08/03/2021 | |
| Andrew Hines | No Interests Declared | | | |
| Mr Michael Pantlin | Harris Jones Recruitment Ltd | Sister-in-law owns company | | |

## Senior Manager numbers by salary band

| Band | Number of senior managers |
|---|---|
| Less than £5,000 | 2 |
| £10,001 - £15,000 | 7 |
| £45,001 - £50,000 | 1 |
| £150,001 - £155,000 | 1 |
| £155,001 - £160,000 | 1 |
| £170,001 - £175,000 | 1 |
| £175,001 - £180,000 | 2 |
| £205,001 - £210,000 | 1 |
| £220,001 - £225,000 | 1 |
| £255,001 - £260,000 | 1 |
| **Total** | **18** |

## Composition of Senior Managers by Gender

| Gender | Headcount | % |
|---|---|---|
| Female | 7 | 39% |
| Male | 11 | 61% |
| **Total** | **18** | **100%** |

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

In 2020/21, there were no such payments to former Trust Board members (none in 2019/20).

## Payments to past directors (Information Subject to Audit)

In 2020/21, there were no such payments (none in 2019/20).

## 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 2020/21 was £255k to £260k (2019/20: £240k to £245k). This was 6.9 times (2019/20: 6.8) the median remuneration of the workforce, which was £37k (2019/20: £36k).

In 2020/21, no individual received remuneration in excess of the highest paid Director (none in 2019/20). Remuneration ranged from the bands £0k-£5k to £255k-£260k (2019/20 £0k-£5k to £240k-£245k).

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

## Staff Costs (Information Subject to Audit)

| | 2020/21 | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently employed cost | Other | Total | Permanently employed cost | Other |
| | £000s | £000s | £000s | £000s | £000s | £000s |
| Salaries and wages | **867,466** | 867,466 | 0 | **785,679** | 785,679 | 0 |
| Social Security costs | **89,572** | 89,572 | 0 | **82,441** | 82,441 | 0 |
| Apprenticeship levy | **4,173** | 4,173 | 0 | **3,889** | 3,889 | 0 |
| NHS Pensions Scheme | **129,563** | 129,563 | 0 | **117,637** | 117,637 | 0 |
| Pension cost - other | **121** | 121 | 0 | **77** | 77 | 0 |
| Termination Benefits | **18** | 18 | 0 | **391** | 391 | 0 |
| Temporary staff | **32,501** | 0 | 32,501 | **37,939** | 0 | 37,939 |
| **Total** | **1,123,414** | **1,090,913** | **32,501** | **1,028,053** | **990,114** | **37,939** |
| | | | | | | |
| Less: costs capitalised as part of assets | **4,098** | 4,098 | 0 | **4,109** | 4,109 | 0 |
| | | | | | | |
| **Total** | **1,119,316** | **1,086,815** | **32,501** | **1,023,944** | **986,005** | **37,939** |

## Staff numbers (Information Subject to Audit)

| | 2020/21 | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| Average staff numbers | Total | Permanently employed | Other Number | Total | Permanently Employed | Other Number |
| Medical and dental | **2,949** | 2,609 | 340 | **2,822** | 2,478 | 344 |
| Administration and estates | **4,052** | 3,706 | 346 | **4,072** | 3,699 | 373 |
| Healthcare assistants and other support staff | **2,077** | 1,656 | 421 | **2,000** | 1,567 | 433 |
| Nursing, midwifery and health visiting staff | **6,042** | 4,990 | 1,052 | **6,015** | 4,909 | 1,106 |
| Scientific, therapeutic and technical staff | **1,955** | 1,699 | 256 | **1,901** | 1,626 | 275 |
| Healthcare Science Staff | **666** | 630 | 36 | **649** | 618 | 31 |
| **Total** | **17,741** | **15,290** | **2,451** | **17,459** | **14,897** | **2,562** |
| Of the above - staff engaged on capital projects | **44** | 30 | 14 | **63** | 54 | 9 |

## Staff composition (as at 31st March 2021)

| Gender | Headcount | % |
|---|---|---|
| Female | **12,914** | **71%** |
| Male | **5,230** | **29%** |
| **Total** | **18,144** | **100%** |

## Sickness absence data

Up to date information can be found at this link to the NHS Digital publication series on NHS sickness absence rates:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

## Staff Turnover Percentage

Up to date information can be found at this link to the NHS Digital publication series on NHS staff turnover rates:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

## Staff Engagement Percentage Score

The NHS Staff Survey is an important indicator of the health and well-being of our staff.

Despite the NHS facing its biggest challenge in 72 years, more staff than ever shared their views, with a record 8,141 responses to the NHS Staff Survey being received.

Our response score is shown below, and we have performed well against a median response rate of 45% (all Acute & Acute and Community Trusts).

| 2020/21 | 2019/20 |
|---|---|
| 51% | 47% |

Further information can be found at: https://www.nhsstaffsurveyresults.com/

## Trade Union Facility Time (Information Subject to Audit)

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 2020/21 | Full-time equivalent employee number |
|---|---|
| 107 | 84.0 |

**Percentage of Union Officials time spent on facility time:**

| Percentage of time | Number of Employees |
|---|---|
| 0% | 89 |
| 1-50% | 17 |
| 51-99% | 0 |
| 100% | 1 |

**Percentage of pay bill spent on facility time:**

| | Figures |
|---|---|
| Total cost of facility time | £76,884 |
| Total pay bill | £1,119,316,000 |
| Percentage of the total pay bill spent on facility time | 0.007% |

**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 | 2.99% |

## Exit Packages (Information Subject to Audit)

| | 2020/21 | | | | | |
|---|---|---|---|---|---|---|
| | Compulsory Redundancies | | Other Departures (see table below) | | Total Exit Packages | |
| Exit package cost band (including any special payment element) | Number | £000s | Number | £000s | Number | £000s |
| Less than £10,000 | | | 11 | 54 | **11** | **54** |
| £10,000 - £25,000 | 1 | 18 | 6 | 100 | **7** | **118** |
| £25,001 - £50,000 | | | 3 | 87 | **3** | **87** |
| £50,001 - £100,000 | | | 1 | 88 | **1** | **88** |
| £100,001 - £150,000 | | | | | | |
| £150,001 - £200,000 | | | | | | |
| >£200,000 | | | | | | |
| **Totals** | **1** | **18** | **21** | **329** | **22** | **347** |

| | 2019/20 | | | | | |
|---|---|---|---|---|---|---|
| | Compulsory Redundancies | | Other Departures (see table below) | | Total Exit Packages | |
| Exit package cost band (including any special payment element) | Number | £000s | Number | £000s | Number | £000s |
| 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 | | | | | | |
| >£200,000 | | | | | | |
| **Totals** | **2** | **17** | **29** | **375** | **31** | **392** |

There were no “Special Payments” in 2020/21 (nil in 2019/20).

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

**Analysis of Other Departures**

| 2020/21 | | |
|---|---|---|
| | 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* | 12 | 144 |
| Exit payments following Employment Tribunals or court orders | 9 | 185 |
| Non-contractual payments requiring HMT approval** | | |
| **Total** | **21** | **329** |

| 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** |

* 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.

*** In 2019-20 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 (Information Subject to Audit)

| | 2020/21 | 2019/20 |
|---|---|---|
| **Consultancy expenditure charged to operating expenses** | **£000s** | **£000s** |
| Consultancy services | 2,785 | 1,056 |

## Off-payroll Engagements

**For all off-payroll engagements as of 31 March 2021, for more than £245 per day:**

| | Number |
|---|---|
| **Number of existing engagements as of 31 March 2021** | 6 |
| *Of which, the number that have existed:* | |
| for less than one year at the time of reporting | 2 |
| for between one and two years at the time of reporting | 4 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | 0 |

**For all new off-payroll engagements between 1 April 2020 and March 2021, for more than £245 per day**

| | Number |
|---|---|
| **No. of temporary off-payroll engagements engaged between 1 April 2020 and 31 March 2021** | 28 |
| *Of which…* | |
| No. not subject to off-payroll legislation | 8 |
| No. subject to off-payroll legislation and determined as in scope of IR35 | 0 |
| No. subject to off-payroll legislation and determined as out of scope of IR35 | 20 |
| No. of engagements reassessed for compliance or assurance purposes during the year | 4 |
| *Of which: no. of engagements that saw a change to IR35 status following review* | 0 |

**For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021**

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

# Annual Accounts

2020 - 2021

For the year ended
31 March 2021

## 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

**28 June 2021**

**Dame Alwen Williams, DBE**
**Group Chief Executive**

**28 June 2021**

**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 on the financial statements

We have audited the financial statements of Barts Health NHS Trust ('the Trust') for the year ended 31 March 2021, 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 the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly 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 section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

### 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 this other information, we are required to report that fact.

We have nothing to report in this regard.

### Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

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

**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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit & Risk Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit & Risk Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit & Risk Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

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

**Matter on which we are required to report by exception**

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

**Responsibilities of the Accountable Officer**

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

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

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

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves 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 work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

### Report on other legal and regulatory requirements

**Opinion on other matters prescribed by the Code of Audit Practice**

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited 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:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters except on 29 June 2021 we referred a matter to the Secretary of State:

- Under section 30(b) of the Local Audit and Accountability Act in relation to the Trust's ongoing breach of its break-even duty for the three year period ended 31 March 2021; and
- Under section 30(a) of the Local Audit and Accountability Act in relation to the trust setting a deficit budget for the year ended 31 March 2021 and the resultant ongoing breach of the Trust's break-even duty for the three year period ended 31 March 2021.

### Use of the audit report

This report is made solely to the Board of Directors of Barts Health NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust 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 Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

### Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

**Lucy Nutley**
For and on behalf of Mazars LLP
Tower Bridge House, St Katharine's Way, London E1W 1DD
29/06/2021

# Audit Completion Certificate issued to the Directors of Barts Health NHS Trust for the year ended 31 March 2021

In our auditor's report dated 29 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 29 June 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

## The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in this respect.

## Certificate

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

**Lucy Nutley**
For and on behalf of Mazars LLP

Tower Bridge House, St Katharine's Way, London, E1W 1DD

10 September 2021

## Statement of Comprehensive Income

| | Note | 2020-21 £000 | 2019-20 £000 |
|---|---|---|---|
| Operating income from patient care activities | 4 | 1,542,799 | 1,455,142 |
| Other operating income | 5 | 444,873 | 242,976 |
| Operating expenses | 6 | (1,920,409) | (1,700,960) |
| **Operating surplus/(deficit) from continuing operations** | | **67,263** | **(2,842)** |
| Finance income | 11 | 16 | 475 |
| Finance expenses | 12 | (64,495) | (75,597) |
| PDC dividends payable | | (5,396) | 0 |
| **Net finance costs** | | **(69,875)** | **(75,122)** |
| Other gains / (losses) | 13 | 120 | 1,680 |
| **Surplus / (deficit) for the year from continuing operations** | | **(2,492)** | **(76,284)** |
| **Surplus / (deficit) for the year** | | **(2,492)** | **(76,284)** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 7 | (71,789) | (7,931) |
| Revaluations | 15 | 4,608 | 89,597 |
| Other reserve movements | | 4 | 0 |
| **Total comprehensive income / (expenditure) for the period** | | **(69,669)** | **5,382** |

**The Trust's financial performance against its Breakeven Duty and Control Total is shown at Note 37.**

## Statement of Financial Position

| | Note | 31 March 2021 £000 | 31 March 2020 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 14 | 62 | 100 |
| Property, plant and equipment | 15 | 1,388,653 | 1,389,714 |
| Receivables | 17 | 15,848 | 13,405 |
| **Total non-current assets** | | **1,404,563** | **1,403,219** |
| **Current assets** | | | |
| Inventories | 16 | 22,006 | 23,385 |
| Receivables | 17 | 130,837 | 193,726 |
| Cash and cash equivalents | 18 | 54,207 | 3,316 |
| **Total current assets** | | **207,050** | **220,427** |
| **Current liabilities** | | | |
| Trade and other payables | 19 | (177,462) | (179,163) |
| Borrowings | 22 | (26,774) | (621,669) |
| Provisions | 24 | (4,106) | (5,315) |
| Other liabilities | 21 | (1,954) | (6,728) |
| **Total current liabilities** | | **(210,296)** | **(812,875)** |
| **Total assets less current liabilities** | | **1,401,317** | **810,771** |
| **Non-current liabilities** | | | |
| Borrowings | 22 | (941,240) | (968,010) |
| Provisions | 24 | (17,640) | (13,859) |
| **Total non-current liabilities** | | **(958,880)** | **(981,869)** |
| **Total assets employed** | | **442,437** | **(171,098)** |
| **Financed by** | | | |
| Public dividend capital | | 1,025,279 | 342,075 |
| Revaluation reserve | | 271,082 | 338,263 |
| Income and expenditure reserve | | (853,924) | (851,436) |
| **Total taxpayers' equity** | | **442,437** | **(171,098)** |

The notes on pages 59 to 88 form part of these accounts.

The financial statements on pages 55 to 88 were approved by the Board on the 28 June 2021 and signed on its behalf by:

**28 June 2021**

**Dame Alwen Williams, DBE, Group Chief Executive**

## Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

| | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Taxpayers' equity at 1 April 2020 - b/f** | **342,075** | **338,263** | **(851,436)** | **(171,098)** |
| Surplus/(deficit) for the year | 0 | 0 | (2,492) | **(2,492)** |
| Impairments | 0 | (71,789) | 0 | **(71,789)** |
| Revaluations | 0 | 4,608 | 0 | **4,608** |
| Public dividend capital received | 683,204 | 0 | 0 | **683,204** |
| Other reserve movements | 0 | 0 | 4 | **4** |
| **Taxpayers' equity at 31 March 2021** | **1,025,279** | **271,082** | **(853,924)** | **442,437** |

## Statement of Changes in Taxpayers' 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 - b/f** | **336,885** | **257,997** | **(776,552)** | **(181,670)** |
| Surplus/(deficit) for the year | 0 | 0 | (76,284) | **(76,284)** |
| Impairments | 0 | (7,931) | 0 | **(7,931)** |
| Revaluations | 0 | 89,597 | 0 | **89,597** |
| Transfer to retained earnings on disposal of assets | 0 | (1,400) | 1,400 | **0** |
| Public dividend capital received | 5,190 | 0 | 0 | **5,190** |
| **Taxpayers' equity at 31 March 2020** | **342,075** | **338,263** | **(851,436)** | **(171,098)** |

**Information on Reserves:**

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

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

**Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the trust.

## Statement of Cash Flows

| | Note | 2020-21 £000 | 2019-20 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | | **67,263** | **(2,842)** |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6 | 56,150 | 50,932 |
| Net impairments | 7 | 15,311 | 1,764 |
| Income recognised in respect of capital donations | 5 | (16,265) | (3,086) |
| (Increase) / decrease in receivables and other assets | 17 | 65,273 | (36,673) |
| (Increase) / decrease in inventories | 16 | 1,379 | 1,013 |
| Increase / (decrease) in payables and other liabilities | 19 | (7,908) | (8,618) |
| Increase / (decrease) in provisions | 24 | 2,093 | 3,494 |
| **Net cash generated from / (used in) operating activities** | | **183,296** | **5,984** |
| | | | |
| Interest received | 11 | 16 | 475 |
| Purchase of property, plant, equipment and investment property | | (120,201) | (60,856) |
| Sales of property, plant, equipment and investment property | | 474 | 6,013 |
| **Net cash generated from / (used in) investing activities** | | **(119,711)** | **(54,368)** |
| | | | |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 683,204 | 5,190 |
| Movement on loans from the Department of Health and Social Care | | (593,246) | 143,251 |
| Capital element of finance lease rental payments | | (1,997) | (1,925) |
| Capital element of PFI | | (24,038) | (23,056) |
| Interest on loans | | (2,383) | (13,475) |
| Other interest | | (5) | (1) |
| Interest paid on finance lease liabilities | | (150) | (212) |
| Interest paid on PFI | | (63,855) | (61,265) |
| PDC dividend (paid) / refunded | | (10,224) | 0 |
| **Net cash generated from / (used in) financing activities** | | **(12,694)** | **48,507** |
| **Increase / (decrease) in cash and cash equivalents** | | **50,891** | **123** |
| **Cash and cash equivalents at 1 April - brought forward** | | **3,316** | **3,193** |
| **Cash and cash equivalents at 31 March** | 18 | **54,207** | **3,316** |

## Notes to the Accounts

# 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 2020/21 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.

In preparing the financial statements the Directors have considered the Trust's overall financial position and expectation of future financial support.

### 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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21
The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership (STP) level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed. The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)
In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

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

In 2019/20, 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.

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.

***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.

***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 the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are derecognised 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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end. (Note 15.4)

### 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. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred. 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 | 2 | 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.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

### 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.

***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 | Minus 0.02% |
| Medium-term | years | 0.18% |
| 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 | 1.20% |
| Year 2 | 1.60% |
| Into perpetuity | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of *minus* 0.95% in real terms (2019/20: minus 0.5%)

### 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 25 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 26 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in Note 26, 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, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

**1.17 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 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

**1.19 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in note 18 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

**1.20 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.

**1.21 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.

**1.22 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2020-21.

**1.23 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 2022. 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 2022, 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be re-measured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

**1.24 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.

**1.25 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 15**

Land and Building assets were revalued at 31st March 2021. 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 2021. BCIS Location Factors are also applied to the national TPI, on a Borough or County specific basis.

## 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)

| | 2020-21 | 2019-20 (Restated)* |
|---|---|---|
| | £000 | £000 |
| Block contract / system envelope income* | 1,309,399 | 1,217,573 |
| High cost drugs income from commissioners (excluding pass-through costs) | 146,546 | 143,380 |
| Other NHS clinical income | 21,697 | 22,280 |
| Community services - Block contract / system envelope income* | 15,866 | 16,212 |
| Private patient income | 1,564 | 5,305 |
| Additional pension contribution central funding** | 39,387 | 35,794 |
| Other clinical income | 8,340 | 14,598 |
| **Total income from activities** | **1,542,799** | **1,455,142** |

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS, and providers and their commissioners moved on to block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements, with a greater focus on system partnership, and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charges) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate, with the additional amount 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)

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| NHS England | 631,553 | 576,833 |
| Clinical commissioning groups | 879,645 | 836,126 |
| Other NHS providers | 14,472 | 11,671 |
| NHS other | 376 | 601 |
| Local authorities | 6,849 | 10,008 |
| Non-NHS: private patients | 1,564 | 5,305 |
| Non-NHS: overseas patients (chargeable to patient) | 4,483 | 4,863 |
| Injury cost recovery scheme | 3,847 | 9,725 |
| Non NHS: other | 10 | 10 |
| **Total income from activities** | **1,542,799** | **1,455,142** |
| **Of which:** | | |
| Related to continuing operations | 1,542,799 | 1,455,142 |

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

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| Income recognised this year | 4,483 | 4,863 |
| Cash payments received in year | 803 | 1,596 |
| Amounts added to provision for impairment of receivables | 11,755 | 5,765 |
| Amounts written off in-year* | 12,874 | 11,571 |

*In 2020/21 and 2019/20, a significant level of Overseas Visitor historical debt was written off. The recovery of this type of debt is challenging, despite best endeavours of credit control processes.

## 5 Other operating income

| | 2020-21 | | | 2019-20 | | |
|---|---|---|---|---|---|---|
| | Contract income | Non-contract income | Total | Contract income | Non-contract income | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Research and development | 49,456 | 0 | **49,456** | 58,825 | 0 | **58,825** |
| Education and training | 69,853 | 0 | **69,853** | 71,182 | 0 | **71,182** |
| Non-patient care services to other bodies | 20,119 | 0 | **20,119** | 24,584 | 0 | **24,584** |
| Provider sustainability fund (2019/20 only) | 0 | 0 | **0** | 4,370 | 0 | **4,370** |
| Financial recovery fund (2019/20 only) | 0 | 0 | **0** | 39,572 | 0 | **39,572** |
| Marginal rate emergency tariff funding (2019/20 only) | 0 | 0 | **0** | 9,360 | 0 | **9,360** |
| Reimbursement and top up funding | 179,780 | 0 | **179,780** | 0 | 0 | **0** |
| Receipt of capital grants and donations | 0 | 16,265 | **16,265** | 0 | 3,086 | **3,086** |
| Charitable and other contributions to expenditure | 0 | 23,031 | **23,031** | 0 | 436 | **436** |
| Rental revenue from operating leases | 0 | 1,722 | **1,722** | 0 | 3,207 | **3,207** |
| Other income* | 84,647 | 0 | **84,647** | 28,354 | 0 | **28,354** |
| **Total other operating income** | **403,855** | **41,018** | **444,873** | **236,247** | **6,729** | **242,976** |
| **Of which:** | | | | | | |
| Related to continuing operations | | | **444,873** | | | **242,976** |

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

| | 2020-21 | 2019-20 |
|---|---|---|
| | £000 | £000 |
| Car Parking income | 428 | 2,169 |
| Catering | 1 | 244 |
| Pharmacy sales | 1,124 | 4,769 |
| Property rental (not lease income) | 858 | 455 |
| Staff accommodation rental | 13 | 0 |
| IT recharges (external) | 230 | 681 |
| Clinical tests | 223 | 1,756 |
| Clinical excellence awards | 1,395 | 2,754 |
| Grossing up consortium arrangements | 383 | 509 |
| Other income generation schemes (recognised under IFRS 15) | 8,801 | 0 |
| Other income not already covered (recognised under IFRS 15)* | 71,191 | 15,017 |
| **Total "Other" Contract Income** | **84,647** | **28,354** |

*Includes £69m from the Trust's main CCG commissioner, and relates to a national top-up payment which covers services and funding that were not included in the 2020/21 block contract values.

## 6 Operating expenses

| | 2020-21 | 2019-20 (Restated)* |
|---|---|---|
| | £000 | £000 |
| Purchase of healthcare from NHS and DHSC bodies | 6,366 | 7,638 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 13,662 | 9,047 |
| Staff and executive directors costs | 1,115,776 | 1,022,592 |
| Remuneration of non-executive directors | 144 | 110 |
| Supplies and services - clinical (excluding drugs costs) | 161,880 | 145,252 |
| Supplies and services - general | 103,104 | 87,457 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 173,598 | 166,948 |
| Consultancy costs | 2,785 | 1,056 |
| Establishment | 11,098 | 10,039 |
| Premises | 86,388 | 62,087 |
| Transport (including patient travel) | 11,178 | 8,464 |
| Depreciation on property, plant and equipment | 56,112 | 50,862 |
| Amortisation on intangible assets | 38 | 70 |
| Net impairments (Note 8) | 15,311 | 1,764 |
| Movement in credit loss allowance: contract receivables / contract assets | 12,356 | 7,909 |
| Change in provisions discount rate(s) | 501 | 884 |
| Audit fees payable to the external auditor - statutory audit* | 143 | 157 |
| Internal audit costs | 823 | 961 |
| Clinical negligence | 53,014 | 43,131 |
| Legal fees | 2,310 | 1,524 |
| Insurance | 1,573 | 1,245 |
| Research and development | 20,939 | 22,077 |
| Education and training | 3,626 | 3,716 |
| Rentals under operating leases | 3,670 | 4,018 |
| Redundancy | 18 | 391 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI) | 26,143 | 25,659 |
| Losses, ex gratia & special payments | 163 | 30 |
| Other | 34,991 | 15,872 |
| **Total** | **1,920,409** | **1,700,960** |
| **Of which:** | | |
| Related to continuing operations | 1,920,409 | 1,700,960 |

*The fee to the external auditors is £143,160, which includes non-recoverable VAT at 20% of £23,860. The audit fee disclosures in 2019/20 have been restated to ensure consistency.

### 6.1 Limitation on auditor's liability

The limitation on auditors liability for external audit work is £0m (2019/20: £2m.)

### 6.2 Nightingale Hospital

During 2020/21, the Trust was a host Trust for a Nightingale facility as part of the regional coronavirus pandemic response.

The facility was located in the ExCeL London exhibition and international convention centre, which was provided for use as a Nightingale facility under licence with NHS England/Improvement. Other payments made by Barts Health in relation to the premises are immaterial, and largely relate to the running of the facility and include costs for services such as maintenance, security, cleaning and catering.

The costs incurred by the Trust in operating the facility have been included within the operating expenses note in these accounts (Note 6). The total costs associated with the facility are disclosed below for information. This includes where existing resources were redeployed, so the note below does not represent the additional cost to the Trust of operating the facility. The incremental costs associated with operating the facility have been reimbursed by NHS England, and included in Note 5 - Reimbursement and top up funding.

| | Gross costs 2020-21 £000 |
|---|---|
| **Running costs:** | |
| Staff costs | 2,673 |
| Other operating costs | 33,264 |
| **Total gross costs** | **35,937** |

## 7 Impairment of assets

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Other (including revaluations)* | 15,311 | 1,764 |
| **Total net impairments charged to operating surplus / deficit** | **15,311** | **1,764** |
| Impairments charged to the revaluation reserve** | 71,789 | 7,931 |
| **Total net impairments** | **87,100** | **9,695** |

When assets are revalued, 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”. As negative balances for individual assets are not permitted in the revaluation reserve, any excess impairment over and above the ring-fenced balance is charged to the Statement of Comprehensive Income (SOCI), and charged to the operating surplus or deficit.

In 2020/21, the general movement of revaluation on buildings was downwards.

*Several of the Trust’s assets, primarily at Newham and Whipps Cross, were impaired by a total of £15.311m over and above their ring-fenced revaluation reserve balances, and this has been charged to the SOCI. The main areas were in relation to fire upgrade works at Newham, and works to theatres, maternity and ward upgrades at Whipps Cross.

**Impairments of £71.789m relating to these and other assets were charged to the available balances in the revaluation reserve.

## 8 Staff Costs

| | 2020-21 Total £000 | 2019-20 Total £000 |
|---|---|---|
| Salaries and wages | 867,466 | 785,679 |
| Social security costs | 89,572 | 82,441 |
| Apprenticeship levy | 4,173 | 3,889 |
| Employer's contributions to NHS pensions* | 129,563 | 117,637 |
| Pension cost - other | 121 | 77 |
| Termination benefits | 18 | 391 |
| Temporary staff (including agency) | 32,501 | 37,939 |
| **Total staff costs** | **1,123,414** | **1,028,053** |
| **Of which:** | | |
| Costs capitalised as part of assets | 4,098 | 4,109 |

*In 2020-21, this includes the additional employer pension contribution of £39.387m (6.3%) which was paid by NHS England on the Trust's behalf (2019/20: £35.794m (6.3%))

### 8.1 Retirements due to ill-health

During 2020-21 there were 3 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £121k (£285k in 2019-20).

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

## 9 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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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% of pensionable pay.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

**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 2020/21 was 3% (2019/20:3%).

## 10 Operating leases

### 10.1 Barts Health NHS Trust as a lessor

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

| | 2020-21 | 2019-20 |
|---|---|---|
| **Operating lease revenue** | **£000** | **£000** |
| Minimum lease receipts | 1,722 | 3,207 |
| **Total** | **1,722** | **3,207** |

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| **Future minimum lease receipts due:** | **£000** | **£000** |
| - not later than one year; | 2,572 | 3,070 |
| - later than one year and not later than five years; | 9,963 | 9,834 |
| - later than five years. | 83,294 | 85,516 |
| **Total** | **95,829** | **98,420** |

### 10.2 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.

| | 2020-21 | 2019-20 |
|---|---|---|
| **Operating lease expense** | **£000** | **£000** |
| Minimum lease payments | 3,670 | 4,018 |
| **Total** | **3,670** | **4,018** |

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| **Future minimum lease payments due:** | **£000** | **£000** |
| - not later than one year; | 2,052 | 3,578 |
| - later than one year and not later than five years; | 1,065 | 1,882 |
| - later than five years. | 207 | 228 |
| **Total** | **3,324** | **5,688** |

## 11 Finance income

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

| | 2020-21 | 2019-20 |
|---|---|---|
| | **£000** | **£000** |
| Interest on bank accounts | 16 | 475 |
| **Total finance income** | **16** | **475** |

## 12 Finance expenses

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

| | 2020-21 | 2019-20 |
|---|---|---|
| | **£000** | **£000** |
| **Interest expense:** | | |
| Loans from the Department of Health and Social Care | 6 | 14,076 |
| Finance leases | 150 | 212 |
| Interest on late payment of commercial debt | 5 | 1 |
| Main finance costs on PFI schemes obligations | 34,099 | 33,631 |
| Contingent finance costs on PFI schemes obligations | 29,756 | 27,634 |
| **Total interest expense** | **64,016** | **75,554** |
| Unwinding of discount on provisions | 479 | 43 |
| **Total finance costs** | **64,495** | **75,597** |

## 13 Other gains / (losses)

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| Gains on disposal of assets | 120 | 1,680 |
| **Total gains / (losses) on disposal of assets** | **120** | **1,680** |

In 2019/20, the Trust disposed of its Steels Lane site, a community health building that was surplus to requirements.
The figures disclosed above are net of the net book value of the assets, and the costs of disposal.

## 14 Intangible assets - 2020-21

| | Software licences | IT (internally generated and 3rd party) | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2020 - b/f** | **1,704** | **670** | **2,374** |
| **Valuation / gross cost at 31 March 2021** | **1,704** | **670** | **2,374** |
| **Amortisation at 1 April 2020 - b/f** | **1,604** | **670** | **2,274** |
| Provided during the year | 38 | 0 | **38** |
| **Amortisation at 31 March 2021** | **1,642** | **670** | **2,312** |
| **Net book value at 31 March 2021** | **62** | **0** | **62** |
| **Net book value at 1 April 2020** | **100** | **0** | **100** |

### 14.1 Intangible assets - 2019-20

| | Software licences | IT (internally generated and 3rd party) | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2019** | **1,619** | **670** | **2,289** |
| Reclassifications | 85 | 0 | **85** |
| **Valuation / gross cost at 31 March 2020** | **1,704** | **670** | **2,374** |
| **Amortisation at 1 April 2019 - as previously stated** | **1,534** | **670** | **2,204** |
| Provided during the year | 70 | 0 | **70** |
| **Amortisation at 31 March 2020** | **1,604** | **670** | **2,274** |
| **Net book value at 31 March 2020** | **100** | **0** | **100** |
| **Net book value at 1 April 2019** | **85** | **0** | **85** |

## 15 Property, plant and equipment - 2020-21

| | 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 2020 - B/F** | **125,316** | **1,149,256** | **1,113** | **32,495** | **186,034** | **162** | **41,163** | **736** | **1,536,275** |
| Additions | 0 | 71,145 | 0 | 12,774 | 38,120 | 0 | 15,860 | 0 | **137,899** |
| Impairments | 0 | (71,769) | (20) | 0 | 0 | 0 | 0 | 0 | **(71,789)** |
| Revaluations | 2,194 | 2,414 | 0 | 0 | 0 | 0 | 0 | 0 | **4,608** |
| Reclassifications | 0 | 7,821 | 0 | (24,221) | 5,158 | 0 | 11,242 | 0 | **0** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (2,201) | 0 | (7,474) | (295) | **(9,970)** |
| **Valuation/gross cost at 31 March 2021** | **127,510** | **1,158,867** | **1,093** | **21,048** | **227,111** | **162** | **60,791** | **441** | **1,597,023** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2020 - B/F** | **0** | **0** | **0** | **0** | **122,980** | **162** | **22,905** | **514** | **146,561** |
| Provided during the year | 0 | 32,084 | 213 | 0 | 16,211 | 0 | 7,569 | 35 | **56,112** |
| Impairments | 0 | 15,311 | 0 | 0 | 0 | 0 | 0 | 0 | **15,311** |
| Disposals / derecognition | 0 | 0 | 0 | 0 | (1,978) | 0 | (7,474) | (162) | **(9,614)** |
| **Accumulated depreciation at 31 March 2021** | **0** | **47,395** | **213** | **0** | **137,213** | **162** | **23,000** | **387** | **208,370** |
| | | | | | | | | | |
| **Net book value at 31 March 2021** | 127,510 | 1,111,472 | 880 | 21,048 | 89,898 | 0 | 37,791 | 54 | **1,388,653** |
| **Net book value at 1 April 2020** | 125,316 | 1,149,256 | 1,113 | 32,495 | 63,054 | 0 | 18,258 | 222 | **1,389,714** |

### 15.1 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 Restated** | **125,596** | **1,065,431** | **3,631** | **24,138** | **173,232** | **162** | **47,427** | **736** | **1,440,353** |
| Additions | 0 | 24,039 | 611 | 28,539 | 11,047 | 0 | 1,454 | 0 | **65,690** |
| Impairments | 0 | (7,931) | 0 | 0 | 0 | 0 | 0 | 0 | **(7,931)** |
| Revaluations | 645 | 88,909 | 43 | 0 | 0 | 0 | 0 | 0 | **89,597** |
| Reclassifications | 0 | 11,126 | (2,762) | (20,182) | 5,481 | 0 | 6,252 | 0 | **(85)** |
| Revaluations (removal of accumulated depreciation) | (925) | (32,318) | (410) | 0 | (3,726) | 0 | (13,970) | 0 | **(51,349)** |
| **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 Restated** | **0** | **0** | **0** | **0** | **110,631** | **162** | **31,456** | **354** | **142,603** |
| Provided during the year | 0 | 28,798 | 410 | 0 | 16,075 | 0 | 5,419 | 160 | **50,862** |
| Impairments | 0 | 1,764 | 0 | 0 | 0 | 0 | 0 | 0 | **1,764** |
| Removal of Accummulated Depreciation (Valuations)* | 0 | (30,562) | (410) | 0 | (3,726) | 0 | (13,970) | 0 | **(48,668)** |
| **Accumulated depreciation at 31 March 2020** | **0** | **0** | **0** | **0** | **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 | 0 | 18,258 | 222 | **1,389,714** |
| **Net book value at 1 April 2019** | 125,596 | 1,065,431 | 3,631 | 24,138 | 62,601 | 0 | 15,971 | 382 | **1,297,750** |

*The Trust carried out a valuation of its land, buildings and dwellings at 31st March 2021 using the services of the Valuation Office Agency. As a result of this exercise, the in year depreciation in 2019/20 for buildings and dwellings totalling £30.958m has been removed in the "Revaluations" line so that the closing accumulated depreciation is shown as nil.

### 15.2 Property, plant and equipment financing - 2020-21

| | 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 2021** | | | | | | | | |
| Owned - purchased | 127,510 | 317,993 | 493 | 19,728 | 73,035 | 37,362 | 53 | **576,174** |
| Finance leased | 0 | 2,152 | 387 | 0 | 0 | 0 | 0 | **2,539** |
| On-SoFP PFI contracts | 0 | 757,317 | 0 | 0 | 0 | 0 | 0 | **757,317** |
| Owned - donated / granted | 0 | 34,010 | 0 | 1,320 | 16,863 | 429 | 1 | **52,623** |
| **NBV total at 31 March 2021** | **127,510** | **1,111,472** | **880** | **21,048** | **89,898** | **37,791** | **54** | **1,388,653** |

### 15.3 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 | 0 | 3,870 | 581 | 0 | 0 | 0 | 0 | **4,451** |
| On-SoFP PFI contracts | 0 | 776,462 | 0 | 0 | 0 | 0 | 0 | **776,462** |
| Owned - donated / granted | 0 | 35,088 | 0 | 3,477 | 8,140 | 425 | 7 | **47,137** |
| **NBV total at 31 March 2020** | **125,316** | **1,149,256** | **1,113** | **32,495** | **63,054** | **18,258** | **222** | **1,389,714** |

### 15.4 Donations of property, plant and equipment

In 2020/21, some providers received assets donated to the Trust by the Department of Health and Social Care (DHSC) as part of the response to the coronavirus pandemic.

Barts Health NHS Trust received the following categories of donated assets from the DHSC:

| | £000 |
|---|---|
| Diagnostic imaging equipment assets | 304 |
| Testing equipment assets | 336 |
| Ventilators and associated equipment assets | 9,411 |
| | **10,051** |

## 16 Inventories

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| | £000 | £000 |
| Drugs | 10,069 | 10,259 |
| Consumables | 11,645 | 12,747 |
| Energy | 292 | 379 |
| **Total inventories** | **22,006** | **23,385** |
| **Of which:** | | |
| Held at lower of cost and Net Realisable Value | 22,006 | 23,385 |

Inventories recognised in expenses for the year were £276,621k (2019-20: £251,705k).

Write-down of inventories recognised as expenses for the year were £0k (2019-20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020-21 the Trust received £22,397k of items purchased by DHSC.

The deemed cost of these inventories was charged directly to expenditure on receipt, with the corresponding benefit recognised in income.

## 17 Trade receivables and other receivables

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| | £000 | £000 |
| **Current** | | |
| Contract receivables | 89,576 | 169,717 |
| Allowance for impaired contract receivables / assets | (15,507) | (22,294) |
| Prepayments (non-PFI) | 6,821 | 4,713 |
| Prepayments (PFI) | 28,976 | 28,592 |
| PFI lifecycle prepayments | 253 | 253 |
| PDC dividend receivable | 4,828 | 0 |
| VAT receivable | 10,763 | 8,640 |
| Other receivables | 5,127 | 4,105 |
| **Total current trade and other receivables** | **130,837** | **193,726** |
| **Non-current** | | |
| Contract receivables | 7,405 | 6,582 |
| PFI lifecycle prepayments | 6,571 | 6,823 |
| Other receivables | 1,872 | 0 |
| **Total non-current trade and other receivables** | **15,848** | **13,405** |
| **Of which receivables from NHS and DHSC group bodies:** | | |
| Current | 67,044 | 113,522 |
| Non-current | 1,872 | 0 |

### 17.1 Allowances for credit losses - 2020-21

| | Contract receivables and contract assets | All other receivables |
|---|---|---|
| | £000 | £000 |
| **Allowances as at 1 Apr 2020 - brought forward** | **22,294** | **0** |
| New allowances arising | 13,717 | 0 |
| Reversals of allowances | (1,361) | 0 |
| Utilisation of allowances (write offs) | (19,143) | 0 |
| **Allowances as at 31 Mar 2021** | **15,507** | 0 |

### 17.2 Allowances for credit losses - 2019-20

| | Contract receivables and contract assets | All other receivables |
|---|---|---|
| | £000 | £000 |
| **Allowances as at 1 Apr 2019 - restated** | **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** |

### 17.3 Exposure to credit risk

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

| | 31 March 2021 | 31 March 2020 (Restated)* |
|---|---|---|
| | Trade and other receivables | Trade and Other Receivables |
| **Non NHS financial assets - Impaired** | **£000** | **£000** |
| 0 - 30 days | 1,349 | 540 |
| 30-60 Days | 214 | 493 |
| 60-90 days | 419 | 142 |
| 90- 180 days | 2,770 | 444 |
| Over 180 days | 10,755 | 14,847 |
| **Total** | **15,507** | **16,466** |
| | | |
| **Non NHS financial assets - Not Impaired** | | |
| 0 - 30 days | 3,663 | 6,145 |
| 30-60 Days | 1,619 | 3,132 |
| 60-90 days | 1,043 | 575 |
| 90- 180 days | 2,385 | 2,715 |
| Over 180 days | 3,223 | 10,568 |
| **Total** | **11,933** | **23,135** |

* The figures above have been restated to exclude financial assets under the NHS Injury Cost Recovery Scheme.

## 18 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.

| | 2020-21 | 2019-20 |
|---|---|---|
| | £000 | £000 |
| **At 1 April** | **3,316** | **3,193** |
| Net change in year | 50,891 | 123 |
| **At 31 March** | **54,207** | **3,316** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 21 | 39 |
| Cash with the Government Banking Service | 54,186 | 3,277 |
| **Total cash and cash equivalents as in SoFP** | **54,207** | **3,316** |
| | | |
| **Total cash and cash equivalents as in SoCF** | **54,207** | **3,316** |

### 18.1 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 2021 | 31 March 2020 |
|---|---|---|
| | £000 | £000 |
| Bank balances | 89 | 85 |
| **Total third party assets** | **89** | **85** |

## 19 Trade and other payables

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| **Current** | **£000** | **£000** |
| Trade payables | 66,764 | 95,129 |
| Capital payables | 6,423 | 4,990 |
| Accruals | 99,904 | 60,313 |
| Social security costs | 0 | 5,095 |
| Other taxes payable | 2,848 | 0 |
| Other payables | 1,523 | 13,636 |
| **Total current trade and other payables** | **177,462** | **179,163** |
| **Of which, payables from NHS and DHSC group bodies:** | | |
| Current | 19,688 | 33,761 |

### 19.1 Early retirements in "Other payables" above

There are nil amounts included in payables to buy out the liability for early retirements (nil in 2019/20).

## 20 Other financial liabilities

There were nil "other financial liabilities" at the 31st March 2021 (nil at 31st March 2020).

## 21 Other liabilities

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| **Current** | **£000** | **£000** |
| Deferred income: contract liabilities (IFRS 15) | 1,954 | 6,728 |
| **Total other current liabilities** | **1,954** | **6,728** |

## 22 Borrowings

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| **Current** | **£000** | **£000** |
| Loans from the Department of Health and Social Care* | 0 | 595,629 |
| Obligations under finance leases | 1,746 | 1,997 |
| Obligations under PFI service concession contracts (excl. lifecycle) | 25,028 | 24,043 |
| **Total current borrowings** | **26,774** | **621,669** |
| **Non-current** | | |
| Obligations under finance leases | 533 | 2,279 |
| Obligations under PFI service concession contracts | 940,707 | 965,731 |
| **Total non-current borrowings** | **941,240** | **968,010** |

*In 2020/21, the Department of Health and Social Care (DHSC) converted interim capital and revenue loans held by NHS providers as at 31 March 2020 to Public Dividend Capital (PDC).

### 22.1 Reconciliation of liabilities arising from financing activities

| | Loans from DHSC | Finance leases | PFI schemes | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April 2020 - brought forward** | **595,629** | **4,276** | **989,774** | **1,589,679** |
| **Cash movements:** | | | | |
| Financing cash flows - payments and receipts of principal | (593,246) | (1,997) | (24,038) | **(619,281)** |
| Financing cash flows - payments of interest | (2,383) | (150) | (34,100) | **(36,633)** |
| **Non-cash movements:** | | | | |
| Application of effective interest rate | 0 | 150 | 0 | **150** |
| Change in effective interest rate | 0 | 0 | 34,099 | **34,099** |
| Other changes | 0 | 0 | 0 | **0** |
| **Carrying value at 31 March 2021** | **0** | **2,279** | **965,735** | **968,014** |

| | Loans from DHSC | Finance leases | PFI schemes | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April 2019** | **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 - carried forward** | **595,629** | **4,276** | **989,774** | **1,589,679** |

## 23 Finance leases

### 23.1 Barts Health NHS Trust as a lessee

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

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| | £000 | £000 |
| **Gross lease liabilities** | **2,347** | **4,474** |
| **Of which liabilities are due:** | | |
| - not later than one year; | 1,803 | 2,128 |
| - later than one year and not later than five years; | 544 | 2,346 |
| - later than five years. | 0 | 0 |
| Finance charges allocated to future periods | (68) | (198) |
| **Net lease liabilities** | **2,279** | **4,276** |
| Of which payable: | | |
| - not later than one year | 1,746 | 1,997 |
| - later than one year and not later than five years | 533 | 2,279 |
| - later than five years. | 0 | 0 |

## 24 Provisions for liabilities and charges analysis

| | Pensions: early departure costs | Pensions: injury benefits | Legal claims | Redundancy | Clinicians' pension tax | Total |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **At 1 April 2020** | **11,262** | **3,963** | **761** | **0** | **3,188** | **19,174** |
| Change in the discount rate | 309 | 192 | 0 | 0 | 0 | **501** |
| Arising during the year | 2,796 | 163 | 214 | 223 | 0 | **3,396** |
| Utilised during the year | (1,015) | (215) | 0 | 0 | 0 | **(1,230)** |
| Reversed unused | (260) | 0 | (314) | 0 | 0 | **(574)** |
| Unwinding of discount | (56) | (20) | 0 | 0 | 555 | **479** |
| **At 31 March 2021** | **13,036** | **4,083** | **661** | **223** | **3,743** | **21,746** |
| **Expected timing of cash flows:** | | | | | | |
| - not later than one year; | 1,133 | 218 | 661 | 223 | 1,871 | **4,106** |
| - later than one year and less than five years; | 4,532 | 872 | 0 | 0 | 1,872 | **7,276** |
| - later than five years. | 7,371 | 2,993 | 0 | 0 | 0 | **10,364** |
| **Total** | **13,036** | **4,083** | **661** | **223** | **3,743** | **21,746** |

The majority of the Trust's provisions (£13.036m) relate to NHS Pensions early departure costs. Expected future cash flows have been discounted using the real discount rate of minus 0.95% (2019/20: minus 0.5%) (set by HM Treasury) to determine the full liability.

The Clinicans' tax liability of £3.743m relates to clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in 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.

## 25 Clinical negligence liabilities

At 31 March 2021, £858.178m was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of Barts Health NHS Trust (31 March 2020: £806.225m).

## 26 Contingent assets and liabilities

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| **Value of contingent liabilities** | **£000** | **£000** |
| NHS Resolution legal claims | (199) | (270) |
| **Gross value of contingent liabilities** | **(199)** | **(270)** |
| **Net value of contingent liabilities** | **(199)** | **(270)** |
| **Net value of contingent assets** | **0** | **0** |

## 27 Contractual capital commitments

| | 31 March 2021 | 31 March 2020 |
|---|---|---|
| | £000 | £000 |
| Property, plant and equipment | 6,338 | 19,379 |
| **Total** | **6,338** | **19,379** |

The 2020/21 capital commitments mainly relate to the fire safety works, reconfiguration, refurbishment and building works across Trust sites as well as clinical equipment purchases.

Approximately half of the 2019/20 capital commitments related to clinical equipment and building works required to increase clinical ITU capacity to treat COVID-19 patients.

## 28 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.

### 28.1 Imputed finance lease obligations on the SoFP

| | Both Sites 31 March 2021 £000 | Barts & RLH 31 March 2021 £000 | Newham 31 March 2021 £000 | Both Sites 31 March 2020 £000 |
|---|---|---|---|---|
| **Gross PFI Obligation** | **1,481,878** | **1,419,935** | **61,943** | **1,540,016** |
| **Of which liabilities are due:** | | | | |
| - not later than one year; | **58,282** | 54,603 | 3,680 | 58,139 |
| - later than one year and not later than five years; | **226,075** | 211,842 | 14,233 | 229,706 |
| - later than five years. | **1,197,521** | 1,153,490 | 44,030 | 1,252,171 |
| Finance charges allocated to future periods | **(516,143)** | (481,383) | (34,760) | (550,242) |
| **Net PFI obligation:** | **965,735** | **938,552** | **27,183** | **989,774** |
| ***Of which liabilities are due:*** | | | | |
| *- not later than one year;* | ***25,028*** | *24,292* | *736* | *24,043* |
| *- later than one year and not later than five years;* | ***101,935*** | *98,592* | *3,343* | *102,006* |
| *- later than five years.* | ***838,772*** | *815,668* | *23,104* | *863,725* |

### 28.2 Total futue PFI payments

| | Both Sites 31 March 2021 £000 | Barts & RLH 31 March 2021 £000 | Newham 31 March 2021 £000 | Both Sites 31 March 2020 £000 |
|---|---|---|---|---|
| **Total future payments committed in respect of PFI schemes** | **4,601,119** | **4,415,931** | **185,188** | **4,802,354** |
| ***Of which liabilities are due:*** | | | | |
| *- not later than one year;* | ***124,420*** | *116,055* | *8,365* | *123,425* |
| *- later than one year and not later than five years;* | ***529,564*** | *493,963* | *35,601* | *525,337* |
| *- later than five years.* | ***3,947,135*** | *3,805,913* | *141,222* | *4,153,592* |

### 28.3 Analysis of amounts paid and payable to service concession operators

| | Both Sites 2020-21 £000 | Barts & RLH 2020-21 £000 | Newham 2020-21 £000 | Both Sites 2019-20 £000 |
|---|---|---|---|---|
| **Unitary payment payable to service concession operator, consisting of:** | | | | |
| - Interest charge | 34,099 | 31,076 | 3,023 | 33,631 |
| - Repayment of finance lease liability | 24,039 | 23,309 | 730 | 23,056 |
| - Service element and other charges to operating expenditure | 26,143 | 24,066 | 2,077 | 25,659 |
| - Capital lifecycle maintenance | 8,700 | 8,161 | 539 | 9,196 |
| - Contingent rent | 29,756 | 27,874 | 1,882 | 27,634 |
| | **122,737** | **114,486** | **8,251** | **119,176** |
| Other amounts paid to operator due to a commitment under the service concession contract, but not part of the unitary payment | 3,352 | 3,352 | 0 | 4,611 |
| **Total amount paid to service concession operator** | **126,089** | **117,838** | **8,251** | **123,787** |

### 28.4 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 | **32,437** | 8,016 | 24,421 |
| Between One and Five Years | **148,340** | 45,176 | 103,164 |
| **Later than Five Years** | **1,168,730** | 375,405 | 793,325 |
| Total | **1,349,507** | **428,597** | **920,910** |

**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 | **83,618** | 24,292 | 30,311 | 29,015 |
| Between One and Five Years | **345,623** | 98,592 | 113,250 | 133,781 |
| Later than Five Years | **2,637,183** | 815,668 | 337,822 | 1,483,693 |
| **Total** | **3,066,424** | **938,552** | **481,383** | **1,646,489** |

### 28.5 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 | **2,764** | 646 | 2,118 |
| Between One and Five Years | **12,570** | 3,460 | 9,110 |
| Later than Five Years | **52,823** | 17,373 | 35,450 |
| Total | **68,157** | **21,479** | **46,678** |

**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 | **5,601** | 736 | 2,944 | 1,921 |
| Between One and Five Years | **23,031** | 3,343 | 10,890 | 8,798 |
| Later than Five Years | **88,399** | 23,104 | 20,926 | 44,369 |
| **Total** | **117,031** | **27,183** | **34,760** | **55,088** |

## 29 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.

## 29.1 Carrying values of financial assets

| Carrying values of financial assets as at 31 March 2021 | Held at amortised cost<br>£000 | Total book value<br>£000 |
|---|---|---|
| Trade and other receivables excluding non financial assets | 77,325 | **77,325** |
| Cash and cash equivalents at bank and in hand | 54,207 | **54,207** |
| **Total at 31 March 2021** | **131,532** | **131,532** |

| Carrying values of financial assets as at 31 March 2020 | Held at amortised cost<br>£000 | Total book value<br>£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** |

## 29.2 Carrying value of financial liabilities

| Carrying values of financial liabilities as at 31 March 2021 | Held at amortised cost<br>£000 | Total book value<br>£000 |
|---|---|---|
| Obligations under finance leases | 2,279 | **2,279** |
| Obligations under PFI | 965,735 | **965,735** |
| Trade and other payables excluding non financial liabilities | 156,224 | **156,224** |
| **Total at 31 March 2021** | **1,124,238** | **1,124,238** |

| Carrying values of financial liabilities as at 31 March 2020 | Held at amortised cost<br>£000 | Total book value<br>£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 | 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 held with DHSC were converted to Public Dividend Capital.

## 29.3 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

| | 31 March 2021<br>£000 | 31 March 2020 (Restated)*<br>£000 |
|---|---|---|
| In one year or less | 216,309 | 858,330 |
| In more than one year but not more than five years | 226,619 | 232,052 |
| In more than five years | 1,197,521 | 1,252,171 |
| **Total at 31 March** | **1,640,449** | **2,342,553** |

## 30 Losses and special payments

| | 2020-21 | | 2019-20 | |
|---|---|---|---|---|
| | Number of cases | Value of cases | Number of cases | Value of cases |
| | Number | £000 | Number | £000 |
| **Losses** | | | | |
| Cash losses | 184 | 501 | 56 | 81 |
| Fruitless payments | 17 | 30 | 0 | 0 |
| Bad debts and claims abandoned* | 2,772 | 12,930 | 2,860 | 11,630 |
| **Total losses** | **2,973** | **13,460** | **2,916** | **11,712** |
| **Special payments** | | | | |
| Compensation under court order or legally binding arbitration award | 1 | 14 | 0 | 0 |
| Ex-gratia payments | 55 | 22 | 72 | 26 |
| **Total special payments** | **56** | **36** | **72** | **26** |
| **Total losses and special payments** | **3,029** | **13,496** | **2,988** | **11,738** |

*In 2020/21 and 2019/20, a significant level of Overseas Visitor historical debt was written off. The recovery of this type of debt is challenging, despite best endeavours of credit control processes.

## 31 Gifts

The disclosure of gifts is only required if the total value of gifts made exceeds £300,000.
No such gifts were received in 2020/21 (2019/20: nil)

## 32 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.

Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust are jointly working to set up a shared pathology service from May 2021. The NHS East and South East London Pathology Partnership will be hosted by Barts Health NHS Trust, and its purpose is to provide patients and clinicians with a high-quality, cost-effective service that ensures the long-term sustainability of NHS pathology services. NHS pathology staff from Homerton and Lewisham and Greenwich will TUPE transfer to Barts Health, and existing Barts Health pathology staff will remain employed by the Trust. The Partnership will have an operating budget of c. £123m per annum, with a workforce establishment of c.900 WTE. Over the next four years, the Pathology Partnership will move to a hub and Essential Service Laboratory structure across the three Trusts.

This is a non-adjusting event, as the arrangements do not come into force until the 2021/22 financial year.

## 33 Related parties

During 2020/21 and 2019/20, 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 and South 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
Basildon and Brentwood CCG
Brent CCG
Castle Point and Rochford CCG
Central London (Westminster) CCG
City and Hackney CCG
Ealing CCG
East and North Hertfordshire CCG
East Berkshire CCG
Hammersmith and Fulham CCG
Havering CCG
Herts Valleys CCG
Kent and Medway CCG
Mid Essex CCG
Newham CCG
North Central London CCG*
North East Essex CCG
Redbridge CCG
South East London CCG*
South West London CCG*
Southend CCG
Southwark CCG
Thurrock CCG
Tower Hamlets CCG
Waltham Forest CCG
West Essex CCG

*In 2020/21, as part of a national NHS service redesign, a number of Clinical Commissioning Groups were merged so that they aligned with local Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs).

## 34 Better Payment Practice code

| | 2020-21 Number | 2020-21 £000 | 2019-20 Number | 2019-20 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total non-NHS trade invoices paid in the year | 171,379 | 1,204,391 | 179,331 | 1,049,390 |
| Total non-NHS trade invoices paid within target | 128,590 | 1,044,124 | 89,823 | 812,434 |
| **% of non-NHS trade invoices paid within target** | **75.0%** | **86.7%** | **50.1%** | **77.4%** |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 6,605 | 287,324 | 4,528 | 240,254 |
| Total NHS trade invoices paid within target | 1,717 | 251,949 | 1,882 | 210,022 |
| **% of NHS trade invoices paid within target** | **26.0%** | **87.7%** | **41.6%** | **87.4%** |

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.

## 35 External Financing

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

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| Cash flow financing | 13,032 | 123,337 |
| **External financing requirement** | **13,032** | **123,337** |
| External financing limit (EFL) | 13,032 | 123,337 |
| **Under / (over) spend against EFL** | **0** | **0** |

## 36 Capital Resource Limit

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| Gross capital expenditure | 137,899 | 65,690 |
| Less: Disposals | (356) | (2,681) |
| Less: Donated and granted capital additions | (16,265) | (3,086) |
| **Charge against Capital Resource Limit** | **121,278** | **59,923** |
| Capital Resource Limit | 121,278 | 60,857 |
| **Under / (over) spend against CRL** | **0** | **934** |

## 37 Breakeven duty financial performance

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| Adjusted financial performance surplus / (deficit) (control total | 123 | (73,119) |
| **Breakeven duty financial performance surplus/(deficit)** | **123** | **(73,119)** |

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

| | 2020-21 £000 | 2019-20 £000 |
|---|---|---|
| Surplus / (deficit) for the period | (2,492) | (76,284) |
| Remove net impairments not scoring to the Departmental expenditure limit (Note 8) | 15,311 | 1,764 |
| Remove I&E impact of capital grants and donations | (12,696) | 1,401 |
| **Adjusted financial performance surplus / (deficit)** | **123** | **(73,119)** |

### 37.2 Breakeven duty rolling assessment

| | 2012/13 £000 | 2013/14 £000 | 2014/15 £000 | 2015/16 £000 |
|---|---|---|---|---|
| Breakeven duty in-year financial performance | 409 | (38,270) | (79,642) | (134,881) |
| Breakeven duty cumulative position | 409 | (37,861) | (117,503) | (252,384) |
| Operating income | 1,324,338 | 1,288,172 | 1,319,964 | 1,342,594 |
| **Cumulative breakeven position as a percentage of operating income** | **0.0%** | **(2.9%)** | **(8.9%)** | **(18.8%)** |

| | 2016/17 £000 | 2017/18 £000 | 2018/19 £000 | 2019-20 £000 | 2020-21 £000 |
|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | (69,481) | (108,363) | (84,243) | (73,119) | 123 |
| Breakeven duty cumulative position | (321,865) | (430,228) | (514,471) | (587,590) | (587,467) |
| Operating income | 1,488,833 | 1,512,726 | 1,526,645 | 1,698,118 | 1,987,672 |
| **Cumulative breakeven position as a percentage of operating income** | **(21.6%)** | **(28.4%)** | **(33.7%)** | **(34.6%)** | **(29.6%)** |

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.

## Large print and other languages

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

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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.

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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.

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