WeCare
Our vision, values and behaviours

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Annual Report and Accounts

2021 - 2022


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Group CEO foreword

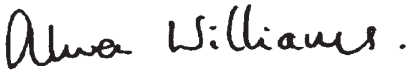
There was much to be proud of during 2021/22; a further year where the Trust's teams faced the challenges posed by Covid-19. The Trust serves some of the most diverse catchment populations in the country and Covid-19 shone a spotlight on health inequalities through its disproportionate impact on BAME communities. In the face of the greatest health emergency in the history of the NHS, our staff have, however, demonstrated resilience, determination, and flexibility. This resilience was further evidenced in our clinical teams' response to severe flooding during July, confirming the importance of both investing in our infrastructure and developing our emergency planning capability. The Trust's preparations for a third wave of Covid reflected learning from its experience in 2020/21, introducing five-point pressure thresholds for escalation, reflecting the need to scale up and down our workforce and bed requirements to align with the severity level faced. In addition to our treatment and infection control response, the Trust's central involvement in reducing the impact of Covid stepped up, with our vaccination hubs delivering over 240,000 inoculations to staff, patients and the public.

As the UK emerges from the worst of the pandemic, the foundations of our healthcare services will need to be reset with a recognition of the learning from recent experience and with a particular emphasis on inclusive care. Setting out on the journey of recovering elective care during 2021/22 has involved accelerating clinical activity to see and treat as many patients as we could while prioritising according to clinical need and risk. This has included establishing a fast-track surgical hubs at each of our hospitals. In addition to these centres, we reopened two theatres (with a bid for funding for two additional theatres) at Newham Hospital supporting high-volume, low-complexity work in general surgery and gynaecology; a pain centre at Mile End; vascular and plastics expansion at The Royal London Hospital and upscaling children's dentistry services at The Royal London dental hospital. Investing in improvements to our infrastructure has been an important focus of the last few years, with further progress made in 2021/22 on our fire safety improvement programme and ambitions to extend our Lifesciences centre at Whitechapel and secure funding for redeveloping Whipps Cross Hospital. Ensuring that the Trust's financial stewardship is considered to be credible will prove an important factor in securing scarce capital funding.

The hard work during recent years in becoming more efficient and sustainable has been reflected during 2021/22 with the Trust's improved financial 'SOF 2' rating and the discontinuation of provider compliance undertakings.

The national shift away from an internal market and towards greater integration has been reflected in the evolution of the Integrated Care System for NE London (and across sectors nationally). This provides an important opportunity for the Trust to influence the design and effectiveness of new partnerships and structures in the region. The benefits of joint working were identified early in creating the East and South East London Pathology Partnership, harnessing the benefits of greater scale and shared expertise across a wide footprint. A highly significant step was outlined in Closer Collaboration and a memorandum of understanding agreed by the boards of Barts Health and Barking, Havering and Redbridge University Hospital NHS Trust during 2021/22. A number of collaboration workstreams have been identified for early prioritisation by the two boards and will provide the basis for wider partnerships across the sector. The appointment of Rt Hon Jacqui Smith as chair-in-common was followed later in the year with the appointment of my successor, Shane DeGaris as the first joint group chief executive for both organisations. The development and alignment of green plans for both trusts in year exemplifies the shared commitment to sustainable development, while plans to align electronic patient record systems would provide an important foundation for closer working. The Trust's introduction of ePrescribing during 2021/22 provided an example of some of the benefits that could be realised for patient safety and quality from digital development.

There have been a number of changes at Board membership and hospital leadership during the year, including movements across the group of hospitals and, increasingly, across our collaboration's two trusts. As I step down in July, I will reflect on the progress made in recent years and a number of exciting opportunities ahead – not least the 900 year anniversary of St Bartholomew's Hospital and the 75th anniversary of the creation of the NHS. I would like to thank many people including local stakeholders such as Barts Charity for their unstinting support, which helps us offer extraordinary healthcare to the people of north east London and look after the wellbeing of our staff.



Dame Alwen Williams, DBE
Group Chief Executive Officer

20 June 2022

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 2021/22 has been provided separately via the monthly Integrated Performance Report published on the Trust website under the section 'about us/our board/board papers'. Details of our objectives and the risks and issues to delivery of our published operational plans 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. Performance on quality standards and clinical transformation is published in the parallel Quality Account.

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 north 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. A WeImprove approach has been adopted to listening, learning and trialling change was introduced as part of the commitment to continuous quality improvement (QI). The Trust has partnered with the Institute for Health Improvement for this work, with a set piece review of progress on QI initiatives and the Trust's safety culture over the last three years conducted in March 2022. This has been used to inform next steps for this ambitious agenda.

The Barts Health group of hospitals is playing a major part in long-term transformation to meet the changing needs of its population, working with local partners. The pandemic has accelerated a number of transformational activities including, for example, workforce redesign and a step change on virtual outpatients appointments. The appointment of a group director of transformation has reflected the importance of this at a Trust and wider sector level.

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 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 – and also similar to the approach set out in the 2022/23 operational plan.

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.

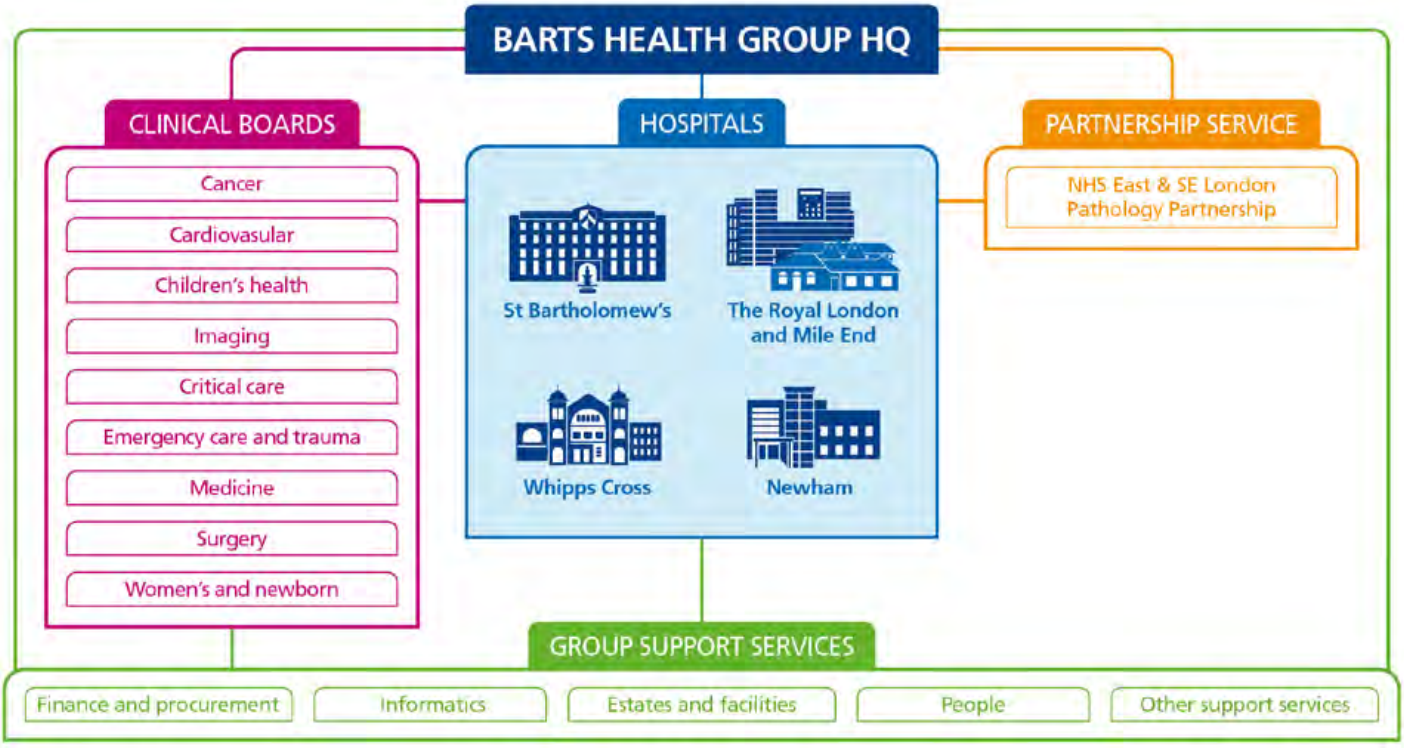
Group model

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. The wider NEL sector governance, summarised elsewhere within this annual report, provides the wider framework within which the Barts Health group operates.

The Barts Health group model comprises an operating model with a supporting accountability framework. This 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 are 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, 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. Increasingly the sector-wide joint working at service level means that the clinical boards look out beyond the Trust in seeking to set standards for clinical services in NEL.
- Group support services (GSS) are led by a management board and comprises 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 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.

External oversight of Barts Health's performance has been provided jointly by NHSE/I London and the NEL integrated care system (North 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 referral to treatment time, A&E, cancer waiting times and diagnostics waiting times.

Analysis within the IPR covers patient feedback from a range of sources including the friends and family test, national patient and staff annual surveys, as well as risk and incident reporting 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 outputs into the Trust's performance management mechanisms and business planning methodology. 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 was established, and key appointments made to support the monitoring of progress on activity increases and reducing 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 uses a next generation reporting platform called 'WeInform', using Qlik Sense as the key 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 team colleagues to advance the insight and application of performance information.

Going concern basis

Barts Health NHS Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust will engage with system partners to validate system envelope funding assumptions, and to align with the wider NHS planning process the budget will be submitted for approval by the Trust Board. Reflecting an increased sector-basis for assessing financial (and other) performance, a review of the drivers of the financial strategy for north east London is being undertaken. Further details on the Trust's financial position are provided in the annual accounts section (and in published monthly finance reporting with board papers).

Barts Health
NHS Trust

Corporate governance report

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

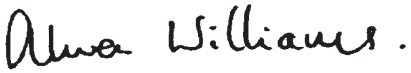
The chief executive of NHS England/Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the group chief executive should be the accountable officer of the Trust. The relevant responsibilities of accountable officers are set out in the NHS Trust accountable 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

20 June 2022

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

Entering the financial year 2021-22, we faced the colossal challenge of returning our services back to normality whilst still responding to the COVID19 pandemic. In addition we were aware of the many people waiting for treatment across our services.

Despite these challenges, we worked with our partners in the North East London Health & Care Partnership (NELHCP) to deliver our collective financial target, whilst successfully delivering a small surplus of £0.6m. This is a significant achievement for the Trust, given our historic financial challenges, and continues the upward trajectory from our 2020/21 surplus of £0.1m. We note that the whole NHS was operating under a different financial framework for 2020/21, due to the challenges faced.

During the year, we invested over £94m in our capital infrastructure and equipment to support the delivery of services, help reduce waiting times, and our continued response to the Covid-19 pandemic. The demolition works paving the way for where the new Whipps Cross Hospital will be built are now complete. The capital programme was funded through various sources, including public dividend capital, internal resources and generous donations from Barts Charity. We continue to work with our partners across the north east London health system, and nationally to secure capital funding in keeping with the size and complexity of our Trust. The PFI schemes for St Bartholomew's Hospital and The Royal London, and Newham Hospital run to 2048 and 2039 respectively, and will require sustained central support given their contractual terms. Our future total net PFI liability at the end of the financial year was £941m, and our unitary charge payments to our PFI providers in the year were £130m. (Notes 25 and 31 of the annual accounts provide further detail). Given the structural nature of the financial commitments of the PFI schemes, we will need to mitigate the excess costs, and will continue to work with our NHS partners to place ourselves on a stronger financial platform.

Looking ahead, managing resources will be challenging this year, and we will aim to do this by improving our productivity and efficiency. As we reset services and respond to the challenges of waiting times, we are encouraged by our financial performance. We continue to work with partners and stakeholders to ensure we maintain financial control through our governance structure. Our financial achievements in 2021-22 have been driven by a set of unique circumstances, however our positive response has allowed us to continue to build a sustainable financial foundation for the future.

Hardev Virdee
Group Chief Finance Officer

Trust Board role

The Trust Board is a unitary board accountable for setting the Trust's strategic direction, vision and values, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the local community. The board consists of the chairman, chief executive, four executive directors and seven non-executive directors (NEDs) all with voting rights, plus four other executive directors and one associate NED 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 NHS Trust. As at 31 March 2021, there were no executive and three non-executive vacancies (which subsequently reduced to two vacancies following the appointment of Adam Sharples with effect from May 2022). The Trust Board seeks to reflect the local population it serves and, as part of succession planning, includes an additional associate non-executive 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 in recent years). Looking ahead, the Trust Board will look to appoint substantively to its two non-executive vacancy positions during quarter 1 of 2022/23.

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 last reviewed on 19 January 2022 and board terms of reference approved in 2019/20). The Trust Board meet regularly in public to discharge its duties (the board met 6 times in public during 2021/22, 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. In view of the collaboration, due consideration is given to the potential for any new appointments to be joint appointments (serving on boards of both Barts Health NHS Trust and Barking, Havering and Redbridge University Hospital NHS Trust).

Independence of NEDs

One of the NEDs (Professor Sir Mark Caulfield) is nominated by Queen Mary University of London. 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). National guidance reflects the wider collaboration across the NHS with increasing numbers of NEDs serving on more than one trust board. Gautam Dalal was the senior independent director and vice chairman of the Trust during 2021/22. The chair 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)

Rt Hon Jacqui Smith (chair in common) Jacqui Smith joined us in October 2021 as chair in common of our trust and Barking, Havering and Redbridge University Hospitals NHS Trust. Prior to that, she was Chair of University Hospitals Birmingham NHS Foundation Trust. Following a successful teaching career, Jacqui was elected as the MP for Redditch in 1997 and served for 13 years. She was one of the longest serving ministers in the Labour government and the first female Home Secretary.
Jacqui is also Chair of the Sandwell Children's Trust, the Jo Cox Foundation and the Precious Trust which is a Birmingham based charity that supports girls at risk of violence or exploitation. She is a Trustee of the Kings Fund and works in the Middle East supporting parliamentary and political development. Jacqui is a weekly contributor to Good Morning Britain and presents the 'For the Many' podcast. In 2020 she took part in Strictly Come Dancing.

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 awarded 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 also served as 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 Sir Mark Caulfield (non-executive director is one of the country's leading authorities on genomic medicine research, and was recently appointed Chief Executive of Barts Life Sciences, our collaboration on cutting-edge clinical innovation with QMUL. Until recently he was Chief Scientist at Genomics England, where he was instrumental in delivering the 100,000 Genomes Project which has delivered life-changing results for many patients. He was knighted for this work in 2019. He remains Professor of Clinical Pharmacology in the William Harvey Research Institute at QMUL, in which capacity he has made substantial contributions to the discovery of genes related to cardiovascular health, cancer and rare diseases, with his research changing national and international guidance for high blood pressure. Sir Mark trained in clinical pharmacology at St Bartholomew's hospital, was a leading force in the creation of the Barts Heart Centre, directs the NIHR Biomedical Research Centre based at the hospital, and still practices as a consultant in the blood pressure clinic.

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.

Lesley Seary CBE (non-executive director) has spent more than three decades in local government as a senior leader. She was chief executive of Islington Council for eight years from 2011-2019 and subsequently acting chief executive at Redbridge Council. Lesley joined Barts Health NHS Trust in February 2022 and is also a non-executive director at Barking, Havering and Redbridge University Hospitals NHS Trust, our partner Trust.

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.

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.

Daniel Waldron (director of people) started his career in the housing and charity sectors where he held a number of senior operational roles before joining the NHS in 2008. In 2013, Daniel became the director of workforce and organisational development at Homerton University Hospital Foundation and in 2019 moved to Guy's and St Thomas' Foundation Trust to become director of workforce and organisational development. Daniel is a fellow of the Chartered Institute of Professional Development (CIPD) as well as a qualified executive coach.

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.

Mark Turner (interim director of strategy and planning) joins us from NHS England and Improvement, where he has been Regional Director of Commissioning for London since April 2019. Mark brings a broad range of experience in strategy development, restructuring and transformation. Over the last 10 years in the NHS this includes leading several significant regulatory interventions (including quality and finance special measures) and helping Cambridge University Hospitals to develop its approach to transformation. Most recently, Mark was senior responsible officer for the Covid-19 vaccine programme in London, delivering over 16 million vaccinations.

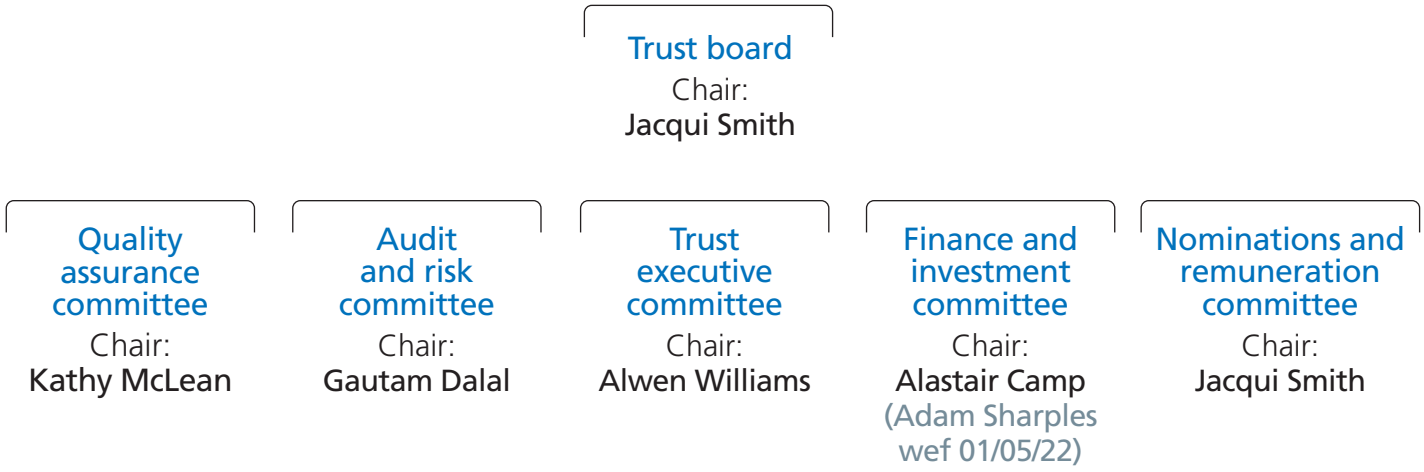
Dr Neil Ashman (director of clinical transformation) is a consultant nephrologist at The Royal London hospital and has held a variety of key posts in recent years. He was formerly deputy chief executive of The Royal London, chair of the medicine clinical board and clinical lead for the outpatient transformation programme. In his executive role Neil will work closely with the group chief medical officer, in co-ordinating the work of our nine clinical boards and shaping our over-arching clinical strategy as we emerge from the pandemic.

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 31 March 2022 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 19 January 2022, 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, Kim Kinnaird, Dr Kathy McLean, one vacancy).

In attendance: 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 2021/22, 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 3 March 2021 the Trust Board approved the most recently revised ToR for the Committee.

Membership: 4 non executive directors (Dr Kathy McLean – chair, Prof Sir Mark Caulfield, Alastair Camp, and one vacancy), associate NED, group chief executive and/or deputy chief executive, chief medical officer, chief nurse, director of corporate development, director of clinical transformation and quality improvement director.

Nominations and remuneration committee

The Trust's nominations and remuneration committee comprises the chair 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 NHSE/I, which also sets the remuneration and terms and conditions for chairs and NEDs of NHS trusts. Appointment, removal, remuneration, allowances and terms and conditions of office for executive directors (and the structure of remuneration, allowances and terms and conditions for other defined senior officers) and any changes to these terms is determined by the nominations and remuneration committee with due regard to performance and national guidance. Exception reports (based on use of a standard proforma reporting template) accompanied by oral updates from the chair are provided to the Trust board following each meeting.

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

Membership: chair 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 19 January 2022, the Trust board approved the committee's annual report, which confirmed compliance with the above key duties in its terms of reference.

Membership: Four non executive directors (Alastair Camp – chair, Gautam Dalal, Kim Kinnaird and one vacancy), associate NED, 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 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 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, 2021-22

*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	3/3 (100%)	3/3 (100%)			2/2 (100%)	
Jacqui Smith	3/3 (100%)	3/3 (100%)			3/3 (100%)	
Gautam Dalal	5/6 (83%)	5/6 (83%)	5/5 (100%)		4/5 (80%)	12/12 (100%)
Alastair Camp	6/6 (100%)	6/6 (100%)			5/5 (100%)	12/12 (100%)
Steve Thornton	2/3 (66%)	2/3 (66%)		3/3 (100%)	1/2 (50%)	
Mark Caulfield	3/3 (100%)	3/3 (100%)		2/3 (66%)	3/3 (100%)	
Clyde Williams	5/6 (83%)	5/6 (83%)			4/5 (80%)	10/12 (83%)
Natalie Howard	0/1 (0%)	0/1 (0%)			1/1 (100%)	0/2 (0%)
Margaret Exley	3/3 (100%)	3/3 (100%)	4/4 (100%)	4/5 (80%)	2/2 (100%)	
Lesley Seary	1/1 (100%)	1/1 (100%)			2/2 (100%)	
Kim Kinnaird	6/6 (100%)	6/6 (100%)	5/5 (100%)		4/5 (80%)	10/12 (83%)
Kathy McLean	6/6 (100%)	6/6 (100%)	5/5 (100%)	6/6 (100%)	4/5 (80%)	
Alwen Williams	6/6 (100%)	6/6 (100%)				4/12* (33%)
Caroline Alexander	5/6 (83%)	5/6 (83%)		5/6 (83%)		
Alistair Chesser	6/6 (100%)	6/6 (100%)		6/6 (100%)		
Hardev Virdee	6/6 (100%)	6/6 (100%)	5/5* (100%)			12/12 (100%)
Shane DeGaris	6/6 (100%)	6/6 (100%)	5/5* (100%)	5/6 (83%)		12/12 (100%)
Raj Bhamber	2/2 (100%)	2/2 (100%)				0/4 (0%)
Daniel Waldron	4/4 (100%)	4/4 (100%)				7/8 (88%)
Ralph Coulbeck	3/3 (100%)	3/3 (100%)				7/8 (88%)
Mark Turner	3/3 (100%)	3/3 (100%)				4/4 (100%)
Andrew Hines	6/6 (100%)	6/6 (100%)	5/5* (100%)	5/6 (83%)		
Neil Ashman	2/3 (66%)	2/3 (66%)				

* In attendance

Board effectiveness

During 2021/22, 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 during 2022/23 as appointments are made, following a number of departures and arrivals among the non executive membership.

Trust board appraisals

The process for appraisals has been established with the chair and regional director of NHSE/I 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 2021/22 were due to be completed by 14 July 2022. Appraisals of the executives (with the group CEO) are due for completion by the end of July 2022/23. 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 clinicians 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. 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. The approval of the 2022 Green Plan will 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. The Trust has stepped up its mission to support an inclusive economy with a levelling up by the health purpose coalition delivered in April 2022. This sets out progress against levelling up goals based on the United Nations' sustainability goals. Along with implementation of social value measurements for procurement this will demonstrate the Trust's progress in this area.

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 140 local people gained work through this route last year, 70 from ethnic minority backgrounds and 50 previously receiving income support or other benefits.

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. Over 70 graduates from the scheme now work at the Trust. In the next 6 months a Project Search cohort is expected to start at Barts Hospital.

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 helped over 100 students enter work or apprenticeships and 187 join health related degree courses, half of whom came from families who had previously never sent anyone to university. On line "work experience" has helped bridge the gap, but we are pleased to report in person work experience is now being restored.

Thanks to funding from Barts Charity and the Prince's Trust, Healthcare Horizons phase II commenced in July 2021, and has extended 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 with other schools.

The Barts Health Futures Centre was launched at Newham College, Stratford in October 2021 by the Executive Mayor of Newham, Rokshana Fiaz and Deputy Mayor of London, Jules Pipe. The centre is an anchor institution approach working with a further education college. Inspired by the emerging Lifesciences programme at Whitechapel, the centre (funded by the GLA) is busy offering routes 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 has been established in 2021 and recently completed a SWOT analysis that will lead to a concerted strategy relating to youth employment and careers.

The Trust will continue working across NEL on its health and care careers programme, joining the dots across the health and care economy and simplifying the communications offer to the local community.

Barts Health anchor framework

Equity of access

Covid-19 has highlighted and intensified inequalities in health in the UK, with north east London experiencing some of the highest mortality rates in the UK. Building on a programme of work overseen by the equity working group since 2017, the Trust has been using routinely collected patient data to review aspects of access, process, outcomes, and experience to identify opportunities to advance equity (with regard to gender, ethnicity, age, social deprivation, and disability). An analysis of established equity indicators for patients during the early stages of the pandemic enabled the Trust to identify some inequalities associated with ethnicity and other characteristics in terms of relative levels of hospital admission and/or mortality rates. This important analysis informed the Trust's approach to aspects of its Covid-19 response including targeting public information and vaccination efforts, staff risk assessment and redeployment.

The Trust's public health team has also:

- Increased its engagement with local communities, sharing information on service utilisation, providing advocacy, and working with local communities on health messaging to minimise the impact of Covid-19.
- Maintained a long-standing programme addressing preventable causes of ill health amongst patients such as smoking cessation and diet advice, and staff initiatives such as flu and Covid vaccines.
- Reviewed and made recommendations regarding the socio-economic causes of ill health in local communities. We have brought together improving sustainability, inclusion, and addressing racism under the banner of an anchor institution. This includes the Trust's work with schools, recruiting local apprentices, and training young people to work at Barts Health.

With the gradually reducing impact of Covid-19, the importance of equitable access and learning the lessons from the pandemic will be embedded in the challenges faced in managing those on long waiting lists and adopting an integrated approach with partners to delivering care.

System development and integrated care

During 2021/22, the Trust continued to engage in important work with system partners at integrated care system (ICS), borough 'place' level, provider collaboration, acute provider collaborative (as well as pan-London and national) level. The publication of the health and social care act 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 north east London Health Care Partnership (NELHCP) ICS featuring a clinical senate which has overseen 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.
- A provider collaboration agreed by the boards of Barts Health and Barking, Havering and Redbridge University Hospital NHS Trust during 2021/22 identified the principles and priorities for joint working. Looking ahead, the development of a sector wide acute provider collaborative will extend some of the prioritised workstreams to the whole NEL footprint. This will build on the closer working developed during the pandemic and early progress made by the acute alliance.
- At borough or 'place' level, our hospitals work closely with primary, community and social care partners in our boroughs. There will be a growing focus on work at this level under the auspices of the NEL ICS. These partnerships will enable improved planning for how health and social care work together in integrated care systems, 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.
- Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust set up a shared pathology service in May 2021. Hosted by Barts Health, 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 TUPE transferred to Barts Health, and existing Barts Health pathology staff have remained employed by the Trust. The partnership has an operating budget of c. £123m per annum, with a workforce establishment of c.900 WTE. Over the next few years, this pathology partnership will move to a hub and essential service laboratory structure across the three Trusts.

- 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 and a north London specialised children's services network.
- 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, North 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.

Closer collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust

The above section describes the NE London context and a model similar to other regions (or sectors) nationally in terms of having an Integrated Care System and supporting collaboratives representing key provider groups, and 'place' based borough working. The Barts Health and Barking, Havering and Redbridge University Hospitals NHS Trust provider collaboration represents an additional and deeper commitment to joint working across the two organisations. A guiding principle for this joint working has been to focus on those aspects that will most swiftly deliver benefits – in terms of access and clinical outcomes – for our local populations.

The publication of Closer Collaboration and a Memorandum of Understanding agreed by the boards of Barts Health and Barking, Havering and Redbridge University Hospital NHS Trust during 2021/22 set out the basis for a provider collaboration between the two trusts. A number of joint appointments at Board level and movement of leaders between the two organisations has demonstrated the long term commitment to joint working. The development and alignment of green plans for both trusts in year exemplifies the shared commitment to sustainable development, while the digital alignment agreed as part of a business case provides an important foundation for closer working. A number of collaboration workstreams have been identified as early priorities by the two boards and will provide the basis for further collaboration across the sector. Areas for immediate focus include:

- Urgent and emergency care. Building on the much closer alignment developed during the pandemic across the sector, a critical care hub has evidenced benefits of joined-up working – ranging from mutual aid and liaison with ambulance services to sharing of expertise in ED leadership.
- Neurosciences joint working. The commitment to joint working in these services has already helped to influence changes to planned reconfigurations, ensuring high quality services for local people and benefitting from the greater scale and expertise of both organisations for services such as stroke, thrombectomy, neurology and neurosurgery.
- Other clinical priorities have included networking in specialised medicine and cooperation on research and clinical trials
- Recognising the greatest dependency for delivering elective recovery, joint work on workforce development, recruitment and retention will be pursued.
- Alignment of digital strategies and infrastructure, including at the most fundamental level of electronic patient records, has already been signalled with business cases agreed in principle.
- There will be closer working across the organisations on financial stability, with initial steps taken to develop a view across the NEL sector on the key financial drivers and underlying position. It is anticipated that this closer working on finance will be accompanied by further alignment of corporate systems, approaches and functions (such as planning).

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. There has been considerable work in 2021/22 to strengthen risk management maturity, including:

- Further development of the board assurance framework with the introduction of a risk appetite domain and risk triggers.
- Use of a dedicated risk tracking mechanism for Covid-19 risk themes.
- 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 benchmarked well with other NHS organisations.
- The increasingly effective work of a trust wide risk review group to support hospitals and group support services in implementing the risk management policy consistently across the group.
- Consistent reporting of risk as part of performance review meetings and at executive and NED-led quality assurance groups.

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, with agreement to introduce a more robust assurance mapping approach. The Trust board owns the board assurance framework, while the executive risk management board plays a central role in regularly monitoring the key risks to the organisation. The board also seeks assurances directly or through its assurance committees on BAF risks (with specific lead roles assigned to board committees for each of the BAF entries) and a programme of deep dive reports to support monitoring of progress.

The BAF entries describe the principal risks to the Trust's operational, clinical quality, financial, workforce, strategic and academic objectives. The Trust Board noted moderate success in mitigating board assurance framework risk scores downwards during 2021/22, with the BAF reflecting risk scores moving in both directions, with the emergence of a number of high risks associated with recovery from the pandemic in the short and longer term. The year-end BAF risk scores reflected continuing operational risks despite progress identified internally and by external stakeholders and regulators in managing these.

Risk register and overarching risk management system

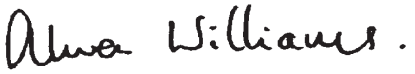
During the year work has continued to strengthen and improve risk management systems and processes across the organisation. CQC inspections in 2018 indicated that risk management systems and processes were well embedded at a hospital-level and group level. An Internal Audit review of the BAF incorporated a developmental review of options for assurance mapping, which will be embedded in a revised BAF format for 2022/23. The overall rating for this Internal Audit review reflected the highest available 'substantial' assurance rating for the design and application of the BAF.

The development of the group model and enhanced site-based leadership has contributed to improved risk management maturity, reflected in the 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 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 essential staff 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 focusing attention on post pandemic elective waiting time risks.



Dame Alwen Williams, DBE
Group chief executive officer

20 June 2022

Annual Governance Statement 2020/21

Barts Health NHS Trust

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 2022 and up to the date of approval of the annual report and accounts.

2021/22 was a year of progress for Barts Health, including the reporting of an unaudited breakeven position for the second consecutive financial year. Following the reintroduction of the system oversight framework (SOF), ratings were determined for each integrated care system (ICS) and NHS trust (including foundation trusts). This rating sought to reflect the scale and general nature of support needs, from no specific support needs (SOF 1) to a requirement for mandated intensive support (SOF 4). The Trust was rated as SOF 2, with the wider NE London system rated as SOF 3. Given this recognition of improved Trust financial resilience, the financial outlook for 2022/23 appears positive while also reflecting the greater emphasis on working as a system to deliver greater financial stability for NE London healthcare. This has been reflected in early work with the whole sector on financial strategy and as part of the collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust.

The CQC suspended its routine inspections during the Covid-19 pandemic to reduce the pressure on health and social care services. However, the CQC undertook some targeted inspection activity during 2021/22, with reviews of imaging services at Whipps Cross and The Royal London Hospital; and a review of maternity services at Newham. There has been no change to the Trust's overall ratings, in 2021/22. In May 2021 CQC inspections of imaging services at The Royal London and Whipps Cross identified a range of concerns ultimately resulting in a warning notice and an 'inadequate' rating for the Whipps Cross service. A wide-ranging improvement programme was put in place and re-inspections in September 2021 confirmed that critical safety actions had been implemented. The overall ratings for the Whipps Cross imaging service and the Royal London Hospital imaging service were confirmed as 'requires improvement' and 'good' respectively. A reduced scope review of Newham's maternity services (focusing on three domains) identified four 'outstanding' areas and resulted in no 'must do' recommendations. While these findings could not result in a change of rating due to the nature of the reduced scope review, the Trust received positive feedback from the inspection team, reflecting the hard work in the unit. A well-led inspection is anticipated to be confirmed during 2022/23 following a post-pandemic resumption of CQC activities.

A very significant development during 2021/22 was the establishment of a provider collaboration between Barts Health NHS Trust and Barking, Havering and Redbridge University Hospital NHS Trust. The respective boards agreed a memorandum of understanding for this collaboration, following an appreciative inquiry process to identify immediate opportunities that would benefit the patient populations in NE London.

The two trusts agreed an initial list of 12 priority areas for closer collaboration – some immediate to drive urgent improvements in clinical services (focusing for example on urgent and emergency care and winter resilience); others facilitating joint initiatives (such as neurosurgery and other specialty configurations); and a few more long-term shared endeavours (including the alignment of digital strategies and infrastructure). This commitment to embedding the principle of joint working was reflected in joint appointments at the most senior level, including the appointment of a chair in common (Rt Hon Jacqui Smith) in October 2021 and a joint group chief executive (Shane DeGaris), due to take up post in August 2022.

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, with an accountability framework in place to clarify the respective roles of each element of the group's structures. The Barts Health group continued its role as a critical care centre for Covid-19 peaks and contingency planning, while also hosting vaccination hubs, providing much needed support for east London's population. The Trust's group operational plan sets out an ambitious agenda for the Trust in 2022/23, almost every aspect of which will require effective working with system partners if we are to deliver the necessary and intended improvements in patient care, healthcare outcomes, and value. Partnership working will be required at multiple levels: at 'place', with borough-level partners including primary care networks; through the deep collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust, following agreement of our memorandum of understanding in 2021; as the largest organisation within the developing NEL acute provider collaborative; and through our contribution to ICS-wide clinical leadership and governance.

Trust Board and Committee structure

The role of the Trust Board is to govern the organisation effectively and to build public and stakeholder confidence that their health and healthcare is in safe hands - providing 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 group 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 a number of changes to the Trust Board's membership during 2021/22 with the appointment of Rt Hon Jacqui Smith as chair in common for Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust. Professor Sir Mark Caulfield and Ms Lesley Seary joined as non executives, while Mr Daniel Waldron, Dr Neil Ashman and Mr Mark Turner joined as non-voting executive board members. There were three non-executive vacancies at the end of the financial year. Following the appointment of Adam Sharples as vice chair in May 2022, further NED appointments were expected to be announced during quarter 1 of 2022/23 to return the board membership to its full complement. Looking ahead into 2022/23, Shane DeGaris was appointed as Group Chief Executive designate ahead of the departure of Dame Alwen Williams in July 2022.

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 key board 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 2021/22, the audit and risk committee returned gradually to its business-as-usual role as the audit programme was refreshed following the pandemic. The internal audit programme, providing audit reviews of key controls such as the board assurance framework, CQC regulations and payroll and pensions informed an assessment of the effectiveness of the Trust's system of controls. The risk-based internal audit programme prioritises high risk / materiality topics covering all areas of the Trust's activities (in addition to some essential regular core financial system reviews). In total, 28 internal audit reviews were completed in year, with outputs identifying six control areas where limited assurance could be gained, four control areas where substantial assurance could be gained and the remainder providing reasonable assurance. The quality assurance committee complements the role of the audit and risk committee in providing assurance to the Trust Board via a combination of quality reporting, hospital and thematic reports and internal audits relevant to efficient and effective patient care, (with a focus this year on areas including clinical audit, infection control and duty of candour arrangements). the committee also monitored progress against the Trust's quality improvement plan, operational and workforce plans and key safety metrics.

The Trust's assessment of its 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 and use of resources.

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 produces its quality accounts as a companion to its annual report and accounts, providing a focus on care quality performance. The timetable for the quality account for 2021/22 indicated a target for publication of 30 June 2022.

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 External Audit assessment of the quality account have been suspended since 2019/20.

3. The risk and control framework and risk assessment

As designated accountable officer, I have overall accountability for risk management in the Trust. During 2021/22, 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 formally 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 confirms 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 and performance issues 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 may arise via exception reporting.
- 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 Trust also has a risk management strategy and arrangements for assessing on an annual basis the risk management maturity of the organisation. The Trust's risk management 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 a 5 x 5 (consequence x likelihood) risk scoring 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 risk management board 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 alternate, as delegated by the hospital CEO) leads on governance and risk issues and is responsible for coordinating and embedding risk management processes within the hospital, 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 input from hospital leads 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 performance review meetings, chaired by the group CEO, include a review of all hospital risks scored 15 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 board 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 2021/22 are summarised at appendix 1.

The board assurance framework is based on 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 the identified risk appetite linked to the relevant objective/enabler and any gaps in control and assurance in relation to the risks, together with actions to address them.

The board assurance framework (BAF) 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 2021/22 internal audit report on the board assurance framework indicated a 'substantial' assurance rating regarding the design and use of the BAF to manage risk across the organisation. Action will be taken by the executive to address recommendations for refinements identified in the audit report, including some good practice developmental steps on assurance mapping.

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. Recognising the close links between the role and the work of the chair in common and the audit and risk committee, the trust secretary has recently been nominated as an anti-fraud champion on behalf of the Trust Board.

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 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 hospitals and for the Barts Health group as a whole. The Trust has also benefitted from some specific external independent assurances during 2021/22 commissioned by the executive team.

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. Staff have been engaged in the design and implementation of many QI initiatives.
- A focus on the WeBelong inclusion strategy, with a number of critical engagement activities including regular webinars
- Activities to engage and develop staff including: leadership development and talent management work; ward development initiatives to improve information sharing; and design and development of the Trust's wellbeing strategy.
- Embedding the work of a number of representative groups including the Trust's diversity networks, the local negotiating committee and staff partnership forum and the Green at Barts group.
- Monitoring of national staff survey findings. Despite pandemic pressures, staff survey completion has remained broadly steady in the last two years. Benchmarked results indicate that the Trust was in the bottom quartile albeit at the upper range (and with results broadly consistent with other London acute trusts).
- Encouraging staff to raise concerns through Guardian of Safe Working and Freedom to Speak Up services.
- The announcement of steps to insource a number of staff groups currently working in the Trust for Serco, responding to strong support among staff groups and unions for this change.

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. A collaborative sector-led approach to healthcare has been formalised through the Health and Care Act and embedded locally through the work of the NEL Integrated Care System.
- Joint strategic planning with healthcare and academic partners, including NHSE/I, Barking, Havering and Redbridge University Hospitals NHS Trust, Queen Mary University of London and UCL Partners.
- Ongoing close working with Barts Charity to invest in health priorities.

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), as required by the 'Managing Conflicts of Interest in the NHS' guidance, with a further publication due in September 2022.

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

Sustainability

During 2021, and in anticipation of the COP26 climate change conference in Glasgow, the NHS declared a health climate emergency. The Board formally endorsed this declaration at its November 2021 meeting. The chair, Rt Hon Jacqui Smith, joined senior leaders in making a series of personal pledges about what they would do in their daily lives to lessen their impact on the environment. In the spirit of our collaboration with our neighbours at Barking, Havering and Redbridge University Hospitals NHS Trust, we shared our plans for further improving our environmental management and sustainability and the boards of both organisations approved aligned green plans during 2021/22.

The NHS report 'delivering a net zero national health service' sets an ambition to be the world's first net-zero health service by 2040. The Trust has made great strides towards that target by reducing our carbon emissions by almost 40% over a decade. The Board approved green plan sets out the target of doubling the reduction in carbon emissions over the next ten years. The green plan addresses specific areas of activity that impact on the Trust's environmental performance. As well as waste, energy and water, these include clinical care, procurement, and travel. The plan sets out the current position in each area, some examples of good practice and achievements, and suggested improvements for the future. For example, plans to build a new hospital at Whipps Cross have zero carbon and active travel proposals embedded in design plans. Befitting our role as an "anchor institution" within east London, there is also a section on supporting healthy and resilient communities. 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. In designing the green plan, the Trust benefitted from helpful engagement and input from a leading staff group concerned about the climate emergency (the Green at Barts group).

The Trust's response to the Covid-19 pandemic has included the roll out of remote working for office-based staff and the ability to hold virtual meetings has reduced staff travel and the associated vehicle miles and emissions. Additionally, establishing new virtual clinics for some outpatients 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.

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, changing facilities with showers and extra lockers have been built to support these active commutes. 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 plan and active travel plan aims to support our staff to continue to travel actively.

The Trust is part of the Breathe London Network for air quality monitoring at our hospitals. 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 hospitals 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 which came into effect in October 2021. 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.

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 (who is also the senior information risk officer) 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 audit and risk committee 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, national data opt out compliance, IG risks, training and priorities).

The NHS Digital data security and protection toolkit has a new annual deadline of 30th June each year so it no longer aligns with a financial year. The Trust expects to meet the standards in full for the 2021/22 submission with one exception – achieving the standard of 95% of staff having received annual training. This area of non-compliance is linked in part to the Trust seeing continued pressures from the Covid-19 pandemic, diverting attention from training initiatives. The Trust are delivering the actions on the improvement plan and will seek 'approaching standards' status if they do not reach the target in time.

The annual Internal Audit review of the data security and protection toolkit for 21/22 is still underway due to the June deadline.

In 2021-22 there were eight personal data breaches that met the legal threshold for reporting to the Information Commissioner's Office:

- A complainant received a complaint response intended for another patient.
- Some hard copy drug charts were destroyed before they were due to be disposed of.
- A patient was sent HIV related medication with another patient's details on it.
- Financial reminder notices were emailed to individuals who should not have received them.
- A member of staff used their record access to look at a colleague's personal information.
- A staff member accessed the health record of someone they knew in error.
- A staff member accessed the health record of someone they knew (investigation still underway).
- A staff member accessed the health record of someone they knew (investigation still underway).

In all cases the ICO have closed the matter with no further action, however in some cases recommendations have been made that the Trust has either completed or will be considering/ completing.

The information governance committee routinely receives assurance that recommendations arising from ICO-reportable incidents have been actioned within the organization. In relation to a recent theme of cases, we will be following the ICO recommendations to consider how we can reduce risk of access being used inappropriately without introducing any inadvertent clinical risk.

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 daily work and ensuring that staff receive appropriate information governance training.

Safe Staffing Assurance

Each year the Trust Board agrees a group 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 2021/22 the Trust Board agreed nursing and midwifery and allied health professional safer staffing workforce plans at its July 2021 Trust Board meeting (with the 2022/23 safer staffing review considered at the May 2022 Trust Board meeting). The nursing and midwifery safe staffing plans are developed at ward, hospital and then group level informed by benchmarking tools such as BirthRate+ for maternity services staffing. The monthly integrated performance report details ward-level safer staffing metrics including fill rates and care hours per patient day. The Trust Board also receives a yearly report from the Trust's 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, with details for AHPs included in the 2021 establishment review board report.

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. During the course of the pandemic, the governance arrangements were designed in accordance with the relative severity of Covid-19 peaks, determining aspects such as the frequency of key meetings. A daily Covid-19 dashboard was established to track caseloads in the community and in hospitals as well as progress with patient treatment.

- Critical care capacity

Learning from the pandemic had identified the potential for significant pressure on hospital critical care requirements. The Trust's response - to rising patient admissions and the national modelling on capacity required to manage peaks - included the repurposing of Trust resources to support increased intensive care capacity as well as group and sector mutual aid to direct resources to the most appropriate setting. The creation of the Queen Elizabeth unit at The Royal London provided the principal pan-London contingency capacity for any further 'surge' in critical care requirements in the third wave and beyond.

- Equipment

A further widely acknowledged pressure point for NHS trusts during the first wave of the pandemic was the provision of suitable equipment to support safety for staff and patients. Centralised procurement arrangements were in place during 2021/22 to support effective planning and resourcing of equipment requirements.

- Workforce, safe staffing, and health and wellbeing

Recognising the learning provided through the experience of Covid-19 and pressures on staff (as well as patients), a sustainable approach to health and wellbeing was identified as a priority. A wellbeing strategy, approved by the Trust Board in March 2022, reflected a co-design process to capture what staff felt was most needed.

This included:

- A focus on basic wellbeing needs for all staff.
- Protecting time and flexibility for all people to have team time and breaks and to access wellbeing enhancing initiatives and to promote agile working.
- Encouraging autonomy and sense of belonging, decision making locally to empower people-driven changes.
- Promoting and enabling access to regular wellbeing activities on site (psychological support, financial wellbeing, exercise classes).
- Providing suitable, sustainable facilities that promote all dimensions of health and wellbeing (green space, technology, rest spaces, healthy food).
- Improving communication and listening.
- Supporting leadership and team development opportunities.
- Supporting physical wellbeing at work (through aspects such as cycling schemes, seating areas etc).
- Providing equitable support for all to embed an inclusive wellbeing culture.

With support from Barts Charity and other benefactors, a range of investments were made possible to permanently improving the working environment and support available to staff. This ranged from the creation of wellbeing hubs and rest areas for staff to team coaching and psychological support.

Elective waiting time data

The Trust has reported on elective waiting times throughout the year, supported by continued pathway validation exercises, to validate waiting time data recorded for all patients currently waiting for treatment. The Trust has rolled out training and analysis, which helps to identify training needs, followed by meaningful intervention. 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 that reflects the high risk associated with growth in waiting times associated with the pandemic. Accompanying this monitoring, the Trust employs a well-established clinical harm process to assess the extent of any harm associated with long waits.

Update on significant control issues in 2020/21

The Trust identified the following significant control issues in its annual governance statement for 2020/21 (with all but one of these carried forward to appear as significant control issues in 2021/22 – for which narrative appears in the relevant later section):

- 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.
- CQC regulations compliance (Imaging services).

The Trust recorded 3 never events during 2021/22 (as compared with 11 in 2020/21). The improvements seen in this domain results in these specific historic issues not reappearing as a control issue in 2022/23. Updates on all other 2020/21 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 2021/22.
- The head of internal audit opinion on the overall arrangements for gaining assurance through the board assurance framework and on the controls reviewed as part of internal audit's annual work plan. the head of internal audit opinion for 2021/22 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 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, quality assurance committee and the audit and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Key roles have been as follows:

- The Trust 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. A performance review mechanism has enabled the executive to retain effective oversight of the progress of hospitals in delivering their operational plans.
- The audit and risk committee (ARC) in conjunction with the quality assurance committee (QAC) 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

The inclusion of Covid-19 as a control issue reflects the context of a continued high level of Covid-19 cases in NE London compared to many regions during 2021/22. Examples of the significant impact of the pandemic for the organisation include patient and staff deaths directly attributed to Covid-19; the need to significantly expand contingency 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. This impact informed changes to the Trust's 'business as usual' controls environment. The Trust's response included physical environment changes (including expansion of additional critical care facilities and introduction of vaccination hubs), infection control-led cohorting and zoning of hospitals to reduce infection risks. The high numbers of Covid-19 patients continued throughout 2021/22 and leaves an important legacy for the Trust entering 2022/23 in matters ranging from staff wellbeing to prioritising equity of access to care.

National performance standards (urgent and emergency care)

In March 2022, emergency care attendances reached their highest for two years, with Barts Health NHS Trust recording the most attendances of any trust in England. Performance against the national four-hour urgent care waiting time standard fell below 80% at points during the year and, while this performance compared reasonably well with peers, infection control restrictions, the increased acuity of patients and the overall pressures on emergency departments throughout NE London represented a control issue in year and significant risk entering 2022/23.

National performance standards (elective waiting times)

The suspension of elective activity during the pandemic had a significant impact on the Trust's overall waiting list size, while infection control zoning and other requirements impacted on the Trust's ability to recover activity to optimal levels. The proportion of those on the waiting list waiting for over 52 weeks rose to 6.4% of the overall waiting list (6047 patients). Progress was made during the year on challenging cancer and diagnostics backlogs and achieving the locally agreed target for reduction of those waiting over 104 weeks. Safely reducing the volume of long waiters will be the highest priority for performance management during 2022/23.

Fire safety remediation

Significant progress on investment and fire safety works at Newham during the year, reflecting concerns identified in the previous year by London Fire Brigade (LFB) inspectors about the pace of improvements. LFB liaised closely with the Trust in monitoring of the programme, resulting in extensions to their enforcement notice deadlines. Looking ahead, this programme will continue to require further scaled-up activity in 2022/23, with a number of challenges for maintaining priority clinical activity.

CQC regulations compliance

Although the Trust's CQC ratings for quality of services has improved 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 (as reported in last year's annual governance statement). Re-inspections of diagnostic imaging services at The Royal London Hospital and Whipps Cross Hospital subsequently resulted in improved ratings for both services (being ranked as 'good' and 'requires improvement' respectively). Further communications are planned with the CQC and other regulators to provide ongoing assurance on actions being taken and evidencing improvements.

Flooding at Whipps Cross University Hospital

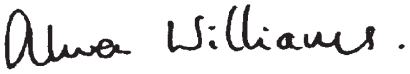
Extreme weather conditions in July 2021 resulted in flooding events at Whipps Cross University Hospital (and to a lesser degree at Newham University Hospital). This flooding caused damage to buildings, the electrical supply and a loss of power at Whipps Cross. A major incident was announced and a high number of patients (around 100) required relocation to other hospitals, mainly within the Barts Health group. The flooding also resulted in ongoing disruption to clinics and emergency care services during the following period and the challenges faced by staff during this period reconfirmed the infrastructure weaknesses at Whipps Cross underpinning the need for redevelopment of this older estate.

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.
- Performance against elective waiting time standards.
- Fire safety remediation.
- CQC regulations compliance (in relation to diagnostic imaging services at The Royal London Hospital and Whipps Cross University Hospital)
- Flooding at Whipps Cross University Hospital

During 2021/22, the Trust has further embedded its group model and supporting governance arrangements at corporate, hospital 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

20 June 2022

Appendix 1: Board assurance framework – principal risks at 31 March 2022

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.
2. Failure to identify healthcare inequalities and to secure equity of access and community connectivity impairs delivery of high quality, equitable healthcare outcomes
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.
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.
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.
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.
7. Delays to implementing Ockenden review recommendations impacts on quality and safety of maternity care provision.
8. Failure to secure and retain a sufficient high-skilled workforce impairs the Trust's ability to provide the best standards of care and retain flexibility for seasonal or other surges in demand for services.
9. Delays to the progress of a robust business case, supported by stakeholders, impairs Whipps Cross redevelopment and delivering the vision of excellent integrated care
10. Failure to sufficiently progress on six identified clinical transformation workstreams (medicine, elective, pathways, safety, GCS and urgent care) impacts on recovery and associated funding.
11. 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.
12. Failure to develop cyber secure information systems due to resourcing and lead time limitations impacts on quality and safety of services.
13. Failure to sufficiently improve infrastructure and equipment due to resourcing and lead time limitations impacts on quality and safety of services.
14. Failure to deliver research and education plans in the context of the pandemic and constrained resources adversely affects income, reputation and delivery of workforce targets.
15. Insufficient leadership capacity and capability and failure to evolve the group model impairs the effectiveness of the organisation and role in system leadership.

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 WeShare intranet site with accompanying guidance, support and forms to assist staff using these.

These policies include Human Rights, Equality and Diversity, and Recruitment and Selection policies 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 Chair 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	2021-22 Salary (bands of £5000) £000	Expense Payments (taxable) (to nearest £100) £00	Performance pay and Bonuses (bands of £5000) £000	Long term Performance pay and bonuses (bands of £5000) £000	All Pension-Related Benefits* (bands of £2,500) £000	Total (bands of £5000) £000
	Executive Directors						
1	Dame Alwen Williams, 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	52.5 to 55	260 to 265
	Professor Alistair Chesser, Group Chief Medical Officer	230 to 235	0	0	0	80 to 82.5	310 to 315
	Caroline Alexander, Group Chief Nurse	170 to 175	0	0	0	35 to 37.5	205 to 210
	Hardev Virdee, Group Chief Financial Officer	180 to 185	0	0	0	50 to 52.5	230 to 235
2	Raj Bhamber, Interim Group Director of People (to 31.08.21)	65 to 70	0	0	0	242.5 to 245	310 to 315
3	Daniel Waldron, Group Director of People (from 02.08.21)	105 to 110	0	0	0	0	105 to 110
4	Ralph Coulbeck, Group Director of Strategy (to 05.12.21)	90 to 95	0	0	0	40 to 42.5	130 to 135
	Mark Turner, Interim Group Director of Strategy (from 19.01.22)	25 to 30	0	0	0	7.5 to 10	35 to 40
	Andrew Hines, Group Director of Corporate Development	150 to 155	0	0	0	45 to 47.5	195 to 200
5	Dr Neil Ashman, Group Director of Clinical Transformation (from 19.01.22)	35 to 40	0	0	0	72.5 to 75	110 to 115
	Non Executive Directors						
	Ian Peters, Chair (to 30.09.21)	25 to 30	0	0	0	0	25 to 30
6	Rt Hon Jacqui Smith, Chair (from 01.10.21)	20 to 25	0	0	0	0	20 to 25
	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
	Professor Steve Thornton, Non Executive Director (to 30.09.21)	5 to 10	0	0	0	0	5 to 10
	Natalie Howard, Non-Executive Director (to 05.05.21)	0 to 5	0	0	0	0	0 to 5
	Margaret Exley, Non-Executive Director (to 31.12.21)	5 to 10	0	0	0	0	5 to 10
	Dr Kathy McLean, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Kim Kinnaird, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Clyde Williams, Non Executive Director	10 to 15	0	0	0	0	10 to 15
7	Tajinder Rehal, Associate Non Executive Director (to 30.09.21)	0	0	0	0	0	0
	Professor Sir Mark Caulfield, Non-Executive Director (from 20.09.21)	5 to 10	0	0	0	0	5 to 10
8	Lesley Seary, Non-Executive Director (from 01.02.22)	0 to 5	0	0	0	0	0 to 5

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

Note 2: The Pensions-Related Benefits figure for this Director is high because a significant increase in pay results in a larger movement in the overall value of their pension entitlement. Please see explanatory note below, which provides a brief summary of how the figure is calculated.

Note 3: This Executive Director opted out of the NHS Pension scheme during the 2021-22 financial year, therefore the Pension-Related Benefits figure is ni

Note 4: This Executive Director is no longer a board member, but continues employment with the Trust as interim CEO of Whipps Cross Hospital from 06.

Note 5: This senior manager's remuneration includes pay for their non Trust Board role.

Note 6: The Trust Chair post is shared jointly with Barking, Havering and Redbridge University Hospital NHS Trust BHRUT. The salary cost in the table above represents Barts' 50% share of these costs. The total salary across both trusts is in the banding 40k to 45k.

Note 7: Ms Tajinder Rehal is an unpaid Associate Non Executive Director.

Note 8: This Non-Executive Director post is shared jointly with BHRUT. The salary costs in the table above represents Barts' 50% share of these costs. The total salary across both trusts is in the banding 10k to 15k (the director was in post at BHRUT for the full year).

***Pension-Related Benefits**

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

20 June 2022

Date

	2020-21						
Note	Name and title	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.

Pensions Table (Information Subject to Audit)

2021/22									
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 2022	Lump sum at pension age related to accrued pension at 31st March 2022	Cash equivalent transfer value at 1st April 2021	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2022	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	£000
	Shane DeGaris, Group Deputy Chief Executive	2.5 to 5	0 to 2.5	55 to 60	20 to 25	752	42	827	0
	Professor Alistair Chesser, Group Chief Medical Officer	5 to 7.5	2.5 to 5	95 to 100	210 to 215	1,896	109	2,058	0
	Caroline Alexander, Group Chief Nurse	2.5 to 5	-2.5 to 0	60 to 65	125 to 130	1,209	44	1,283	0
	Hardev Virdee, Group Chief Financial Officer	2.5 to 5	0 to 2.5	55 to 60	110 to 115	905	49	984	0
	Raj Bhamber, Interim Group Director of People (to 31.08.21)	2.5 to 5	10 to 12.5	40 to 45	95 to 100	637	94	888	0
1 & 2	Daniel Waldron, Group Director of People (from 02.08.21)	5 to 7.5	-32.5 to-30	30 to 35	0	355	27	391	0
1	Ralph Coulbeck, Group Director of Strategy (to 05.12.21)	0 to 2.5	0	15 to 20	0	137	7	167	0
3	Mark Turner, Interim Group Director of Strategy (from 19.01.22)	0 to 2.5	0	30 to 35	0	400	5	431	0
	Andrew Hines, Group Director of Corporate Development	2.5 to 5	0 to 2.5	55 to 60	115 to 120	944	44	1,015	0
	Dr Neil Ashman, Director of Clinical Transformation (from 19.01.22)	0 to 2.5	0 to 2.5	60 to 65	125 to 130	1,136	13	1,230	0

Note 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.

Note 2: This officer opted out of the NHS Pension scheme during 2021-22.

Note 3: This officer is a member of the Civil Service Pension.

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).

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	£000
	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

Note 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.

Register of Interests - Directors

Title	Organisation of Interest	Description of Interest	Interest Start	Interest End
Non-Executive Directors				
Ms Jacqui Smith	Barts Charity	Trustee	01/10/2021	
	Jo Cox Foundation	Chair	01/10/2021	
	The Precious Trust	Chair	01/10/2021	
	Sandwell Children's Trust	Chair	01/10/2021	
	King's Fund	Trustee	01/10/2021	
	UCLP	Board member	01/10/2021	
	Jacqui Smith Advisory Ltd	Director	01/10/2021	
	Dalgety Ltd	Director	01/10/2021	
	Barking & Havering & Redbridge NHS Trust	Chair in Common	01/10/2021	
	Global Partners Governance	Associate	01/10/2021	
Mr Gautam Dalal	National Gallery	Member of Audit and Finance Committees	26/03/2017	
	Camellia Plc	Director	01/03/2018	
	The Booktrust	Trustee and Chair of the Finance, Risk and Audit	24/06/2021	
	Moxico Resources Plc	NED and Chair of the Audit Committee	01/02/2021	
Mr Alastair Camp	University Hospital Plymouth	Start date - 06/04/21	06/04/2021	
	China Fleet Trust	Trustee	01/01/2017	
	Local Justice Area - S and W Devon	Magistrate	01/06/2009	
	London Institute of Banking & Finance	Chairman, pension fund	12/02/2014	
Professor Steve Thornton	Royal College of Obstetricians and Gynaecologists	Various roles	01/01/2016	
	Ferring Pharmacy	Consultancy advice	01/01/2016	
	General Medical Council	Chair, UKMed	01/03/2017	
	Glaxo Smith Kline	Consultancy advice	01/01/2016	
	GSK	Advisory Board	01/04/2019	
	Hologic	Consultancy advice	01/01/2016	
	Janssen	Advisory Board	01/04/2019	
	Medcity	Board member	01/01/2017	
	Medical Schools Council	Executive	01/03/2017	
	Queen Mary University of London	QMUL VP	12/01/2016	
	UCLP	Board member	01/01/2016	16/01/2022
	Wellbeing for Women	Trustee	01/03/2017	05/08/2019
	William Harvey Research Foundation	Board member	11/03/2019	20/12/2021
	Monash University	Advisory Board	01/04/2019	
Professor Mark Caulfield	Genomics England	Chief Scientist	01/07/2013	01/07/2021
	Global Alliance for Genomic Health	Co-Chair, Genomic Healthcare Implementation Forum	01/07/2021	
	Queen Mary University of London	Vice Principal (Health)	01/01/2022	
	United Arab Emirates government	Genomics - consultancy advice	01/07/2021	
	Barts Lifesciences	CEO	01/07/2021	
Ms Kim Kinnaird	Lloyds Banking Group	Full-time Employment	01/03/2010	
Dr Kathy McLean	Kathy McLean Limited	Private limited company to offer health related advice	04/09/2019	
	Care Quality Commission	Inspection lead roles	28/09/2019	02/04/2022
	Public Sector Consultancy	senior clinical advisor	02/02/2021	
	University Hospitals of Derby and Burton NHS FT	Chair	01/08/2019	
	Nottingham and Nottinghamshire Integrated Care	Chair designate	01/02/2021	
	NHS Providers	Trustee/Director	24/06/2021	
	NHS England	Lay advisor to a Trust Board / Occasional consultancy work	22/02/2021	
	NHS Employers	Chair of national Staff and Associate Specialists	01/12/2019	31/03/2021
	NHS Employers	Chair of the Joint Negotiating Committee (SAS) Staff and	01/07/2021	
	NHS Employers	Policy board member	24/06/2021	
	Oxehealth	Advisory board member	01/04/2022	
Mr Clyde Williams	ShoNet Ltd	Director	11/09/2020	
Ms Lesley Seary	Zen Housing Ltd	Chair	01/02/2022	
	Barking, Havering and Redbridge - NHS Trust	Non Executive Director	01/02/2022	
	Lesley Seary Ltd	Director	01/02/2022	
	London Borough of Redbridge	Interim CEO	01/02/2022	
	The Big House	Trustee	01/02/2022	
Executive Directors				
Dr Neil Ashman	No Interests Declared			
Ms Caroline Alexander	Foundation of Nursing Studies (FONS)	Trustee	01/02/2019	
Mr Ralph Coulbeck	Barts Health NHS Trust	Spouse has employment contract	07/03/2018	
Mr Hardev Virdee	King's Fund	Member - General Advisory Council	01/01/2020	
	North East London Integrated Care System	Acting Chief Finance Officer	01/02/2021	01/07/2021
	Point of Care Foundation	Trustee	20/11/2019	31/07/2021
	One NHS Finance (NHSE/I)	Chair of national finance academy	01/03/2021	
	CIPFA	Chair of workforce forum, member of equality and inclusion board and public finance board	01/08/2021	
Ms Alwen Williams	No Interests Declared			
Professor Alistair Chesser	No Interests Declared			
Mr Daniel Waldron	No Interests Declared			
Mr Mark Turner	No Interests Declared			
Mr Andrew Hines	No Interests Declared			
Mr Shane DeGaris	No Interests Declared			
Ms Raj Bhamber	No interests declared			

Senior Manager numbers by salary band

A number of the senior managers in the note below were in post for only part of the financial year 2021-22 (please refer to the Salaries table), and hence their salary bandings in the table below reflect their part year salaries only.

Band	Number of senior managers
Less than £5,000	3
£5,001 - £10,000	3
£10,001 - £15,000	5
£20,001 - £25,000	1
£25,001 - £30,000	2
£35,001 - £40,000	1
£65,001 - £70,000	1
£90,001 - £95,000	1
£105,001 - £110,000	1
£150,001 - £155,000	1
£170,001 - £175,000	1
£180,001 - £185,000	1
£205,001 - £210,000	1
£230,001 - £235,000	1
£255,001 - £260,000	1
Total	**24**

Composition of Senior Managers by Gender

Gender	Headcount	%
Female	10	42%
Male	14	58%
Total	**24**	**100%**

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

In 2021-22 and 2020-21, there were no such compensation payments.

Payments to past directors (Information Subject to Audit)

In 2021-22 and 2020-21, there were no such payments.

Fair Pay and Pay Ratio Disclosure (Information Subject to Audit)

For several years, the Government Financial Reporting Manual (FReM) has required NHS trusts to disclose the median remuneration and the ratio between median remuneration, and the banded remuneration of the highest paid director.

From 2021-22, the FReM now also requires the disclosure of top to median, lower quartile and upper quartile staff pay multiples (ratios) as part of the Remuneration Report.

The additional requirements for the 2021-22 financial year are reported below, and also included is a glossary to explain some of the technical terms used in the disclosure.

a. The percentage change in remuneration of the highest paid director

In 2021-22, there was an increase of 3% from the last financial year in the remuneration of the highest paid director.

This increase is in line with national NHS guidance on the annual pay award of Very Senior Managers for 2021-22.

The highest paid director was not paid performance pay or bonuses in 2021-22, nor in 2020-21.

b. The average percentage change in the remuneration of employees of the entity, taken as a whole

In 2021-22, there was an increase of 4.3% from the last financial year in the average remuneration of all employees, taken as a whole, and including temporary and agency staff.

In 2021-22, permanent staff on NHS Agenda for Change Terms and Conditions received a national pay award of 3%.

None of the employees of the Trust received performance pay or bonuses in 2021-22, nor in 2020-21.

c. The range of staff remuneration

In 2021-22, the remuneration of all staff ranged from the bands £0k-£5k to £255k-£260k. (2020-21: £0k-£5k to £255k-£260k)

d. The 25th percentile, median and 75th percentile of staff remuneration

The 25th percentile, median and 75th percentile of total remuneration of the reporting entity's staff (based on annualised, full-time equivalent remuneration of all staff, including temporary and agency staff), as at the reporting date, are shown below. The figures are the same for the **salary component** of remuneration of the reporting entity's staff (based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date.

	2021-22	2020-21
	£	£
25th percentile	28,808	28,243
Median	38,767	37,241
75th percentile	50,017	48,613

e. The 25th percentile, median and 75th percentile of staff remuneration, as compared to the highest paid director

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce. This is shown as a ratio of the highest paid director's remuneration as compared to the 25th percentile, median and 75th percentile salary.

The banded remuneration of the highest paid director / member in Barts Health NHS Trust in the financial year 2021-22 was £255k to £260k (2020-21, £255k to £260k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

	2021-22		2020-21	
	£	Highest Paid Director: Ratio	£	Highest Paid Director: Ratio
25th percentile	28,808	8.9	28,243	9.1
Median	38,767	6.6	37,241	6.9
75th percentile	50,017	5.1	48,613	5.3

g. The highest paid director

In 2021-22, no individual received remuneration in excess of the highest paid Director (none in 2020-21).

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.

Glossary

Percentile	A percentile is a measure in statistics. It is a way of expressing where an observation falls in a range of other observations. For example, if a score falls in the 25th percentile, this means that 25 percent of all the scores recorded are lower.
Median	The median is the middle number in a sorted, ascending or descending, list of numbers. In the context of these disclosures, it is the salary that is in the middle of all salaries.
Annualised Salary	Where an individual works part-time, for the purposes of this disclosure only, the full time salary is used in the calculations.
Mid-point	As the highest paid director remuneration is already disclosed as a banded amount (£5,000), using the mid-point remuneration of this band rather than the exact remuneration in calculating the pay multiple ensures a level of anonymity consistent with the rest of the Remuneration Report.

Staff Costs (Information Subject to Audit)

	2021/22			2020/21		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	**926,214**	926,214	0	**867,466**	867,466	0
Social Security costs	**96,288**	96,288	0	**89,572**	89,572	0
Apprenticeship levy	**4,479**	4,479	0	**4,173**	4,173	0
NHS Pensions Scheme	**137,329**	137,329	0	**129,563**	129,563	0
Pension cost - other	**129**	129	0	**121**	121	0
Termination Benefits	**231**	231	0	**18**	18	0
Temporary staff	**48,582**	0	48,582	**32,501**	0	32,501
Total	**1,213,252**	**1,164,670**	**48,582**	**1,123,414**	**1,090,913**	**32,501**
Less: costs capitalised as part of assets	**5,784**	5,784	0	**4,098**	4,098	0
Less: costs recharged to other bodies	**16,486**	16,486	0	**0**	0	0
Total	**1,190,982**	**1,142,400**	**48,582**	**1,119,316**	**1,086,815**	**32,501**

Staff numbers (Information Subject to Audit)

	2021/22			2020/21		
Average staff numbers	Total	Permanently employed	Other	Total	Permanently Employed	Other
Medical and dental	**3,011**	2,668	343	**2,949**	2,609	340
Administration and estates	**4,232**	3,804	428	**4,052**	3,706	346
Healthcare assistants and other support staff	**2,126**	1,626	500	**2,077**	1,656	421
Nursing, midwifery and health visiting staff	**6,268**	5,075	1,193	**6,042**	4,990	1,052
Scientific, therapeutic and technical staff	**2,176**	1,847	329	**1,955**	1,699	256
Healthcare Science Staff	**768**	768	0	**666**	630	36
Total	**18,581**	**15,788**	**2,793**	**17,741**	**15,290**	**2,451**
Of the above - staff engaged on capital projects	**68**	51	17	**44**	30	14

Staff composition (as at 31st March 2022)

Gender	Headcount	%
Female	12,945	**72%**
Male	5,075	**28%**
Total	**18,020**	**100%**

Sickness absence data

NHS organisations are required to report sickness absence data in their annual reports. The data is reported on a **calendar** year basis (not on a financial year basis).

For the 12 month period from 1 Jan 2021 to 31 Dec 2021, the average number of sick days per Whole Time Equivalent staff member was **10.8** days:

	Calendar Year 2021
Total days lost	175,379
Total staff years	16,244
Average working days lost (per WTE)	**10.8**

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the Electronic Staff Records (ESR) Data Warehouse

Additional information can also 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-workforce-statistics

Staff Turnover Percentage

Up to date information on Barts Health NHS Trust's staff turnover figures can be found at the link below to the NHS Digital publication series on NHS staff turnover rates.

The series is an official statistics publication complying with the UK Statistics Authority's Code of Practice. Data is provided for a number of staff groups.

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 huge challenges in the past couple of years, more staff than ever shared their views, with a record 8,116 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 46% (all Acute & Acute and Community Trusts).

2021-22	2020-21
47%	47%

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

Trade Union Facility Time

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

Relevant Union Officials

Number of employees who were relevant union officials during 2021/22	Full-time equivalent employee number
84	76.6

Percentage of Union Officials time spent on facility time:

Percentage of time	Number of Employees
0%	54
1-50%	29
51-99%	0
100%	1

Percentage of pay bill spent on facility time:

	Figures
Total cost of facility time	£42,774
Total pay bill	£1,213,252,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.004%

Paid trade union activities:

Time spent on paid trade union activities as a percentage of	
Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours x 100	1.23%

Exit Packages (Information Subject to Audit)

	2021/22					
	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	5	31	20	98	**25**	**129**
£10,000 - £25,000	9	159	2	45	**11**	**204**
£25,001 - £50,000	1	32	1	41	**2**	**73**
£50,001 - £100,000	1	62	1	54	**2**	**116**
£100,001 - £150,000	0	0	0	0	**0**	**0**
£150,001 - £200,000	0	0	0	0	**0**	**0**
>£200,000	0	0	0	0	**0**	**0**
Totals	**16**	**284**	**24**	**238**	**40**	**522**

	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	0	0	11	54	**11**	**54**
£10,000 - £25,000	1	18	6	100	**7**	**118**
£25,001 - £50,000	0	0	3	87	**3**	**87**
£50,001 - £100,000	0	0	1	88	**1**	**88**
£100,001 - £150,000	0	0	0	0	**0**	**0**
£150,001 - £200,000	0	0	0	0	**0**	**0**
>£200,000	0	0	0	0	**0**	**0**
Totals	**1**	**18**	**21**	**329**	**22**	**347**

There were no “Special Payments (departures)” in 2021/22 (nil in 2020/21).

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

2021/22		
	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*	14	120
Exit payments following Employment Tribunals or court orders	11	118
Non-contractual payments requiring HMT approval**		
Total	**25*** **	**238**

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**

* 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 2021-22, the total number of payments (25) differs to the figure of 24 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)

	2021-22	2020-21
Consultancy expenditure charged to operating expenses	**£000s**	**£000s**
Consultancy services	1,306	2,785

Off-payroll Engagements

NHS bodies are required to include information about off-payroll arrangements in their remuneration report.

The off-payroll working rules have been in place since 2000. They are designed to make sure that an individual who works like an employee, but through their own limited company (usually a personal service company) or other intermediary, pays broadly the same Income Tax and National Insurance contributions (NICs) as other employees.

HM Treasury guidance confirms that the reported data should include (where paid £245 or more per day per day) those appointments to which the off-payroll legislation ('IR35') applies whereby the Trust is required to undertake assessments.

Reported data should also include those appointments that are not on payroll, and where the off-payroll legislation does not apply.

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

	31-Mar-22	31-Mar-21
The number of existing engagements as of 31 March	**10**	**6**
Of which, the number that have existed:		
- for less than one year at the time of reporting	5	2
- for between one and two years at the time of reporting	3	4
- for between 2 and 3 years at the time of reporting	2	0
- for between 3 and 4 years at the time of reporting	0	0
- for 4 or more years at the time of reporting	0	0

For all new off-payroll engagements during the financial year, between 1 April and 31 March, for more than £245 per day:

	2021-22	2020-21
Total number of new temporary off-payroll engagements engaged during the financial year	**23**	**28**
Of which, the number:		
- not subject to off-payroll legislation	14	8
- subject to off-payroll legislation and determined as in scope of IR35	0	0
-subject to off-payroll legislation and determined as out of scope of IR35	4	16
- reassessed for compliance or assurance purposes during the year	5	4
Of which: number of engagements that saw a change to IR35 status following review	0	0

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

	2021-22	2020-21
The number of **off-payroll** engagements of board members, and /or senior officers with significant financial responsibility, during the financial year	0	0
Total number 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 includes both on payroll and off-payroll engagements.**	24	18

Annual Accounts

2021 - 2022

For the year ended
31 March 2022

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

20 June 2022

Dame Alwen Williams, DBE
Group Chief Executive

20 June 2022

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 2022, 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 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, 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 2022 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 2021/22; 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 2021/22 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.

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 journals, fraudulent income recognition (Covid-19 related) and fraudulent expenditure recognition. 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 and 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 and 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 and 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 Comptroller and Auditor General in September 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 2022.

We have nothing to report in this respect.

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.

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 of the Local Audit and Accountability Act 2014 (as amended) 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 December 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 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.

Matter to be reported by exception

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency. Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 provides that each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account.

This duty is known as 'the breakeven duty'. The phrase 'taking one year with another' has been interpreted by the Department of Health and Social Care and HM Treasury as meaning that the duty is met if income equals or exceeds expenditure over a three-year rolling period, or exceptionally a five-year rolling period with the agreement of NHS Improvement (NHSI).

Considering the 'Statutory breakeven duty: a guide for NHS trusts' issued by NHSI in April 2018, we have reason to believe that Barts Health NHS Trust has taken a course of action which has breached the Trust's breakeven duty for the three-year period ending 31 March 2022 (requiring a referral under section 30(b) of the 2014 Act). The Trust's expenditure has exceeded its income for the three-year period ending 31 March 2022 by £72,442,000.

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.

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.

Suresh Patel, Key Audit Partner
For and on behalf of Mazars LLP

30 Old Bailey, London, EC4M 7AU

20 June 2022

Statement of Comprehensive Income

	Note	2021-22 £000	2020-21 Restated (Income)* £000
Operating income from patient care activities	7	1,829,710	1,780,455
Other operating income	8	202,791	207,217
Operating expenses	9	(1,975,735)	(1,920,409)
Operating surplus/(deficit) from continuing operations		**56,766**	**67,263**
Finance income	14	110	16
Finance expenses	15	(64,163)	(64,495)
PDC dividends payable		(6,402)	(5,396)
Net finance costs		**(70,455)**	**(69,875)**
Other gains / (losses)	16	(6,674)	120
Surplus / (deficit) for the year from continuing operations		**(20,363)**	**(2,492)**
Surplus / (deficit) for the year		**(20,363)**	**(2,492)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	10	(30,294)	(71,789)
Revaluations	18	61,062	4,608
Other reserve movements		0	4
Total comprehensive income / (expenditure) for the period		**10,405**	**(69,669)**

*In 2021-22, top up funding was incorporated into our block contract income from CCGs, and classified as patient treatment income. In 2020-21, these top-up funding payments came from NHS England, and were classified as “other” operating income. To ensure comparability year on year, the 2020-21 income figures have been restated to ensure alignment with the 2021-22 classification.

Each NHS trust must ensure that its revenue is sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account. This is known as the "breakeven duty", and the breakeven surplus / (deficit) is calculated differently to the surplus / (deficit) figure shown above.

In 2021-22, the Trust achieved a surplus of £554k against its in year statutory breakeven duty (2020-21: £123k)
This is shown in further detail in Note 2 of these financial statements.

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	17	172	62
Property, plant and equipment	18	1,430,826	1,388,653
Receivables	20	15,150	15,848
Total non-current assets		**1,446,148**	**1,404,563**
Current assets			
Inventories	19	24,334	22,006
Receivables	20	127,593	130,837
Cash and cash equivalents	21	86,655	54,207
Total current assets		**238,582**	**207,050**
Current liabilities			
Trade and other payables	22	(231,697)	(177,462)
Borrowings	25	(27,116)	(26,774)
Provisions	27	(18,676)	(4,106)
Other liabilities	24	(7,217)	(1,954)
Total current liabilities		**(284,706)**	**(210,296)**
Total assets less current liabilities		**1,400,024**	**1,401,317**
Non-current liabilities			
Borrowings	25	(917,664)	(941,240)
Provisions	27	(5,979)	(17,640)
Other liabilities	24	(500)	0
Total non-current liabilities		**(924,143)**	**(958,880)**
Total assets employed		**475,881**	**442,437**
Financed by			
Public dividend capital		1,048,318	1,025,279
Revaluation reserve		301,850	271,082
Income and expenditure reserve		(874,287)	(853,924)
Total taxpayers' equity		**475,881**	**442,437**

The notes on pages 63 to 93 form part of these accounts.

The financial statements on pages 59 to 93 were approved by the Board on the 20 June 2022 and signed on its behalf by:

20 June 2022

Dame Alwen Williams DBE, Group Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021 - brought forward	**1,025,279**	**271,082**	**(853,924)**	**442,437**
Surplus/(deficit) for the year	0	0	(20,363)	**(20,363)**
Impairments	0	(30,294)	0	**(30,294)**
Revaluations	0	61,062	0	**61,062**
Public dividend capital received	23,039	0	0	**23,039**
Taxpayers' equity at 31 March 2022	**1,048,318**	**301,850**	**(874,287)**	**475,881**

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 - brought forward	**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**

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	2021-22 £000	2020-21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**56,766**	**67,263**
Non-cash income and expense:			
Depreciation and amortisation	9	60,457	56,150
Net impairments charged to operating expenses	10	15,138	15,311
Income recognised in respect of capital donations		(4,780)	(16,265)
(Increase) / decrease in receivables and other assets	20	(886)	65,273
(Increase) / decrease in inventories	19	(2,328)	1,379
Increase / (decrease) in payables and other liabilities	22	61,251	(7,908)
Increase / (decrease) in provisions	27	3,010	2,093
Net cash generated from / (used in) operating activities		**188,628**	**183,296**
Interest received	14	110	16
Purchase of intangible assets		(130)	0
Purchase of property, plant, equipment and investment property		(86,486)	(120,201)
Sales of property, plant, equipment and investment property		210	474
Net cash generated from / (used in) investing activities		**(86,296)**	**(119,711)**
Cash flows from financing activities			
Public dividend capital received		23,039	683,204
Movement on loans from the Department of Health and Social Care		0	(593,246)
Capital element of finance lease rental payments		(2,064)	(1,997)
Capital element of PFI		(25,028)	(24,038)
Interest on loans		0	(2,383)
Other interest		(1)	(5)
Interest paid on finance lease liabilities		(72)	(150)
Interest paid on PFI		(64,191)	(63,855)
PDC dividend (paid) / refunded		(1,567)	(10,224)
Net cash generated from / (used in) financing activities		**(69,884)**	**(12,694)**
Increase / (decrease) in cash and cash equivalents		**32,448**	**50,891**
Cash and cash equivalents at 1 April - brought forward		**54,207**	**3,316**
Cash and cash equivalents at 31 March	21	**86,655**	**54,207**

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 2021-22 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

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.3 Joint Operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties, and has rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

In May 2021, Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust set up a shared pathology service, the NHS East and South East London Pathology Partnership, hosted by Barts Health NHS Trust. 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. The arrangement is a joint operation as defined by IFRS11, with Barts Health NHS Trust accounting for its share of the assets, liabilities, income and expenses of the service.

1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021-22 and 2020-21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020-21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. 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 also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020-21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021-22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets, including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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 8.1.

1.5 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.

1.6 Expenditure on Staff Costs

Short-term staff costs

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.

1.7 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.

1.8 Property, plant and equipment

1.8.1 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.

1.8.2 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.

1.8.3 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.

1.8.4 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.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England 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.

1.8.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual (*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 31.

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.

1.8.6 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	4	65
Plant & machinery	2	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.

1.9 Intangible assets

1.9.1 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.

1.9.2 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.

1.9.3 Useful economic life of intangible assets

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

1.10 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 2021-22 and 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.

1.11 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.

1.12 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.

1.13 Leases

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

1.13.1 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 as 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.

1.13.2 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.

1.14 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 from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	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 from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

1.15 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 28 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.

1.16 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 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in Note 29, 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.

1.17 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.

1.18 Value added tax

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

1.19 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.

1.20 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 21.1 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

1.21 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.

1.22 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.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021-22.

1.24 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 without restatement and 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. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. 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.

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	37,171
Additional lease obligations recognised for existing operating leases	(37,171)
Net impact on net assets on 1 April 2022	**0**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(10,310)
Additional finance costs on lease liabilities	(397)
Lease rentals no longer charged to operating expenditure	10,541
Estimated impact on surplus / (deficit) in 2022/23	**(166)**
Estimated increase in capital additions for new leases commencing in 2022/23	**8,413**

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. 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. HM Treasury is expected to provide guidance regarding the implementation of changes to accounting for PFI arrangements, which will be consulted upon in the 2022-23 financial year. Therefore, the impact of IFRS16 on the Trust's PFI contracts has not been quantified in the 2021-22 financial statements.

1.25 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 service potential that those assets have.

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.

1.26 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 18

Land and Building assets were revalued at 31st March 2022. 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 Existing Use Value (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 2022. BCIS Location Factors are also applied to the national TPI, on a Borough or County specific basis.

2 Breakeven duty financial performance

	2021-22 £000	2020-21 £000
Adjusted financial performance surplus / (deficit)	554	123
Breakeven duty financial performance surplus/(deficit)	**554**	**123**

2.1 The Trust's performance against its Breakeven duty is set out in further detail below:

	2021-22 £000	2020-21 £000
Surplus / (deficit) for the period	(20,363)	(2,492)
Add back all I&E impairments / (reversals)	15,138	15,311
	(5,225)	**12,819**
Remove I&E impact of capital grants and donations	(1,055)	(12,696)
Remove loss recognised on return of donated COVID assets to DHSC	6,834	0
Adjusted financial performance surplus / (deficit)	**554**	**123**

2.2 Breakeven duty rolling assessment

	2012-13 £000	2013-14 £000	2014-15 £000	2015-16 £000	2016-17 £000	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000
Breakeven duty in-year financial performance	409	(38,270)	(79,642)	(134,881)	(69,481)	(108,363)	(84,243)	(73,119)	123	554
Breakeven duty cumulative position	409	(37,861)	(117,503)	(252,384)	(321,865)	(430,228)	(514,471)	(587,590)	(587,467)	(586,913)
Operating income	1,324,338	1,288,172	1,319,964	1,342,594	1,488,833	1,512,726	1,526,645	1,698,118	1,987,672	2,032,501
Cumulative breakeven position as a percentage of operating income	**0.0%**	**(2.9%)**	**(8.9%)**	**(18.8%)**	**(21.6%)**	**(28.4%)**	**(33.7%)**	**(34.6%)**	**(29.6%)**	**(28.9%)**

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.

3 External Financing

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

	2021-22 £000	2020-21 £000
Cash flow financing (from SoCF)	(36,501)	13,032
External financing requirement	**(36,501)**	**13,032**
External financing limit (EFL)	(36,501)	13,032
Under / (over) spend against EFL	**0**	**0**

4 Capital Resource Limit

	2021-22 £000	2020-21 £000
Gross capital expenditure	93,993	137,899
Less: Disposals	(6,883)	(356)
Less: Donated and granted capital additions	(4,780)	(16,265)
Plus: Loss on disposal of donated / granted assets	6,834	0
Charge against Capital Resource Limit	**89,164**	**121,278**
Capital Resource Limit	92,887	121,278
Under / (over) spend against CRL	**3,723**	**0**

5 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.

6 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.

7 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy Note 1.4.

7.1 Income from patient care activities (by nature)

	2021-22	2020-21 Restated*
	£000	£000
Block contract / system envelope income	1,563,679	1,547,055
High cost drugs income from commissioners (excluding pass-through costs)	159,164	146,546
Other NHS clinical income	22,790	21,697
Community services - Block contract / system envelope income	16,067	15,866
Private patient income	2,973	1,564
Elective recovery fund	12,060	0
Additional pension contribution central funding**	41,763	39,387
Other clinical income	11,214	8,340
Total income from activities	**1,829,710**	**1,780,455**

*In 2021-22, top up funding was incorporated into our block contract income from CCGs, and classified as patient treatment income. In 2020-21, these top-up funding payments came from NHS England, and were classified as “other” operating income. To ensure comparability year on year, the 2020-21 income figures have been restated to ensure alignment with the 2021-22 classification.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charges) from 1 April 2019. Since that date, NHS providers have continued to pay over contributions at the former rate, with the additional 6.3% being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

7.2 Income from patient care activities (by source)

	2021-22	2020-21 Restated*
	£000	£000
NHS England	636,524	631,553
Clinical commissioning groups	1,156,209	1,117,301
NHS Foundation Trusts	16,574	14,472
Local authorities	6,040	6,849
NHS other	176	376
Non NHS: private patients	2,973	1,564
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	5,924	4,483
Injury cost recovery scheme	5,274	3,847
Non NHS: other	16	10
Total income from activities	**1,829,710**	**1,780,455**
Of which:		
Related to continuing operations	1,829,710	1,780,455

7.3 Overseas visitors (relating to patients charged directly by the Trust)

	2021-22 £000	2020-21 £000
Income recognised this year	5,924	4,483
Cash payments received in year	657	803
Amounts added to provision for impairment of receivables	8,172	11,755
Amounts written off in-year*	3,402	12,874

*In 2020-21 and prior years, a significant level of very aged Overseas Visitor historical debt was written off. The recovery of this type of debt is challenging, despite best endeavours of credit control processes. From 2021-22 onwards, the level of write-off is anticipated to level off, as the debt is less aged.

8 Other operating income

	2021-22			2020-21 Restated*		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	51,618	0	**51,618**	49,456	0	**49,456**
Education and training	72,874	0	**72,874**	69,853	0	**69,853**
Non-patient care services to other bodies	17,184	0	**17,184**	20,119	0	**20,119**
Reimbursement and top up funding	17,671	0	**17,671**	11,466	0	**11,466**
Receipt of capital grants and donations	0	4,780	**4,780**	0	16,265	**16,265**
Charitable and other contributions to expenditure	0	7,758	**7,758**	0	23,031	**23,031**
Rental revenue from operating leases	0	2,165	**2,165**	0	1,722	**1,722**
Other income (see below)	28,741	0	**28,741**	15,305	0	**15,305**
Total other operating income	**188,088**	**14,703**	**202,791**	**166,199**	**41,018**	**207,217**
Of which:						
Related to continuing operations			**202,791**			**207,217**

8.1 Other Income is analysed in further detail below:

	2021-22	2020-21 Restated*
	£000	£000
Car Parking income	894	428
Catering	0	1
Pharmacy sales	912	1,124
Property rental (not lease income)	885	858
Staff accommodation rental	13	13
IT recharges (external)	0	230
Clinical tests	303	223
Clinical excellence awards	3,288	1,395
Grossing up consortium arrangements	487	383
Other income generation schemes (recognised under IFRS 15)	10,038	8,801
Other income not already covered (recognised under IFRS 15)	11,921	1,849
Total "Other" Contract Income	**28,741**	**15,305**

*In 2021-22, top up funding was incorporated into our block contract income from CCGs, and classified as patient treatment income. In 2020-21, these top-up funding payments came from NHS England, and were classified as “other” operating income. To ensure comparability year on year, the 2020-21 income figures have been restated to ensure alignment with the 2021-22 classification.

9 Operating expenses

	2021-22	2020-21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	12,583	6,366
Purchase of healthcare from non-NHS and non-DHSC bodies	20,898	13,662
Staff and executive directors costs	1,189,814	1,118,475
Remuneration of non-executive directors	191	144
Supplies and services - clinical (excluding drugs costs)	157,015	161,880
Supplies and services - general	76,716	103,104
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	190,239	173,598
Consultancy costs	1,306	2,785
Establishment	10,225	11,098
Premises	62,781	86,388
Transport (including patient travel)	14,405	11,178
Depreciation on property, plant and equipment	60,437	56,112
Amortisation on intangible assets	20	38
Net impairments (Note 10)	15,138	15,311
Movement in credit loss allowance: contract receivables / contract assets	15,031	12,356
Change in provisions discount rate(s)	143	501
Audit fees payable to the external auditor - statutory audit*	144	143
Internal audit costs	650	823
Clinical negligence - amounts payable to NHS Resolution (premium)	56,673	53,014
Legal fees	1,029	2,310
Insurance	1,600	1,573
Research and development	23,715	20,939
Education and training	4,969	3,626
Rentals under operating leases	5,374	3,670
Redundancy	231	18
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	26,794	26,143
Hospitality	340	3,361
Losses, ex gratia & special payments	331	163
Other	26,943	31,630
Total	**1,975,735**	**1,920,409**
Of which:		
Related to continuing operations	1,975,735	1,920,409

*The fee to the external auditors for their audit of the financial statements is £143,880, which includes non-recoverable VAT at 20% of £23,980.
(2020-21: £143,160, which included non-recoverable VAT at 20% of £23,860)

No other services were provided by the external auditors in 2021-22 and 2020-21.

9.1 Limitation on auditor's liability

The limitation on auditors liability for external audit work is £0m (2020-21: £0m.)

10 Impairment of assets

	2021-22 £000	2020-21 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price*	15,138	15,311
Total net impairments charged to operating surplus / deficit	**15,138**	**15,311**
Impairments charged to the revaluation reserve**	30,294	71,789
Total net impairments	**45,432**	**87,100**

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 2021-22, the general movement of revaluation on buildings was upwards.

*However, several of the Trust's assets, primarily at Newham Hospital and Whipps Cross Hospital, were impaired by a total of £15.138m over and above their ring-fenced revaluation reserve balances, and this has been charged to the Statement of Comprehensive Income. The main areas were in relation to fire upgrade works at Newham, and works to the Victorian and Edwardian blocks at Whipps Cross.

**Impairments of £30.294m relating to these and other assets were charged to the available balances in the revaluation reserve.

11 Staff Costs

	2021-22 Total £000	2020-21 Total £000
Salaries and wages	926,214	867,466
Social security costs	96,288	89,572
Apprenticeship levy	4,479	4,173
Employer's contribution to NHS pensions*	137,329	129,563
Pension cost - other	129	121
Termination benefits	231	18
Temporary staff (including agency)	48,582	32,501
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure**	(16,486)	0
Total staff costs	**1,196,766**	**1,123,414**
Of which:		
Costs capitalised as part of assets	5,784	4,098

*In 2021-22, this includes the additional employer pension contribution of £41.763m (6.3%) which was paid by NHS England on the Trust's behalf (2020-21: £39.387m (6.3%))

** In May 2021, Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust set up a shared pathology service. The arrangement is a joint operation as defined by IFRS11, with the Trust accounting for its share of the assets, liabilities, income and expenses of the service. The adjustment of £16,486k relates to the netting off of the partners' shares of the staff costs.

11.1 Retirements due to ill-health

During 2021-22 there were 6 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £335k (£121k in 2020-21).

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

12 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 2022, is based on valuation data as at 31 March 2021, updated to 31 March 2022 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 also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 (see **Amending Directions 2021**) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at

https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

The 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 2021-22 was 3% (2020-21:3%).

13 Operating leases

13.1 Barts Health NHS Trust as a lessor

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

	2021-22	2020-21
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	2,165	1,722
Total	**2,165**	**1,722**

	31 March 2022	31 March 2021
Future minimum lease receipts due:	**£000**	**£000**
- not later than one year;	2,582	2,572
- later than one year and not later than five years;	10,435	9,963
- later than five years.	84,547	83,294
Total	**97,564**	**95,829**

13.2 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.

	2021-22	2020-21
Operating lease expense	**£000**	**£000**
Minimum lease payments	5,374	3,670
Total	**5,374**	**3,670**

	31 March 2022	31 March 2021
Future minimum lease payments due:	**£000**	**£000**
- not later than one year;	7,892	2,052
- later than one year and not later than five years;	27,158	1,065
- later than five years.	4,385	207
Total	**39,435**	**3,324**

14 Finance income

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

	2021-22	2020-21
	£000	**£000**
Interest on bank accounts (Government Banking Service)	110	16
Total finance income	**110**	**16**

15 Finance expenses

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

	2021-22	2020-21
	£000	**£000**
Interest expenses:		
Loans from the Department of Health and Social Care	0	6
Finance leases	72	150
Interest on late payment of commercial debt	1	5
Main finance costs on PFI schemes obligations	33,255	34,099
Contingent finance costs on PFI schemes obligations	30,936	29,756
Total interest expenses	**64,264**	**64,016**
Unwinding of discount on provisions	(101)	479
Total finance costs	**64,163**	**64,495**

16 Other gains / (losses)

	2021-22 £000	2020-21 £000
Gains on disposal of assets*	160	120
Losses on disposal of assets**	(6,834)	0
Total gains / (losses) on disposal of assets	**(6,674)**	**120**

The figures disclosed above are the net book value of the assets, less the costs of disposal.

*In 2021-22 and 2020-21, the Trust sold a number of minor equipment items which had reached the end of their useful life.

**In 2020-21, the Trust received a number of donated assets from the Department of Health & Social Care (DHSC), in support of its response to COVID. In 2021-22, the Trust returned some of these assets to DHSC. Although in technical accounting terms this is treated as a loss, it has no impact on the Trust's financial position.

17 Intangible assets 2021-22

	Software licences	IT	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - b/f	**1,704**	**670**	**2,374**
Additions	130	0	**130**
Valuation / gross cost at 31 March 2022	**1,834**	**670**	**2,504**
Amortisation at 1 April 2021 - b/f	**1,642**	**670**	**2,312**
Provided during the year	20	0	**20**
Amortisation at 31 March 2022	**1,662**	**670**	**2,332**
Net book value at 31 March 2022	**172**	**0**	**172**
Net book value at 1 April 2021	**62**	**0**	**62**

17.1 Intangible assets 2020-21

	Software licences	IT	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020	**1,704**	**670**	**2,374**
Valuation / gross cost at 31 March 2021	**1,704**	**670**	**2,374**
Amortisation at 1 April 2020 - as previously stated	**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**

18 Property, plant and equipment 2021-22

	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 2021 - B/F	**127,510**	**1,158,867**	**1,093**	**21,048**	**227,111**	**162**	**60,791**	**441**	**1,597,023**
Additions	0	53,103	0	11,665	20,426	0	8,625	44	**93,863**
Impairments charged to the revaluation reserve	0	(29,177)	(1,117)	0	0	0	0	0	**(30,294)**
Revaluations	1,005	12,662	(213)	0	0	0	0	0	**13,454**
Reclassifications	0	3,231	2,578	(9,602)	3,227	0	566	0	**0**
Disposals / derecognition	0	0	0	0	(12,690)	0	(2,255)	0	**(14,945)**
Valuation/gross cost at 31 March 2022	**128,515**	**1,198,686**	**2,341**	**23,111**	**238,074**	**162**	**67,727**	**485**	**1,659,101**
Accumulated depreciation at 1 April 2021 - B/F	**0**	**47,395**	**213**	**0**	**137,213**	**162**	**23,000**	**387**	**208,370**
Provided during the year	0	31,120	212	0	18,062	0	11,014	29	**60,437**
Impairments charged to operating expenses	0	15,138	0	0	0	0	0	0	**15,138**
Revaluations	0	(47,395)	(213)	0	0	0	0	0	**(47,608)**
Disposals / derecognition	0	0	0	0	(5,807)	0	(2,255)	0	**(8,062)**
Accumulated depreciation at 31 March 2022	**0**	**46,258**	**212**	**0**	**149,468**	**162**	**31,759**	**416**	**228,275**
Net book value at 31 March 2022	128,515	1,152,428	2,129	23,111	88,606	0	35,968	69	**1,430,826**
Net book value at 1 April 2021	127,510	1,111,472	880	21,048	89,898	0	37,791	54	**1,388,653**

18.1 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 Restated	**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 charged to the revaluation reserve	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	**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 charged to operating expenses	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**

18.2 Property, plant and equipment financing 2021-22

	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 2022								
Owned - purchased	128,515	326,678	1,711	22,685	78,802	35,708	25	**594,124**
Finance leased	0	4,290	193	0	0	0	0	**4,483**
On-SoFP PFI contracts	0	783,578	0	0	0	0	0	**783,578**
Owned - donated / granted	0	37,882	225	426	9,804	260	44	**48,641**
NBV total at 31 March 2022	**128,515**	**1,152,428**	**2,129**	**23,111**	**88,606**	**35,968**	**69**	**1,430,826**

18.3 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**

19 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	10,766	10,069
Consumables	13,385	11,645
Energy	183	292
Total inventories	**24,334**	**22,006**
Of which:		
Held at lower of cost and Net Realisable Value	24,334	22,006

Inventories recognised in expenses for the year were £285,139k (2020-21: £276,621k).
Write-down of inventories recognised as expenses for the year were £0k (2020-21: £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 2021-22 the Trust received £7,214k of items purchased by DHSC. (2020-21:£22,397k). The deemed cost of these inventories was charged directly to expenditure on receipt, with the corresponding benefit recognised in income.

20 Trade receivables and other receivables

	31 March 2022	31 March 2021
Current	£000	£000
Contract receivables (Note 20.2)	110,696	89,576
Allowance for impaired contract receivables / assets	(26,534)	(15,507)
Prepayments (non-PFI)	6,543	6,821
Prepayments (PFI)	31,185	28,976
PFI lifecycle prepayments	253	253
PDC dividend receivable	0	4,828
VAT receivable	4,484	10,763
Other receivables	966	5,127
Total current trade and other receivables	**127,593**	**130,837**
Non-current		
Contract receivables	8,832	7,405
PFI lifecycle prepayments	4,105	6,571
Other receivables	2,213	1,872
Total non-current trade and other receivables	**15,150**	**15,848**
Of which receivables from NHS and DHSC group bodies:		
Current	59,849	67,044
Non-current	2,213	1,872

20.1 Allowances for credit losses: Contract receivables and contract assets

	2021-22	2020-21
	£000	£000
Allowances as at 1 April - brought forward	**15,507**	**22,294**
New allowances arising	18,896	13,717
Reversals of allowances (where receivable is collected in-year)	(3,865)	(1,361)
Utilisation of allowances (where receivable is written off)	(4,004)	(19,143)
Allowances as at 31 March	**26,534**	**15,507**

20.2 Exposure to credit risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Included in the contract receivables figure in Note 20 are invoiced amounts of £83,838k.

Of this amount, £55,836k relates to Department of Health & Social Care Group bodies (no credit risk), and £28,002k relates to non-NHS organisations.

Of the invoices raised to non-NHS organisations, the non impaired values, by days outstanding, is shown below. The majority of the unimpaired value relates to receivables due from local authorities and charities (low credit risk).

	31 March 2022	31 March 2021
	£000	£000
0 to 30 days	6,516	3,663
30 to 60 days	1,272	1,619
60 to 90 days	563	1,043
90 to 180 days	1,202	2,385
Over 180 days	374	3,223
Total	**9,927**	**11,933**

21 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.

	2021-22	2020-21
	£000	£000
At 1 April	**54,207**	**3,316**
Net change in year	32,448	50,891
At 31 March	**86,655**	**54,207**
Analysed as:		
Cash in hand	16	21
Cash with the Government Banking Service	86,639	54,186
Total cash and cash equivalents as in SoFP	**86,655**	**54,207**
Total cash and cash equivalents as in SoCF	**86,655**	**54,207**

21.1 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 2022	31 March 2021
	£000	£000
Bank balances	91	89
Total third party assets	**91**	**89**

22 Trade and other payables

	31 March 2022	31 March 2021
Current	**£000**	**£000**
Trade payables	69,014	66,764
Capital payables	5,163	6,423
Accruals	136,849	99,904
Social security costs	4,148	0
Other taxes payable	0	2,848
PDC dividend payable	7	0
Other payables*	16,516	1,523
Total current trade and other payables	**231,697**	**177,462**
Of which, payables from NHS and DHSC group bodies:		
Current	33,581	19,688

* The majority of this balance relates to the Trust's payover of pension contributions to NHS Pensions.

22.1 Early retirements in "Other payables" above

In 2021-22, there are nil amounts included in "other" payables to buy out the liability for early retirements (nil in 2020-21).

23 Other financial liabilities

There were nil "other financial liabilities" at the 31st March 2022 (nil at 31st March 2021).

24 Other liabilities

	31 March 2022	31 March 2021
Current	**£000**	**£000**
Deferred income: contract liabilities (IFRS 15)	7,217	1,954
Total other current liabilities	**7,217**	**1,954**
Non-current		
Deferred income: contract liabilities (IFRS 15)	500	0
Total other non-current liabilities	**500**	**0**

25 Borrowings

	31 March 2022	31 March 2021
Current	**£000**	**£000**
Obligations under finance leases	1,779	1,746
Obligations under PFI service concession contracts (excl. lifecycle)	25,337	25,028
Total current borrowings	**27,116**	**26,774**
Non-current		
Obligations under finance leases	2,293	533
Obligations under PFI service concession contracts	915,371	940,707
Total non-current borrowings	**917,664**	**941,240**

25.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	PFI schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021 - brought forward	**0**	**2,279**	**965,735**	**968,014**
Cash movements:				
Financing cash flows - payments and receipts of principal	0	(2,064)	(25,028)	**(27,092)**
Financing cash flows - payments of interest	0	(72)	(33,254)	**(33,326)**
Non-cash movements:				
Additions	0	3,857	0	**3,857**
Interest charge arising in year (application of effective interest rate)	0	72	33,255	**33,327**
Carrying value at 31 March 2022	**0**	**4,072**	**940,708**	**944,780**

	Loans from DHSC	Finance leases	PFI schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**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:				
Interest charge arising in year (application of effective interest rate)	0	150	34,099	**34,249**
Carrying value at 31 March 2021 - carried forward	**0**	**2,279**	**965,735**	**968,014**

26 Finance leases

26.1 Barts Health NHS Trust as a lessee

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

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**4,134**	**2,347**
Of which liabilities are due:		
- not later than one year;	1,819	1,803
- later than one year and not later than five years;	2,315	544
- later than five years.	0	0
Finance charges allocated to future periods	(62)	(68)
Net lease liabilities	**4,072**	**2,279**
Of which payable:		
- not later than one year	1,779	1,746
- later than one year and not later than five years	2,293	533
- later than five years.	0	0

27 Provisions for liabilities and charges analysis

	Pensions: early departure costs*	Pensions: injury benefits	Legal claims	Redncy	Other**	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2021	**13,036**	**4,083**	**661**	**223**	**3,743**	**21,746**
Change in the discount rate	0	143	0	0	0	**143**
Arising during the year	386	38	317	0	20,006	**20,747**
Utilised during the year	(13,161)	(212)	0	(214)	0	**(13,587)**
Reversed unused	(199)	(33)	(318)	0	(3,743)	**(4,293)**
Unwinding of discount	(62)	(39)	0	0	0	**(101)**
At 31 March 2022	**0**	**3,980**	**660**	**9**	**20,006**	**24,655**
Expected timing of cash flows:						
- not later than one year;	0	214	660	9	17,793	**18,676**
- later than one year and less than five years;	0	856	0	0	2,213	**3,069**
- later than five years.	0	2,910	0	0	0	**2,910**
Total	**0**	**3,980**	**660**	**9**	**20,006**	**24,655**

*In 2021-22, the Trust entered into an agreement with NHS Pensions to buy out its liabilities relating to its early retirement provision. The buy out will generate both revenue and cash savings in future years.

**Other provisions include:

- a tax liability of £2.3m for 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 will be re-imbursed by NHS England for this charge.

- a potential liaibility of £17.8m relating to arrears of staff pay.

28 Clinical negligence liabilities

	31 March 2022 £000	31 March 2021 £000
Included in the provisions of NHS Resolution in respect of clinical negligence liabilities of Barts Health NHS Trust	1,306,214	858,178

29 Contingent assets and liabilities

	31 March 2022	31 March 2021
Value of contingent liabilities	**£000**	**£000**
NHS Resolution legal claims	(197)	(199)
Gross value of contingent liabilities	**(197)**	**(199)**
Net value of contingent liabilities	**(197)**	**(199)**
Net value of contingent assets	0	0

30 Contractual capital commitments

Property, plant and equipment	7,302	6,338
Total	**7,302**	**6,338**

The 2021-22 capital commitments, similar to the 2020-21 capital commitments, relate mainly to fire safety, redevelopment and building works across various Trust sites, as well as clinical equipment purchases.
The largest commitments are £2.9m to provide a second CT scanner at Newham Hospital; £0.7m to provide a new MRI scanner at Mile End Hospital as part of a community development; and £0.7m for the continuation the programme of fire safety works at Newham Hospital.

31 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.

31.1 Imputed finance lease obligations on the SoFP

	Both Sites 31 March 2022 £000	Barts & RLH 31 March 2022 £000	Newham 31 March 2022 £000	Both Sites 31 March 2021 £000
Gross PFI Obligation	**1,423,597**	**1,365,334**	**58,263**	**1,481,878**
Of which liabilities are due:				
- not later than one year;	**57,713**	53,791	3,922	58,282
- later than one year and not later than five years;	**223,735**	210,285	13,450	226,075
- later than five years.	**1,142,149**	1,101,258	40,891	1,197,521
Finance charges allocated to future periods	**(482,889)**	(451,073)	(31,816)	(516,143)
Net PFI obligation:	**940,708**	**914,261**	**26,447**	**965,735**
Of which liabilities are due:				
- not later than one year;	**25,337**	24,270	1,067	*25,028*
- later than one year and not later than five years;	**103,165**	100,252	2,913	*101,935*
- later than five years.	**812,206**	789,739	22,467	*838,772*

31.2 Total futue PFI payments

	Both Sites 31 March 2022 £000	Barts & RLH 31 March 2022 £000	Newham 31 March 2022 £000	Both Sites 31 March 2021 £000
Total future payments committed in respect of PFI schemes	**4,732,489**	**4,543,027**	**189,462**	**4,601,119**
Of which liabilities are due:				
- not later than one year;	**134,867**	125,681	9,186	*124,420*
- later than one year and not later than five years;	**574,041**	534,942	39,099	*529,564*
- later than five years.	**4,023,581**	3,882,404	141,177	*3,947,135*

31.3 Analysis of amounts paid and payable to service concession operators

	Both Sites 2021-22 £000	Barts & RLH 2021-22 £000	Newham 2021-22 £000	Both Sites 2020-21 £000
Unitary payment payable to service concession operator, consisting of:				
- Interest charge	33,255	30,311	2,944	34,099
- Repayment of finance lease liability	25,028	24,292	736	24,039
- Service element and other charges to operating expenditure	26,794	24,549	2,245	26,143
- Capital lifecycle maintenance	8,662	8,016	646	8,700
- Contingent rent	30,936	29,015	1,921	29,756
	124,675	**116,183**	**8,492**	**122,737**
Other amounts paid to operator due to a commitment under the service concession contract, but not part of the unitary payment	5,747	5,747	0	3,352
Total amount paid to service concession operator	**130,422**	**121,930**	**8,492**	**126,089**

31.4 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	**36,007**	10,019	25,988
Between One and Five Years	**161,068**	51,308	109,760
Later than Five Years	**1,175,967**	382,543	793,424
Total	**1,373,042**	**443,870**	**929,172**

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	**89,674**	24,270	29,521	35,883
Between One and Five Years	**373,874**	100,252	110,033	163,589
Later than Five Years	**2,706,437**	789,739	311,519	1,605,179
Total	**3,169,985**	**914,261**	**451,073**	**1,804,651**

31.5 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	**2,729**	346	2,383
Between One and Five Years	**15,546**	4,946	10,600
Later than Five Years	**53,586**	16,695	36,891
Total	**71,861**	**21,987**	**49,874**

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	**6,457**	1,067	2,855	2,535
Between One and Five Years	**23,553**	2,913	10,537	10,103
Later than Five Years	**87,591**	22,467	18,424	46,700
Total	**117,601**	**26,447**	**31,816**	**59,338**

32 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 2022 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.

32.1 Carrying values of financial assets

	2021-22	2020-21
	Held at amortised cost	Held at amortised cost
Carrying values of financial assets as at 1 April	**£000**	**£000**
Trade and other receivables excluding non financial assets	85,097	77,325
Cash and cash equivalents at bank and in hand	86,655	54,207
Total at 31 March	**171,752**	**131,532**

32.2 Carrying value of financial liabilities

	2021-22	2020-21
	Held at amortised cost	Held at amortised cost
Carrying values of financial liabilities as at 1 April	**£000**	**£000**
Obligations under finance leases	4,072	2,279
Obligations under PFI	940,708	965,735
Trade and other payables excluding non financial liabilities	207,611	156,224
Total at 31 March	**1,152,391**	**1,124,238**

32.3 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 2022	31 March 2021
	£000	**£000**
In one year or less	267,143	216,309
In more than one year but not more than five years	226,050	226,619
In more than five years	1,142,149	1,197,521
Total at 31 March	**1,635,342**	**1,640,449**

33 Losses and special payments

	2021-22		2020-21	
	Number of cases	Value of cases	Number of cases	Value of cases
	Number	£000	Number	£000
Losses				
Cash losses	6	2	184	501
Fruitless payments	0	0	17	30
Bad debts and claims abandoned*	2,389	4,002	2,772	12,930
Total losses	**2,395**	**4,004**	**2,973**	**13,460**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	1	14
Ex-gratia payments**	78	331	55	22
Total special payments	**78**	**331**	**56**	**36**
Total losses and special payments	**2,473**	**4,336**	**3,029**	**13,496**

*In 2021-22 and 2020-21, 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.

**Included in ex-gratia payments is a sum of £287k, which represents settlement of the "Flowers" court case. The court found that staff who work "regular" overtime are entitled to have both non-guaranteed and voluntary overtime taken into account for the purposes of calculating their statutory and contractual holiday pay. This is a ruling that affects all NHS organisations.

34 Gifts

The disclosure of gifts is only required if the total value of gifts made exceeds £300,000.
No such gifts were received in 2021-22 (2020-21: nil)

35 Events after the reporting date

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

In 2021-22, there were no such events affecting the Trust.

36 Related parties

During 2021-22 and 2020-21, Barts Health NHS Trust has had a significant number of material transactions (income and expenditure, and 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:

NHS 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
Lewisham and Greenwich NHS Trust
Mid and South Essex Hospital Services NHST
Moorfields Eye Hospital NHS Foundation Trust
North East London NHSFT
Royal Free London NHSFT
University College London Hospitals NHSFT

Other

Care Quality Commission
Community Health Partnerships
Department of Health and Social Care
Health Education England
HM Revenue & Customs
NHS England (including London & East of England Regional Offices)
NHS Pensions
NHS Property Services
NHS Resolution

NHS Clinical Commissioning Groups

Basildon and Brentwood CCG
Castle Point and Rochford CCG
East and North Hertfordshire CCG
Herts Valleys CCG
Kent and Medway CCG
Mid Essex CCG
North Central London CCG*
North East Essex CCG*
North East London CCG*
North West London CCG*
South East London CCG*
South West London CCG*
Southend CCG
Thurrock CCG
West Essex CCG

Local Authorities

Common Council of the City of London
Newham London Borough Council
Tower Hamlets London Borough Council
Waltham Forest London Borough Council

*In 2021-22 and 2020-21, as part of the continuing 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).

37 Better Payment Practice code

	2021-22		2020-21	
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	185,649	1,263,891	171,379	1,204,391
Total non-NHS trade invoices paid within target	148,229	1,126,501	128,590	1,044,124
% of non-NHS trade invoices paid within target	**79.8%**	**89.1%**	**75.0%**	**86.7%**
NHS Payables				
Total NHS trade invoices paid in the year	5,011	266,047	6,605	287,324
Total NHS trade invoices paid within target	2,013	230,442	1,717	251,949
% of NHS trade invoices paid within target	**40.2%**	**86.6%**	**26.0%**	**87.7%**

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

Large print and other languages

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

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

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

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

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

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

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

Switchboard: 020 3416 5000
www.bartshealth.nhs.uk

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