

# Quality Accounts and Annual Report

2015/16





# Contents Page

## Introduction and overview

CEO and Chair statement	5
About us	6

## Our performance over 2015/16

### Delivering Safe and Compassionate care in our hospitals

1. Overview	9
2. Safe and effective care	12
3. Compassionate care and patient experience	20
4. End of life care	28
5. Our Workforce	29
6. Emergency pathway and patient flow	32
7. Outpatients and medical records	33
8. Leadership and organisational development	34

### Delivering Safe and Compassionate care in our communities

1. Community Health Services	38
2. Public health	40

## Innovation in healthcare

1. Our Education Academy	43
2. Research and development	45
3. Working with Barts Charity	46
4. Sustainable healthcare	46

## CQUINs

Our performance against CQUINs in 2015-16	52
---	----

## Our year ahead

1. Summary of our priorities for 2016/17	55
2. Our 16-17 CQUINs	58

## Quality Assurance

Mandated indicators	63
Participation in Mandatory Quality Account	
National Clinical Audit Projects 2015-16	72

## Appendix 1: Barts Health governance structure

Appendix 2: Feedback and reports from our stakeholders	86
--	----

# Contents Page (continued)

## **Corporate Governance Report**

The Trust Board	102
-----------------	-----

## **Annual Governance Statement 2015-16**

Appendix 1: Barts Health NHS Trust	115
1. Scope of responsibility	115
2. Governance framework of the organisation	115
3. The risk and control framework and risk assessment	119
4. Review of effectiveness of risk management and internal control	124

Appendix 1: board assurance framework - principal risks at March 2016	128
--	-----

## **Staff Policies and Benefits**

129

## **Annual Accounts 2015/16**

Foreword	145
Independent Auditor's Report to the Directors of Barts Health NHS Trust	148
Notes to the Accounts	157

# Introduction and overview

## Introduction

Everyone working at Barts Health has a common goal: to make sure the care we provide is as good as it can be. We want patients to have access to high quality care when they need it; we want our staff to feel valued and supported at all times and we want our local community and partner organisations to be confident in Barts Health as a provider of excellent care and an employer of choice.

Our staff are rightly proud of the many things we do well, but are also keen to make sure that we make the necessary improvements to provide excellent care across all of our services. The Care Quality Commission (CQC) reports published in spring 2015 found that the care provided at Whipps Cross, Newham and The Royal London hospitals was inadequate and we are sorry that we have let our patients down.

We have reflected on the challenges facing the Trust and what we need to do to address these and bring about improvements in patient and staff experience. In September 2015, we published an ambitious improvement plan to ensure we consistently deliver safe and compassionate care across our hospitals and community services.

We have made considerable progress towards achieving the goals we set for ourselves and are proud of the achievements we've made that

are highlighted in this report. We recognise that we are at the start of our journey and we are confident that we can build on our achievements from the past year to improve our CQC ratings from inadequate as a significant step towards exiting special measures. We are receiving welcome support under the 'special measures' regime to help us meet this ambition. We also value the support of our stakeholders, our partner organisations and, crucially, our staff, as we work together to deliver the necessary improvements for our patients.

This is a critical time for Barts Health. By working together now we can deliver lasting improvements that will benefit staff, patients and communities for years to come.

I confirm that to the best of my knowledge all the information in this document is accurate.

**John Bacon,**  
Chair of the Board

**Alwen Williams,**  
Chief Executive



## About us

The Barts Health group of hospitals provides a huge range of clinical services to people in east London and beyond. We operate from four major hospital sites (The Royal London, St Bartholomew's, Whipps Cross and Newham) and a number of community locations, including Mile End hospital. Around 2.5 million people living in east London and beyond look to our services to provide them with the healthcare they need.



The Royal London in Whitechapel is a major teaching hospital, providing local and specialist services in state-of-the-art facilities. Whipps Cross in Leytonstone is a large general hospital with a range of local services. Newham in Plaistow is a busy district hospital with innovative facilities such as its orthopaedic centre. Mile End hospital is a shared facility in Mile End for a range of inpatient, rehabilitation, mental health and community services. And St Bartholomew's in the City, London's oldest hospital, is a regional and national centre of excellence for cardiac and cancer care.

As well as district general hospital facilities for three London boroughs, Tower Hamlets, Waltham Forest and Newham, we have the largest cardiovascular centre in the UK, the second largest cancer centre in London, an

internationally-renowned trauma team, and the home of the London Air Ambulance. The Royal London also houses one of the largest children's hospitals in the UK, a major dental hospital, and leading stroke and renal units.

Bolstered by our partnership with Queen Mary University of London (QMUL), we have a strong reputation for medical teaching and multi-disciplinary research. This attracts top clinicians to work for us, and generates innovations in patient care; each year we recruit 30,000 patients into pioneering clinical trials. We are also part of nationally-recognised vanguard projects for developing cancer services (across north east London) and integrating out-of-hospital care (within Tower Hamlets).

We are determined to be at the forefront of efforts to improve public health and tackle health inequalities for one of the most diverse and deprived populations in the country. More than half our patients are from black and minority ethnic communities, more than 60 languages are spoken in our hospitals, and there are high levels of poverty, overcrowding, unemployment and poor health in our catchment areas. Our population is also growing rapidly: in 15 years it is estimated we will have an additional 270,000 residents – the size of an extra London borough.

Our aim is to be renowned for delivering safe and compassionate care on a daily basis, and we are on an exciting journey to improve the quality of all our services for patients.



## Barts Health NHS Trust in numbers

Our local population is growing:

within 15 years it is estimated there will be another

**270,000**

residents

living locally –

equivalent to the size of another London borough.



We have **16,000** committed and dedicated staff, caring for almost



**6,000 patients**

who pass through our doors every single day.



During a year, our staff deliver **16,500 babies**,

treat **167,000 inpatients**,

look after **455,000** emergency cases,

and care for **1.5 million** outpatients.



We recruit

**30,000 patients**

into research trials.



# Our performance from 2015-16



## Delivering safe and compassionate care in our hospitals

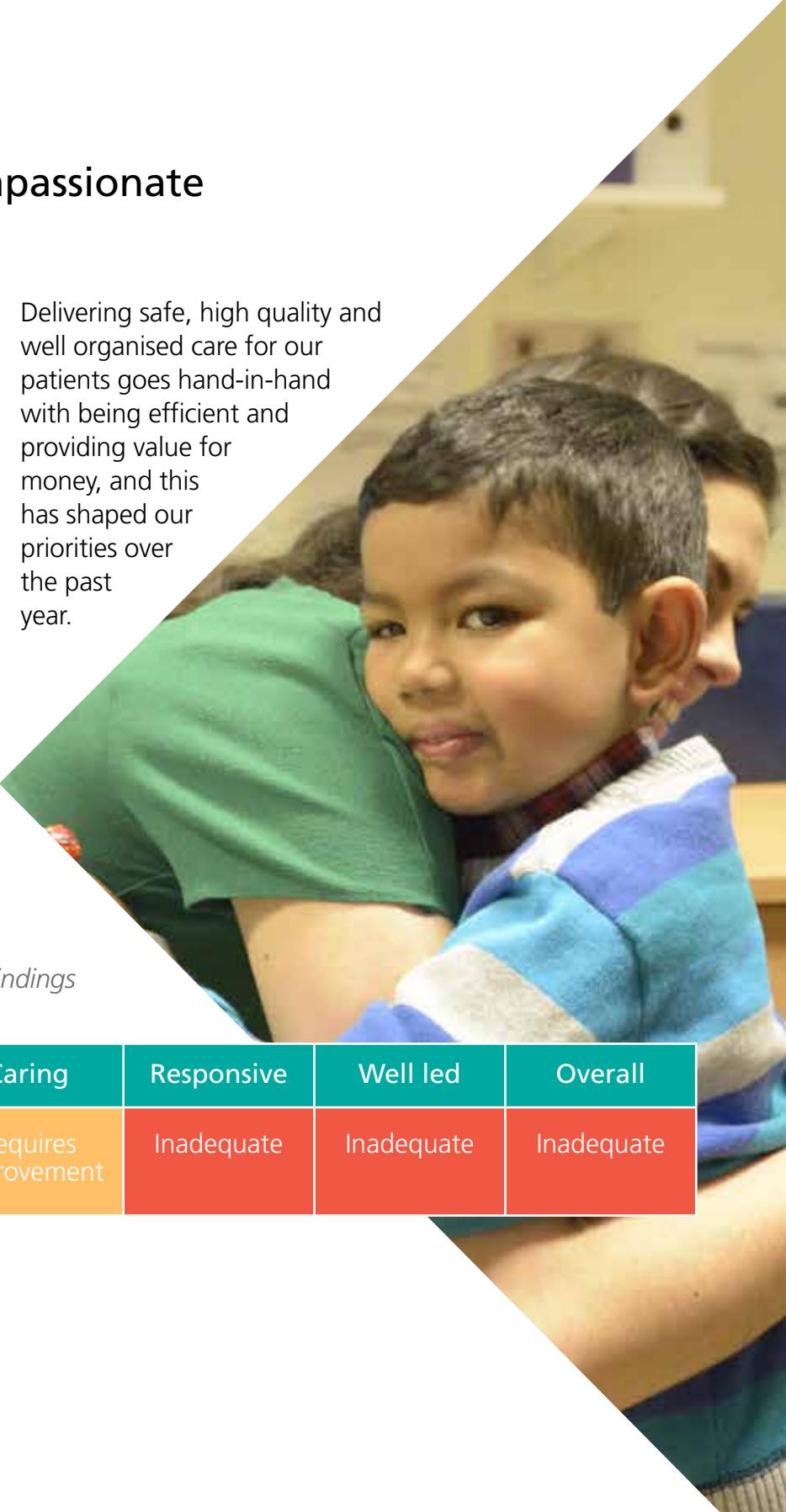
### Overview of our performance

In March 2015, the Care Quality Commission (CQC) rated us as "inadequate" and placed the Trust into special measures. Following this, we began a journey to ensure that all our services achieve the same high standards as those which are already nationally and internationally recognised. We took steps to make rapid improvements in our patient care, enhanced our operational performance, and put our finances on a firmer footing for the future.

Delivering safe, high quality and well organised care for our patients goes hand-in-hand with being efficient and providing value for money, and this has shaped our priorities over the past year.

*Summary of Care Quality Commission findings published in May 2015*

Safe	Effective	Caring	Responsive	Well led	Overall
Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate



Publication of the CQC reports a year ago found that our staff were caring and compassionate, but the organisation and its procedures had let them down and allowed standards to slip. We recognised the need to renew and reshape our leadership team to lead our ambitious improvement plan, *Safe and Compassionate*, which defined our seven priorities and objectives for 2015-16. Our new Chair, John Bacon, and new Chief Executive, Alwen Williams, have recruited a top-class team with a view to maintaining discipline and control over short-term operational performance as we developed a long-term clinical strategy.

Monthly reports from our Board, which are published on *NHS Choices* and our website, have charted this improvement journey to demonstrate that the care our patients receive in all of our hospitals is safe and compassionate as a matter of course. The reports have shown how we have empowered and supported clinical teams to improve care, ensured the patient voice is heard throughout the organisation, and we have embedded a zero-harm safety culture in the way we work.

We prioritised action to address the CQC warning notices and ensure compliance with failings. For example at Whipps Cross, we reduced non-clinical cancellations by 40 per cent in six months, trained four out of five staff in techniques that were previously lacking, and raised nurse staffing levels.

Across the Trust, we adopted the *Sign up to Safety* campaign, made safety huddles a daily feature of hospital life, trained 112 safety champions to spread best practice, and launched a monthly bulletin to disseminate learning. As a result of an internal campaign, 80 wards achieved 30 days free of hospital-acquired pressure ulcers and 40 per cent of our wards achieved 100 days. The number of outstanding complaints and serious incidents fell, and staff compliance with

statutory and mandatory training requirements rose to over 90 per cent. We adopted *iWantGreatCare* as part of a new way to improve patient experience, and listen and respond to what patients are telling us.

Part of our challenge has been to maintain the operational standards laid down in the NHS Constitution. We have improved our performance against the eight cancer standards, meeting all standards for three months during 2015-16. This is a significant improvement from 18 months ago, where we only met one standard. We met the diagnostics standard consistently for a year and continued to meet the trajectory we agreed with local commissioners to get back on track with waiting times for operations. However, we have not reported how many patients were waiting longer than 18 weeks for treatment because of problems with data quality. We are continuing to validate the data and rebuild our patient tracking list, with a view to resuming reporting against the standard later in the year. We have also implemented a recovery plan in our emergency departments to raise the proportion of patients seen within four hours from 88 per cent to the 95 per cent standard.

It is crucial for the good running of our hospitals that we have an accurate picture of our operational performance. Although it has been a major undertaking, we are well on the way to rebuilding an effective and robust way for reporting patient waiting list data that holds true across all of our hospitals.



Our staff know better than anyone what can be improved and how, so we adopted a new staff-led approach to change. Conversations about what staff felt was needed to provide our patients with high quality care inspired the measures in our improvement plan *Safe and Compassionate*. The ideas from Big Conversations with our staff led to profound and fundamental changes to services, structures and systems across and within our services. Our staff are now at the centre of change, and challenge leaders not only to listen to them, but to give them permission and support to fix the problems they find at a local level for the benefit of their patients.

One of the issues that staff raised in the Big Conversations was their dissatisfaction with our IT equipment and customer service arrangements. In response, we invested £2m to upgrade IT equipment at Whipps Cross and used a triage system to channel calls to the helpdesk to improve the service staff received. In addition, small hospital-based teams were deployed to fix faults, and reduced the accumulated backlog of unresolved incidents by half.



Providing quality healthcare is expensive, and like all other NHS organisations the biggest single element of our finances are the wages and salaries of our doctors, nurses and support staff. This accounted for 60 per cent of our annual turnover in 2015-16. Recruiting and retaining sufficient numbers of clinical staff is crucial to maintaining the quality of our services to patients and this year we appointed 800 more permanent employees than last year.

Like other NHS trusts, we had a statutory duty to break even. However, like many other NHS providers in the current economic climate, we spent more money than we received. As the biggest NHS trust in the country, it is not surprising we had the largest deficit, forecast to be £135m for 2015-16. Some of this was accumulated debt, such as the £53m of fines and penalties imposed by local commissioners for failing to meet national standards in 2014-15, particularly in relation to waiting times for treatment. But we also fell short of our own commitment to make efficiency savings, a failing that only worsened in 2015-16. This equated to a loss of more than £11m a month, and meant that we were dependent on cash support from central government to stay in business.

Nevertheless, the new leadership team has taken concerted steps to stabilise our financial position in the year ahead. We instigated a turnaround programme, supported by experts from Deloitte and paid for by NHS Improvement, that helped us reduce unnecessary costs and improve productivity.

We also took steps to improve how we capture the activity that took place in our hospitals to accurately raise income. The creation of Barts Health from three former NHS trusts brought particular challenges in bringing together three separate operating systems and sets of data, and the process of aligning them is still not complete. One of the consequences of this has been that we failed to adequately capture and code all activity, and until this is resolved we will receive less income than we are entitled to.

This report demonstrates how far we have come in the past year, and outlines our achievements against our seven priorities alongside a blueprint for delivering further improvements in our hospitals and community services in 2016-17.

## Safe and effective care

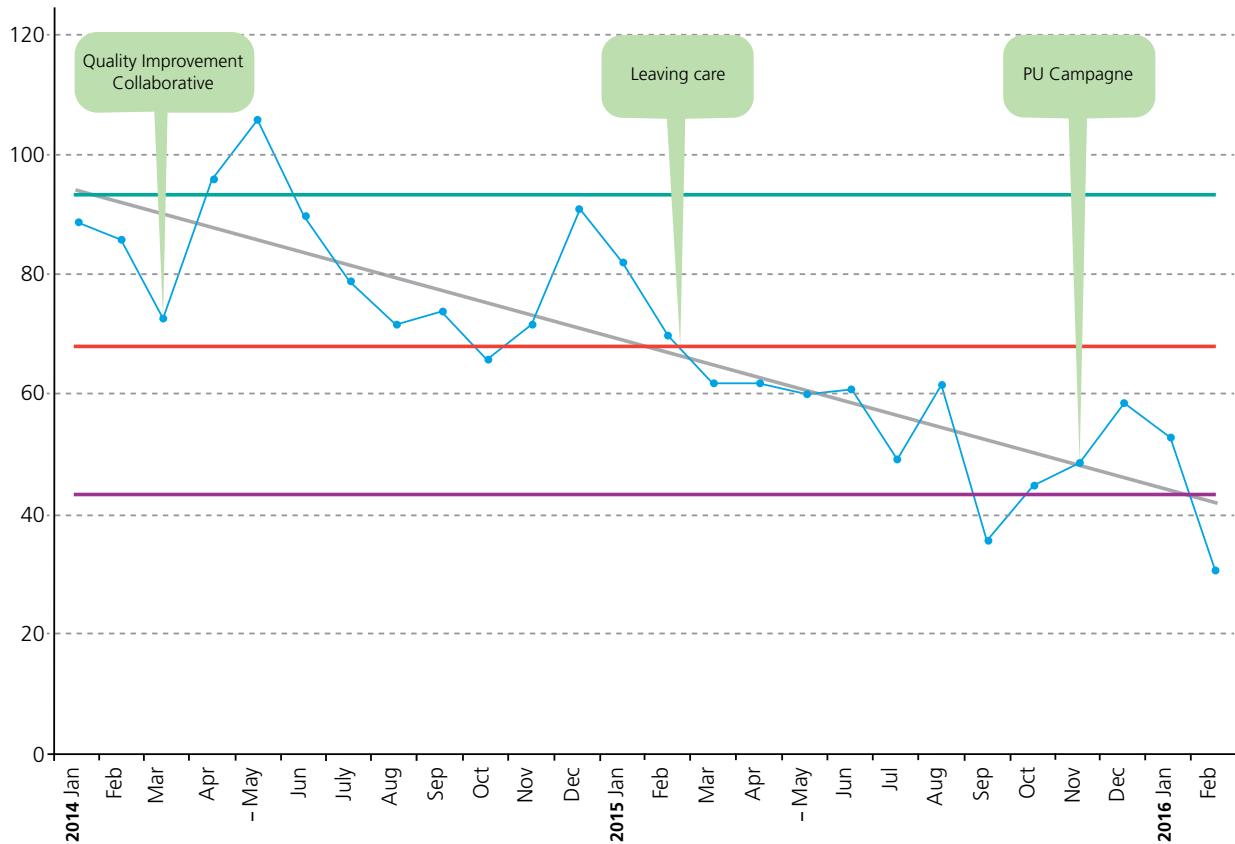
A number of concerns were raised in relation to the safety of our care from the Care Quality Commission (CQC) report published in May 2015. The CQC inspections found that we didn't place safety at the heart of everything we do – for example, we didn't always use best practice guidelines in the delivery of our care, the management of our medicines could have been improved, and we didn't always learn from the mistakes we made.

Improving the safety of our care, and responding to the concerns raised by the CQC, was a key priority over the past year and we were pleased that the impact of the changes we've made led to some improvements in safer care for our patients. For example, we saw a 37 per cent reduction in grade 2–4 hospital acquired pressure ulcers between January 2015 and January 2016. We also saw an increase in calls for medical emergencies, resulting in a reduction in cardiac arrests at Whipps Cross.

*We saw a reduction in hospital acquired pressure ulcers  
(January 2014 - February 2016)*

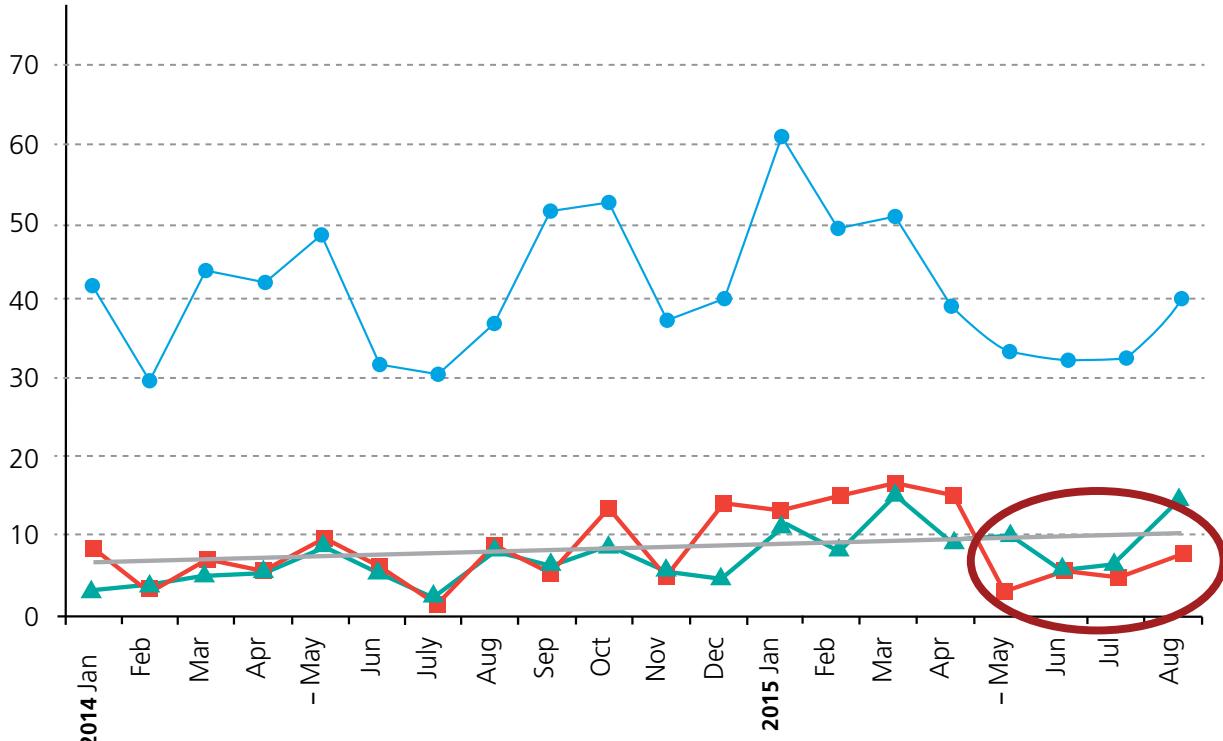
HAPU's from 01/04/14 Trust

Key	
●	Data
—	Mean
—	UCL
—	LCL
—	Linear Data



We saw a reduction in cardiac arrests at Whipps Cross Hospital  
(April 2015 - March 2016)

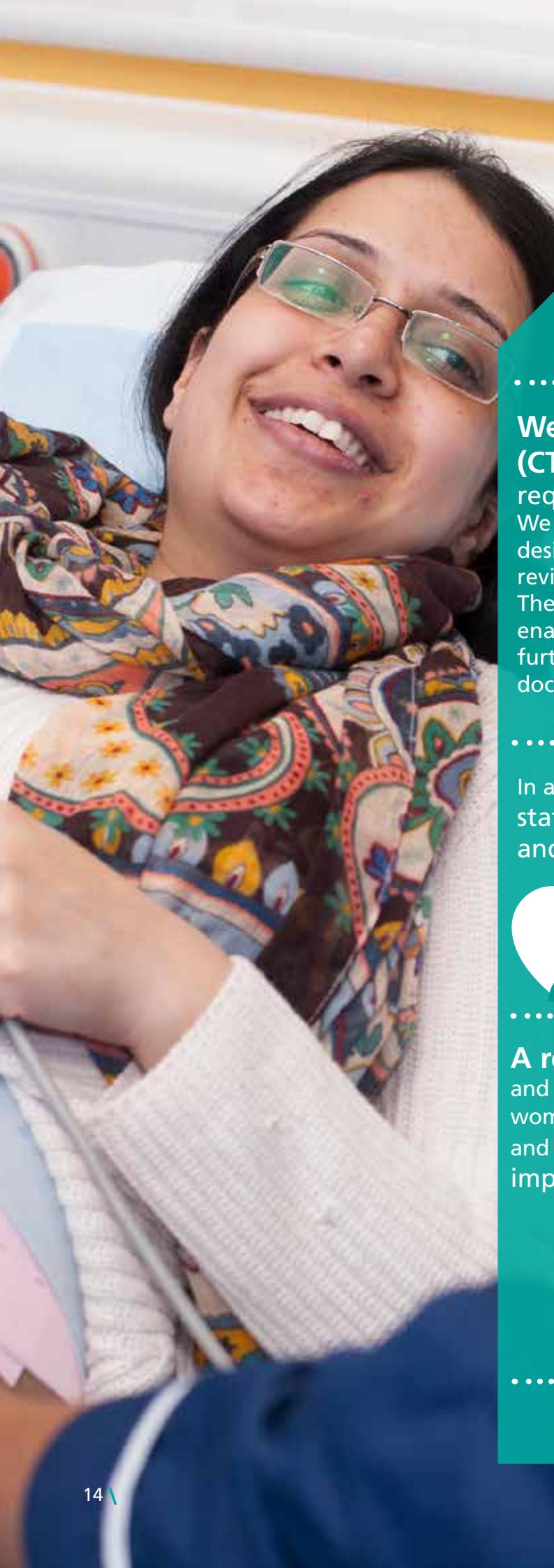
### WXH ward vs total calls



### **Safer care**

We started to screen for sepsis, which can cause patients significant harm and deterioration. As part of the sepsis CQUIN, a simple screening form was introduced at Whipps Cross maternity and A&E departments. This increased the number of patients with severe sepsis that

received antibiotics within an hour – 33 per cent and 23 per cent respectively. We launched the screening form at Newham's A&E department in January 2016.



## Improving care for mothers

We implemented a cardiotocograph (CTG) analysis for mothers that required continual monitoring in labour. We were the first to implement the newly designed monitors, enabling touch screen review and central station second eyes analysis. The ability of the system to only enable thumb print recognition further improved safety in documentation.



In addition, the care bundle 'triggers' staff to follow steps for consideration and instruction of escalation when abnormalities occur. This development is attracting external interest, and collaborations are planned.



A review of the care pathway and the required facilities for the highest risk women in labour was conducted, and improvements are being implemented.



## Safer staffing

In responding to the concerns raised about our care, we made sure that our staff had the right skills in place to deliver the best care to our patients. At the end of March 2016, 91.27 per cent of our 16,000 staff were compliant with their statutory and mandatory training – this is a record high for the Trust. We also improved the skills of our staff to focus on reducing harm to patients: 112 safety champions led on initiatives to embed safe care, and a further 200 staff received training in improvement methods which have helped them work with their teams to support safer care.

Over the past year, we also made sure that our staffing levels were safe by recruiting an additional 186 registered nurses and 132 non registered nurses.

## Caring for vulnerable people

A set of metrics were developed and agreed with our local authorities to monitor safeguarding activity. Each of our directors of nursing received monthly reports on these metrics, which included compliance with our training. Last year, 97 per cent of our staff were compliant with level one, and 80 per cent of our staff were compliant with level two adult and children safeguarding training. 81 per cent of our staff were compliant with level three children safeguarding training.

In November, we held a Mental Capacity Act Awareness Week and raised awareness of The Deprivation of Liberty Safeguards (DoLS). In addition to an internal campaign, an open lecture on legal issues relating to DoLS was delivered by our solicitors. We also launched a new "Capacity to Consent to Admission and Treatment" form across our hospitals for all admitted adult patients.

## A safe culture

We 'Signed Up To Safety', a national campaign

that supports implementation of the latest evidence-based practice in patient care, and established foundations for delivering safe care consistently across our hospitals. We responded rapidly to issues and shared learning from the mistakes we made. Thanks to grants received by the NHS Litigation Authority, we increased training to teams to deliver harm free care in pilot wards across our hospitals, and focused specifically on reducing pressure ulcers, falls, cardiac arrests, sepsis, deteriorating patients and obstetrics and intrapartum safety and care.

Key to instilling a culture of safety across the Trust is to improve communication and raise awareness of the resources available to deliver safe care. Over the past year, we launched a monthly safety newsletter that shared learning and signposted our staff to resources; promoted safety issues through campaigns, events and our staff intranet; and improved the accessibility of our policies and procedures on the intranet so that they can be found easily at the point in which they're needed. We held campaigns that focused specifically on reducing harm, including the reduction of pressure ulcers and falls, eliminating 'never events' from nasogastric tubes and we implemented national Safety Standards For Invasive Procedures (NatSSIPs). These harm free care events and mini conferences will continue in 2016-17.

## Improved governance

We embedded escalation processes to raise concerns, and held daily safety huddles in all our hospitals to respond to issues in a timely manner, and support staff to deal with complex issues. We also set up governance teams and quality and safety boards at each of our hospitals (see Appendix 1) that drove local improvements, responded to incidents and complaints, and escalated risks and issues. Importantly, these teams helped us learn from our patients' complaints and improve the care we provide.

## Using data to improve our care

Measuring the impact of the improvements we've put in place was an important aspect of our work over the past year. To help us do this, we established a quality and safety dashboard for wards that was used to view and track our performance at a team, ward and Trust level.

We also ran training programmes for our staff so that they can use the dashboards effectively to run their wards and ensure the care we're providing is consistently safe and issues are responded to effectively.

## When things go wrong

We saw improvements to our incident reporting culture and reported 25,905 patient safety incidents via the Datix reporting system during 2015-16. This was an increase of 2,159 incidents compared to last year, placing us in the middle range of reporters across the NHS, and demonstrates that we have embedded a culture of openness, honesty and transparency across the Trust. We provided investigation training to 269 staff and are developing a handbook that will be launched later this year to improve the quality of Serious Incident (SI) investigations.

We reported 398 SIs in 2015-16 (40 were de-escalated as they did not meet the Serious Incident Framework 2015 criteria) in comparison with 459 last year, where 31 were de-escalated as they did not meet the criteria. During 2014-15, our commissioners raised concerns regarding the 100 overdue SI investigations; we

have reduced this to 19. However, there was an increase of 'never events' in all of our four main hospitals – 14 over the year, compared with five last year. This is not acceptable and has to stop. To eliminate these never events, we investigated each incident thoroughly and found that staff were honest about the failings and transparent with the patients involved and their carers. We worked with teams and individuals to learn from these mistakes and raised awareness of everyone's personal responsibility for safe patient care. We also held a risk summit to identify areas that we need to improve and shared an action plan with local commissioners to eliminate these never events from occurring again.

We regretted a number of patient safety incidents in 2015-16 that involved severe harm to or the death of a patient, either as a direct result of the incident or linked to it in some way. The table across shows the specific numbers involved, including the difference between the Barts Health (Datix reporting system) and NRLS figures. This difference is accounted for by changes to the original level of harm which are sometimes required to be made to the Trust's incident database (Datix) when the full investigation report has been completed.

	NRLS Death Data	Datix Death Data	NRLS Severe Harm Data	Datix Severe Harm
Quarters 1 and 2	18	17*	22	15*
Quarters 3 and 4	TBC	11*	TBC	17*
Total	18 to date	28	22 to date	32

Based on the number of severe harm/death incidents reported in Datix – 60 – for the year 1 April 2015 to 31 March 2016, severe harm/death incidents represented 0.2 per cent of the total number of incidents we reported in the period.

\*As at June 2016, we are still waiting on the outcome of investigations to confirm the level of harm for each incident.

The table below outlines the number of claims made to the NHS Litigation Authority and the payments made to patients and their families in damages.

	Number of claims for 2015-16	Damage payments for 2015-16
CNST (Clinical Negligence)	138 reported to the NHS Litigation Authority	£2,313,123
LTPS (Personal Injury)	45 reported to the NHS Litigation Authority	£464,074

A photograph showing several healthcare professionals in green scrubs and surgical caps performing a procedure on a patient. One surgeon's hands are visible in the foreground, holding surgical instruments over a patient's body.

## When things go wrong

---

**When things go wrong it's important to our patients that we are open and honest regarding what has happened.**

We have a duty to do this – the duty of candour.

The duty of candour is now a statutory requirement, complementing the existing professional duty for healthcare professionals.



Our aim is that in all cases where duty of candour is applicable we will discharge our obligation to:

- **notify the relevant person that the incident has occurred** 
  - **apologise** 
  - **provide reasonable support to the relevant person in relation to the incident** 
  - **provide details of any investigations that will be required** 
  - **provide results of any further enquiries into the incident** 
  - **write to the relevant person detailing all of the points above.** 
-

Mechanisms were put in place to support our site teams to fulfil the duty of candour, including the launch of a new Safety Hub on the intranet and a new film for staff. Our risk management database contains live information on all applicable incidents and the database was also used to record progress. Every two weeks we provided tailored site reports detailing all qualifying incidents to ensure that no incidents were missed. We monitored our progress and provided the Trust Board with monthly and quarterly reports. We will review our processes in the coming year to ensure that we continue to embed a culture of openness and honesty throughout the organisation as well as making sure that we share learning and improvements to our patient care.

The screenshot of the Barts Health NHS Trust intranet shows the 'Safety is everyone's responsibility' section. It features a purple header with the text 'Help us shape our values'. Below this, there are several sections: 'Safe and Compassionate Quality Improvement Plan', 'Statutory and Mandatory Training', 'Report an Incident', and 'Learning from the mistakes we made', 'Safety Leadership', 'Safety Metrics', and 'Safe and Effective Care Workforce'. A large green button with a white shield icon and a checkmark is prominently displayed in the center. A large grey arrow points towards this button from the bottom right. The photograph on the right shows a healthcare professional with short grey hair and glasses, wearing blue scrubs with 'Great Work' printed on the chest, looking down at something off-camera.

## Compassionate care and patient experience

Our patients deserve respectful, compassionate care and a positive experience when they visit our hospitals.



We developed the skills of our nurses by introducing a number of training and support programmes. These included face-to-face training, e-learning packages and a skills passport where nurses recorded the skills they learned and developed. 1,300 nurses completed e-learning training, and 500 nurses attended face-to-face training. 1,000 nurses completed the clinical skills passport. Targeted teams, led by expert nurses, supported wards to improve the fundamentals of care that our patients received. Staff concentrated on several key areas of care such as preventing falls, pressure area care and nutrition and hydration.

A new nursing documentation pack was developed based on best practice from across the NHS. The pack supported our nurses to deliver high quality care by ensuring individualised assessments and person-centred care plans are in place and carried out. Measuring the quality of our care and performance at a ward level has led to a number of improvements for our patients. By introducing our ward dashboards, individual wards have been able to measure quality indicators such as the number of incidents recorded, number of pressure ulcers, patient falls, complaints, infection rates and other key indicators that affects patient care. Over the last year, our wards have used the dashboards to reduce the number of complaints we received, the number of pressure ulcers acquired whilst in hospital, and infections such as MRSA.



## Spotlight on improving care for patients with dementia

---

Supporting our elderly patients is important to us, and we made significant improvements for our patients with dementia.

We developed a 'dementia-friendly' ward at Whips Cross, with dedicated easy-to-understand signage, matt flooring and curved furniture to protect people from hurting themselves on sharp corners. New bathroom facilities such as toilet seats and hand rails were painted in bold colours to improve visibility and safety, and a dining table and chairs encouraged people to eat and relax away from the bedside. Since the changes were introduced, the safety of our patients has improved and no one on the ward has fallen or developed a pressure ulcer.

We collected feedback from our carers of those living with dementia via a questionnaire to help make improvements in the care we provide. The feedback led to new ways of working, including the production of new dementia and delirium information leaflets. We also recruited volunteers known as 'Dementia Buddies' who facilitated activities and opportunities for social engagement for patients with dementia on the wards.

Our dementia team developed the "Forget Me Not" form which has improved communication, interaction and the whole patient experience. It provides important information about the individual, such as their likes and dislikes and things the patient may need help with. The team has found that understanding the patients' preferences has significantly reduced the agitation experienced by patients who find it difficult to communicate.

---

A key measure of whether we are treating our patients well is listening to what our patients are telling us. To help us do this, we developed a new patient experience strategy that has established a framework for engaging with our patients and formalises our commitment to listening and responding to the needs of our local people. It ensures that our patients, carers and the communities we serve are at the heart of everything we do, and that they are engaged to proactively inform and shape our services in a way that reflects their diverse needs.

Over the coming year, we will be establishing compassionate care and patient experience groups at each of our hospitals. These groups will include patient panel members and Healthwatch representatives to ensure local issues are captured and acted upon. We are also establishing a patient experience committee at a Trust level, which will report to the quality assurance and improvement committee.

As part of our patient experience strategy, we launched iWantGreatCare in March 2016 which provided us with real-time feedback from patients. Our aim is to be in the top 10 per cent of response rates nationally and whilst we have some way to go to achieve this, we have already started to see improvements in our real time feedback rates. For example, maternity services increased from 2.2 per cent in March 2016 to 28 per cent in April 2016. We have plans in place to improve in other areas too including our launch of 'You said, We did' in June 2016. iWantGreatCare is being used in conjunction with our already established patient feedback channels, including the national patient experience survey, Friends and Family Test, Patient Advice and Liaison Service (PALS), NHS Choices and the NHS National Cancer Patient Experience Survey, to analyse and respond to the needs of our patients.

### We will know we are successful when we see:

- improvements in all national patient surveys results:

**95%**

of complaints are acknowledged in  
**3 working days**

**80%**

of complaints are responded to within  
**25 working days.**

- a reduction in complaints

We are in the top

**10%**

for Friends and Family Test response rate by the end of 2016.

**95%** of our patients felt they were treated with dignity and respect.

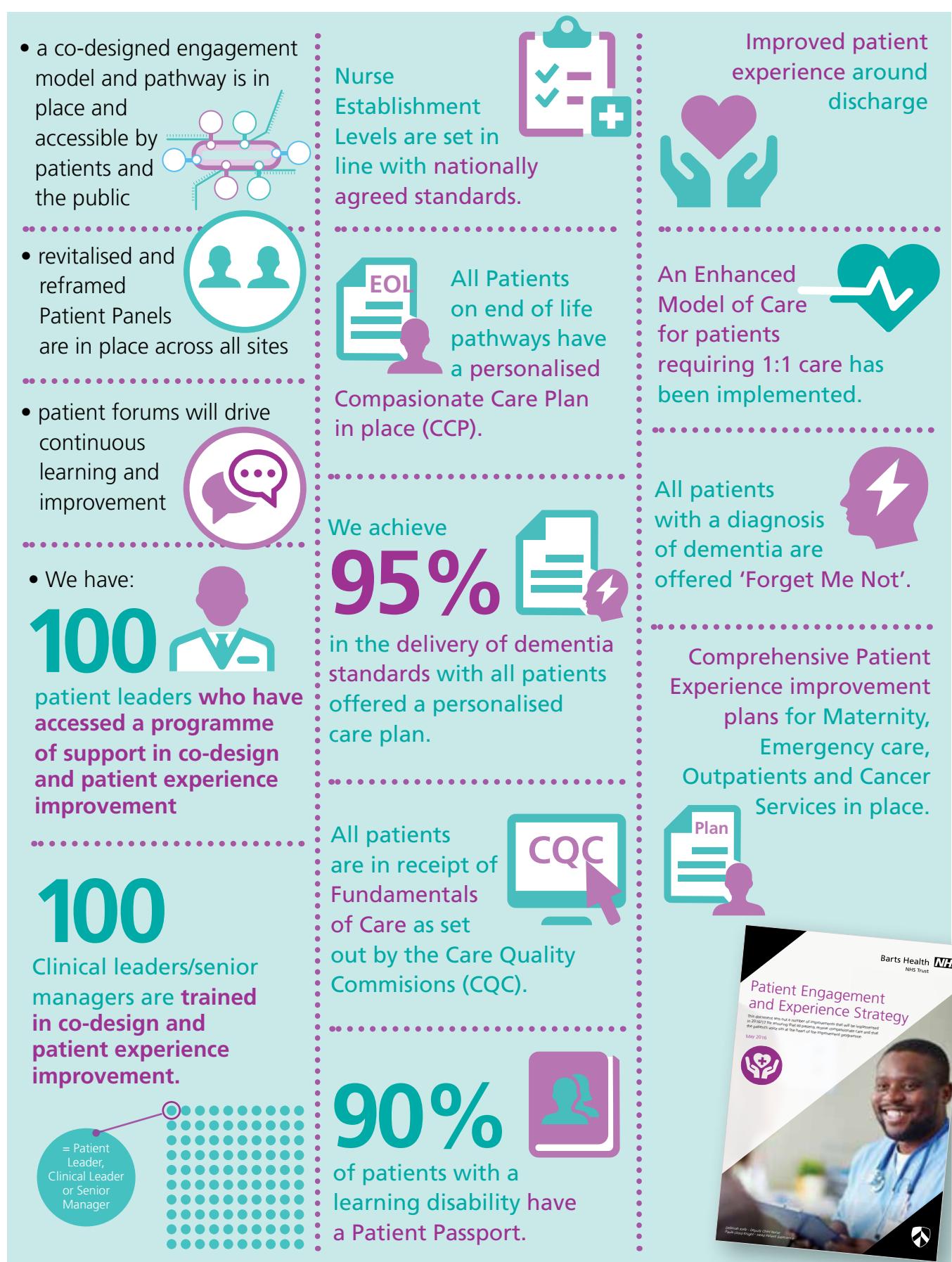
**95%** of our patients felt involved enough in decisions made about them.

**95%** of our patients felt they received timely information about their care and treatment.

**95%** of our patients tell us they were treated with kindness and compassion by the staff looking after them.

**95%** of our patients tell us they were cared for in an environment that was clean.





*2015 Care Quality Commission adult inpatient survey,  
comparing Barts Health to other participating trusts.*

S1 The Emergency/A&E Department  
(answered by emergency patients only)



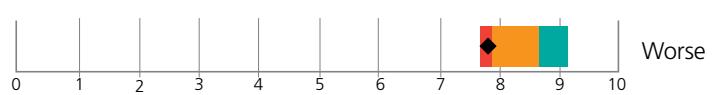
S2 Waiting list and planned admissions  
(answered by those referred to hospitals)



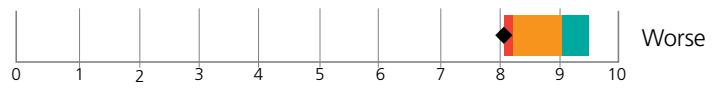
S3 Waiting to get to a bed on a ward



S4 The hospital and ward



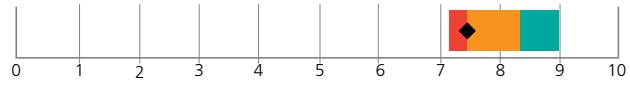
S5 Doctors



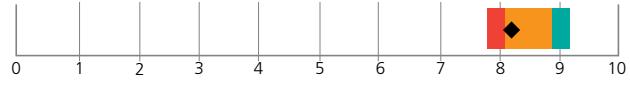
S6 Nurses



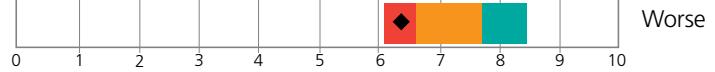
S7 Care and treatment



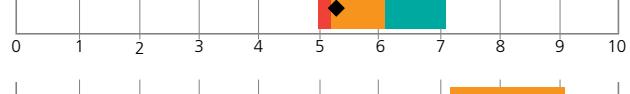
S8 Operations and procedures  
(answered by patients who had an operation or procedure)



S9 Leaving hospital



S10 Overall views of care and services



S11 Overall experience



## Patient Advice and Liaison Service (PALS)

Over the last year, we saw an increased number of patient enquiries and concerns to PALS – 7,512 in comparison with 7,196 in 2014-15. The complexity of cases also increased as we attempted to resolve concerns before they became formal complaints.

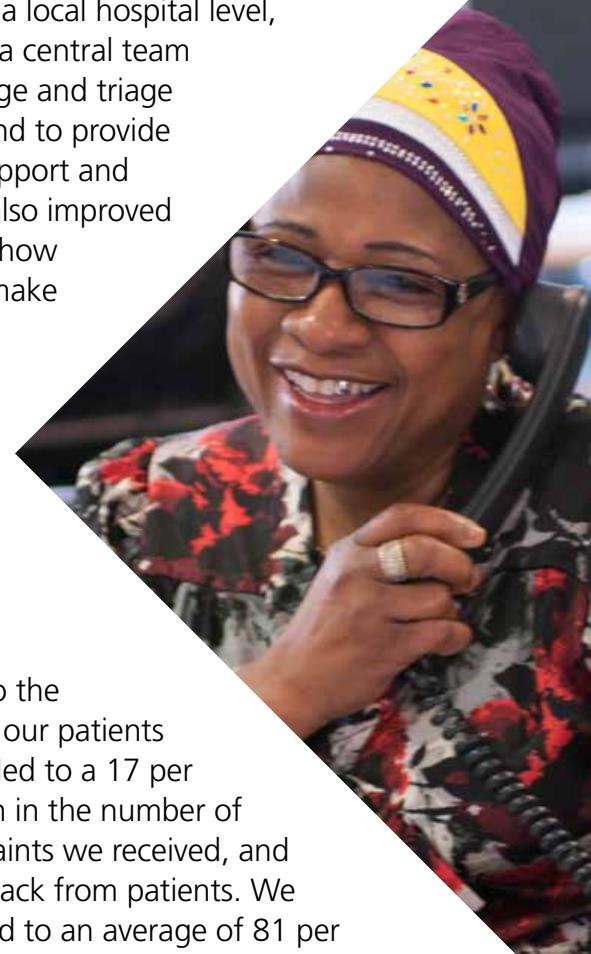
To improve the continuity of service provided to our patients and colleagues, we now have dedicated staff working at Whipps Cross, Newham and The Royal London hospitals. This has helped us resolve concerns promptly, prevented issues from escalating and created a more integrated service. Over the next year, we are planning on establishing a base at St Bartholomew's and improving our office at Whipps Cross to create a better experience for our patients.

We also focused our efforts on strengthening our reporting processes and sharing the lessons we've learnt from patient feedback, including daily attendance at the safety huddles. We recognise that patients can experience difficulties in accessing our service by telephone and we are working to rectify this.

## Patient complaints

We have improved our handling of patient complaints over the past year. We want our patients to feel heard, so we are dealing with concerns at the earliest opportunity. This has

been made possible by a new complaints model that placed the handling of complaints at a local hospital level, supported by a central team to acknowledge and triage complaints, and to provide leadership, support and training. We also improved awareness of how patients can make a complaint, including improved leaflets, posters and promotional banners.



Responding to the complaints of our patients as they arose led to a 17 per cent reduction in the number of formal complaints we received, and positive feedback from patients. We also responded to an average of 81 per cent of our formal complaints within three working days. Whilst we still have more to do to achieve our ambition to acknowledge 100 per cent of complaints within three working days, this was consistently achieved for more than 90 per cent of complaints over the last few months of the year.

Number of formal complaints	
2014-15	2015-16
3,028	2,505

Acknowledgement of complaints within three working days (average figure over the year)	
2014-15	2015-16
73%	81%

We aim to reply to formal complaints in a timely way. For example, one key measure we use is how many responses to complaints are made within 25 days. This rose from 42 per cent in April 2015 to 65 per cent in March 2016. The time we take to reply is agreed with the complainant and is dependent on the complexity of the issues raised. We also increased the use of local resolution meetings to address concerns.

We saw a reduction in the number of complaints we received in all subject categories, with the exception of 'surgical/invasive procedures' and 'transport'. In response to the feedback from our patients, we implemented national safety standards for invasive procedures (NatSSPs) and took action to improve the experience our patients have in getting to and from hospital.

Getting vulnerable people to hospital in time for their appointment, and getting them home as soon as possible after they are discharged from treatment, are key elements in our commitment to providing safe and compassionate care to all our patients. We provided 30,000 non-emergency journeys a month for patients who cannot rely on public transport or use their own vehicles, but standards of service were not high enough, and too many patients had to wait too long.

In response to patient feedback, we have been working with ERS Medical, our transport

provider, to stabilise and improve the service provided to patients. In April 2016, we agreed to exit the existing contract and undertake a safe transition to alternative providers. During 2016-17, we will be going out to tender for eight separate services across the Trust, including a central transport call-centre, and general non-emergency patient transport, as well as dedicated transport services for those needing kidney dialysis, attending high dependency units, or with mental health needs.

During the transition period, the safety of our patients will continue to be our top priority. Both the Trust and ERS Medical are fully committed to improving patient transport and will work in partnership to continue to improve the current service while arrangements are made for a handover. We had already changed the arrangements for managing transport for renal patients which resulted in a significant improvement in patient experience, feedback and performance. We also significantly reduced the number of incidents and complaints in the last three months on 2015-16.

Concerns, complaints and compliments are a rich and valuable source of learning. We are working across our hospitals to embed learning and improve our data collection on Datix to track trends and improvements.

#### Responding to feedback has reduced the number of complaints we've received in key areas

Appointments and clinics	55 per cent reduction
Advice and information	49 per cent reduction
Security and behaviour	31 per cent reduction



Tell us how  
we're doing



Visit NHS Choices:  
[www.nhs.uk](http://www.nhs.uk)



Visit our website:  
[bartshealth.nhs.uk/your-visit/  
advice-and-support/patient-  
feedback/](http://bartshealth.nhs.uk/your-visit/advice-and-support/patient-feedback/)



Write to us:  
**Central Complaints Team,  
3rd Floor, 9 Prescot Street,  
London, E1 8PR**

Email us:  
[complaints@bartshealth.nhs.uk](mailto:complaints@bartshealth.nhs.uk)

## End of life care



All people nearing the end of their life and their families should expect good care. In addition to physical symptoms such as pain, breathlessness, nausea and fatigue, they may experience anxiety, depression, social and spiritual difficulties. It is important that we work with our local health partners to ensure that we can compassionately support and care for our patients at this time of their life.

However, information about patients at the end of life is not always shared across our health and social care systems which results in uncoordinated care, inappropriate admissions to hospital, and inappropriate interventions. Families, friends and carers can also have difficulties during this time and their needs should be addressed too. Many patients experience good care at our hospitals, but some patients wish to die at home. We need to increase the number of patients that are able to die in the place of their choice.

The Care Quality Commission (CQC) found that our staffing levels were not adequate to provide good end of life care, and the care we delivered was not always measured in line with national quality standards. Patients nearing the end of their life were not necessarily identified, their needs were not always assessed and met, and complaints were not always acknowledged

or dealt with appropriately. There was little evidence of clear leadership or the development and implementation of an end of life care strategy. The CQC also found that the Margaret Centre at Whipps Cross was not fit for purpose and needed refurbishment.

In response to these findings, we established a clear leadership and accountability structure for our end of life care strategy to deliver improvements to the care and experience our patients receive at the end of their life at both a local hospital and Trust-wide level. Our chief medical officer and the end of life care team are working collaboratively with local health and social care partners to improve the delivery of a more joined up experience.

We have a clear training plan to improve the skills of our staff to deliver compassionate care that met the needs of our patients, identified link nurses for each ward, and started working with wards to create quiet spaces for families and carers. We made progress towards creating a system that identifies patients nearing the end of their life, including attending daily safety huddles, to help us provide a better, coordinated approach to the care we provide. We also ensured that we had care and consent discussions at the right time in the right way with patients and their families.

We're proud of the improvements we made to the Margaret Centre following a £180,000 refurbishment – which included £73,000 generously donated by patients' families, supporters and Barts Charity. The refurbishment has created a safer place and a better environment for our patients, their families and carers as well as our staff. We built new bathrooms and a day room for relatives and carers to provide a comfortable private space with new kitchen facilities. A secure medicine storage area was also created, a welcoming reception area designed and new flooring laid

throughout the centre to make the building cleaner and brighter.

## Our workforce

In order to provide a high quality service to our patients at all times, we need the right number of staff with the right skills in each of our wards and departments. A stable, largely permanent workforce improves the quality of care we provide because people working in our hospitals understand our ways of working, build positive relationships with their colleagues and local communities, and share a stake in our future success.

Over the past year we focused on making sure our staffing levels were safe, our turnover was low, high quality candidates were recruited to at least 95 per cent of our posts and our use of agency staff was reduced.

In the past year, we increased the number of permanent employees from 13,217 in 2014-15 to 14,048 in 2015-16, and we look to increase this even further over the coming year.



A photograph of several healthcare workers in scrubs, including a woman in red and a man in blue, smiling at the camera.

## Improving our workforce in numbers

Safe staffing levels  
were at an average of  
**102%**  
during 2015-16,  
against a target of 100%



At the end of March 2016,  
**87.1%**  
of our staff were  
**permanently employed**,  
against a target of 95%



Annual voluntary turnover  
within the Trust was  
**13.9%**

of our workforce at the  
end of February 2016,  
against a target of 14%



We increased our  
use of Bank staff by

**40%**  
in the past 18 months  
(to February 2016) and  
reduced our reliance on  
expensive agency staff



## The workforce across our hospitals

### Newham

We increased our staffing in maternity, including additional midwives to meet a birth ratio of one midwife to 28 women and increased our consultant cover. We also increased the number of nurses across our hospital, many of whom are local Newham residents. At the end of February 2016, 86.6 per cent of our staff were permanent.

### Whipps Cross

We increased our permanent workforce – by the end of February 2016, 82.2 per cent of our workforce were permanent, a growth of 60 whole time equivalent staff in post.

### St Bartholomew's

The opening of the Barts Heart Centre in May 2015 led to a large number of vacancies due to an inherited nursing vacancy rate as well as the increased staffing requirements to manage the new centre effectively. The hospital had a fill rate of 84.1 per cent at the end of February 2016, and a key focus for 2016-17 is to recruit staff to the hospital.

### The Royal London Hospital

We implemented a plan to recruit high quality candidates to our vacant posts and at the end of March 2016, 85.4 per cent of our staff were permanent. We also improved the experience our staff had at work so they are more likely to stay employed with us. We also increased opportunities for learning and development and new career pathways.



## Emergency pathway and patient flow

Our patients have a right to have their healthcare needs met within a reasonable amount of time. Having our patients 'flow' through our hospitals efficiently improves the service we provide, increases patient safety and is essential to ensuring that patients receive the right care, in the right place, at the right time, all of the time.

In May 2015, the Care Quality Commission reported a number of issues that impacted on our ability to treat our patients within good time. Our hospitals had a high bed occupancy rate of above 90 per cent which affected our ability to admit, treat and move patients because there was a shortage of beds. Patients well enough to leave hospital were delayed due to staffing and transport issues, and there wasn't a consistent practice of seven day working across our hospitals, limiting our capacity to treat the number of patients required. Operations were cancelled due to a lack of available beds, delays in treatment, and patients being cared for in inappropriate clinical areas given the complexity of the patients' needs. We also failed to meet key national targets, meaning that patients were experiencing unacceptable delays, including waiting more than 18 weeks from referral to treatment.

Over the past year, we improved the way we manage our emergency departments and have reduced delays faced by patients waiting to go home. This led to reductions in our bed occupancy rate – in February and March 2016, it was an average of 92.8 per cent. The experience of our patients requiring emergency treatment improved and the number of patients waiting in the emergency department at any one time has reduced, improving overall patient safety. Despite improvements to our emergency departments, demand from patients and

ambulances continued to increase, and we did not meet the national target of 95 per cent of patients being seen, treated, admitted or discharged in under four hours. Across the Trust, 88.38 per cent of patients were treated within the four hour standard.

We did not meet our target for theatre cancellations due to lack of bed availability in wards and the high dependency units, patient cancellations, out of theatre time cancellations and patients who did not attend their appointments.

Over the next year, we will be addressing these issues through the re-establishment of the theatre improvement plan, led by clinical leads and matrons at our hospitals.

We made significant progress in all aspects of our cancer performance and achieved all eight standards in October, November and March. This was the first time we achieved all cancer targets in 18 months. We also reduced the waiting lists for elective care within the 18 week referral to treatment standard, and stabilised the number of patients that waited too long for treatment.

Finally, work commenced on a co-located midwifery-led birthing centre at The Royal London, providing additional choice and capacity for 1,500 mothers giving birth every year.

The quality of our data continued to impact on our ability to make sound decisions; improving the accuracy and availability of real-time data will be a key priority for 2016-17.



<b>Barts Health</b>	<b>88.0 per cent</b>
Newham University Hospital	88.0 per cent
The Royal London Hospital	84.6 per cent
St Bartholomew's Hospital	100 per cent
Whipps Cross Hospital	84.4 per cent

A&E performance against the four hour standard, March 2015 - April 2016

## Outpatients and medical records

We want our patients to have access to efficient and well run outpatient care supported by a medical records service that delivers full sets of patient notes to staff when and where they are needed. The Care Quality Commission (CQC) reported in May 2015 that while our

patients were treated with compassion, dignity and respect, they did not always feel fully involved in decisions about their care and treatment.

Patients experienced difficulties contacting the hospital on the telephone and receiving appointments, resulting in delays accessing care and treatment. Medical records were not always delivered in a timely manner for appointments, and IT systems – the computers as well as data collection – led to delays and risks to patient care.

Following the inspection by the CQC, we prioritised improving the accessibility of our



services for patients. In particular, we wanted our patients' phone calls to our central appointments departments to be answered within 60 seconds.

March 2015	44%
March 2016	54%

*Number of phone calls answered in 60 seconds*

To provide a more timely summary for the GPs of those patients who were unable to attend, we wanted to reduce the number of instances where this summary was delayed. At the end of March 2016, 99.2 per cent of patients who didn't attend were summarised within five working days, compared to only 98.5 per cent in November 2015. We were proud that the impact of the improvements we've made to date in outpatients has seen a reduction in outpatient – related complaints.

April 2015	33
March 2016	5

*Reduction in outpatient related complaints: April 2015 - March 2016*

We made considerable effort reducing the number of patients that did not turn up to their appointment as this leads to delays to clinics, wasted resources and impacts on the accessibility of our service for other patients. In January 2016, we introduced a call reminder service at Whipps Cross to remind patients of their appointments. Early indications suggest that the service is effective and we are planning to roll it out across our other hospitals.

Medical notes availability reached 97 per cent in February 2016 moving us close to our overall target of 98 per cent. The medical records team will continue to deliver and sustain performance

improvement over the coming months to ensure that this target is achieved. We also invested £2 million to upgrade our IT equipment at Whipps Cross and we improved our data quality and collection by upgrading our electronic health record system (Cerner Millennium) at The Royal London, St Bartholomew's, Whipps Cross and Mile End hospitals. Newham will be merged onto the new version in 2017.

## Leadership and organisational development

The Care Quality Commission reports published in March and May 2015 found that our staff were caring and compassionate, but the organisation and its procedures had let them down and allowed standards to slip. Performance and practice was not universally poor, but there was too much variation between sites, teams and wards, and not enough corporate support for those who were struggling to do their best. In response, we resolved to raise our game as a Trust and ensure that in future the whole is more than the sum of its parts.

The most significant change was to renew and reshape the leadership team within a new organisational structure. Our new Chair, John Bacon, and new Chief Executive, Alwen Williams, recruited a top-class team with a view to maintaining discipline and control over short-term operational performance as we developed a long-term clinical strategy. As well as a new Chief Medical Officer, Dr Alistair Chesser, and a new Chief Nurse, Caroline Alexander, the team now includes a Deputy Chief Executive responsible for quality, Dr Tim Peachey, and a Chief Operating Officer responsible for performance, Jacqueline Totterdell.

Refreshing the corporate centre was combined

with devolving power to the front-line. Each hospital was made accountable for the operational delivery of high quality care, while a network of clinical academic groups focused on strategic change and Trust-wide clinical standards. Each hospital now has its own expert managing director, supported by a medical director, a director of nursing, and an operations director responsible for day-to-day delivery. A similar triumvirate of lead clinician, lead nurse and lead manager manages each department and runs each service line.

Each hospital managed its own budget and with dedicated support with finance, HR and other corporate functions, staff and stakeholders now know who to go to at each hospital to get things done. The top team set the strategic direction, decided policy, and provided a consistent and coherent framework of corporate support for shared functions; while the hospital teams got on with the business of treating patients on the front-line and were held to account for their performance. Our hospital teams were also the first point of contact for our local stakeholders, including patient groups and commissioners.

Changing the way our hospitals are run has enabled us to better support our staff and hear their views. Our staff know better than anyone what can be improved and how, so we adopted a new staff-led approach to change. Conversations about what staff felt was necessary to provide our communities with high quality care inspired the measures in our Safe and Compassionate improvement plan, and we delivered profound and fundamental changes to services, structures and systems as a result.

In order to deliver this improvement programme, we started to change the way we did things around the Trust by signing up to an approach to improving how we all work together called

Listening into Action. This was tried and tested by many other NHS organisations, and enabled frontline staff to influence and shape the care and services they provide. It put the staff who know most at the centre of change, and they challenged leaders not only to listen to them, but to give them permission and support to fix the problems they found at a local level for the benefit of their patients.

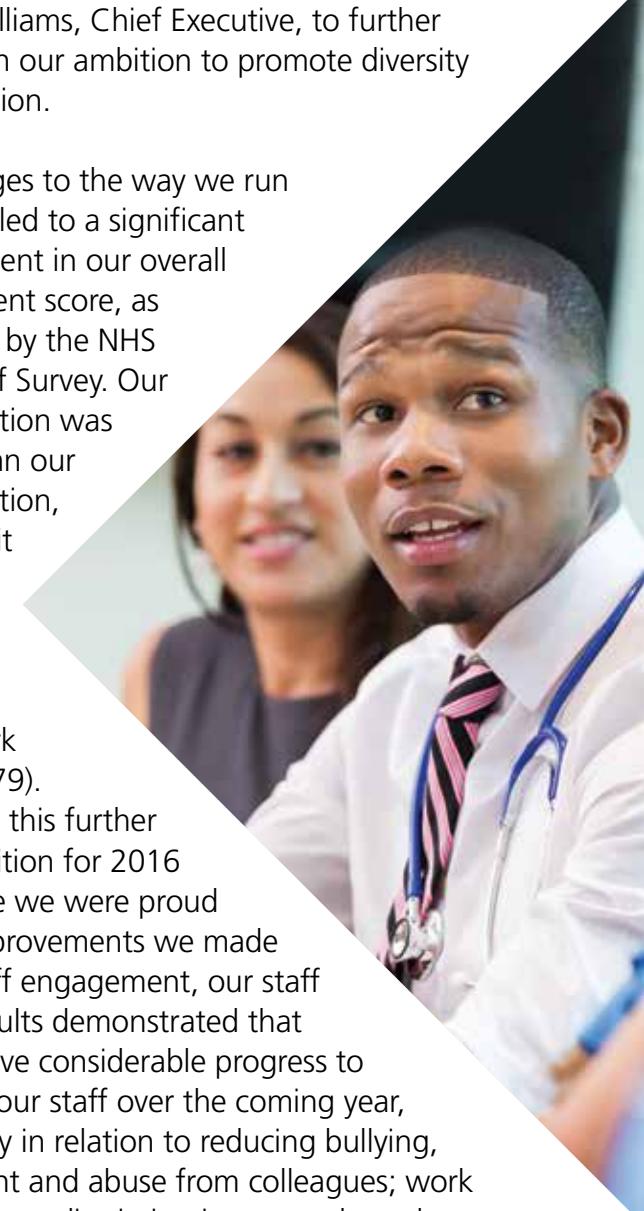
Many clinicians and managers enthusiastically embraced this way of working to tackle a range of specific issues at each hospital. More than 40 clinical teams turned their ideas into positive results, and made the Listening into Action approach a primary vehicle for empowering staff to make the improvements to patient care set out in Safe and Compassionate.

We implemented a number of Professor Duncan Lewis' recommendations to effectively tackle the ill-treatment at work experienced by many of our staff. We provided training on promoting diversity and civility in the workplace, and delivered specific training for managers to promote health and wellbeing practices. We also used our data to inform targeted interventions. The combination of these improvements is driving forward a positive workplace culture.

We made progress creating a diverse and inclusive workforce and promoted equality of opportunity in career progression. We saw some encouraging testimonies and promotions achieved from the first cohorts of staff through our career development programme that supported staff from BME groups and women into more senior positions – groups that were under-represented in bands seven and above. This work has been agreed to continue in 2016-17. Focused work to train our recruiting panels to recognise and eliminate unconscious bias also started. A new equality and inclusion board launched in March 2016, chaired by

Alwen Williams, Chief Executive, to further strengthen our ambition to promote diversity and inclusion.

The changes to the way we run as a Trust led to a significant improvement in our overall engagement score, as measured by the NHS 2015 Staff Survey. Our 2015 position was higher than our 2014 position, although it remained below average for our benchmark group (3.79). Improving this further is an ambition for 2016-17. While we were proud of the improvements we made in our staff engagement, our staff survey results demonstrated that we still have considerable progress to make for our staff over the coming year, particularly in relation to reducing bullying, harassment and abuse from colleagues; work related stress; discrimination at work; and promoting equal opportunities for career progression and promotion.



Staff survey indicator	2014	2015
Staff engagement	3.62 per cent	3.68 per cent 
Bullying, harassment and abuse from colleagues	34 per cent	37 per cent 
Work related stress	44 per cent	43 per cent 
Discrimination at work	20 per cent	21 per cent 
Promoting equal opportunities for career progression and promotion	71 per cent	70 per cent 

### Refreshing our values and behaviours

One of the many things that came out of our Big Conversations last year was how we treat each other as colleagues. Many people felt that we could do better to be kinder, more compassionate and more professional. Among the suggestions that staff put forward to address this was to revisit our values to see what more we could do to help guide the way we do things across the Trust.

During 2016-17, we will be refreshing our values to align them with our purpose to

be a consistently safe and compassionate organisation for patients and staff, to respond to staff feedback that we don't treat colleagues consistently well, and to work constructively on treating each other better in light of the high levels of work place stress, bullying, harassment and discrimination reported in the 2015 staff survey results. Our aim is to set organisational values shaped by our staff and patients that are simple, memorable and inspiring and to recognise and appreciate these values as they are practised.



## Supporting our staff in numbers

---



**700** of our managers and supervisors participated in the leading changing lives workshops

**1,500** staff participated in our Listening into Action Big Conversations

**36** people used our new Guardian Service at Whipps Cross

**1,197** people used our employee assistance programme provided by CiC

**118** people used our SpeakInConfidence service

**67** trained mediators were available to resolve reported cases of bullying and harassment

**200+** people participated in new leadership development and management training opportunities, including a programme to support the transition of new leaders joining Barts Health

**100+** people participated in leading care for ward nurses and matrons

**25** people participated in our clinical director development programme with the King's Fund

---

# Delivering safe and compassionate care in our communities

## Community Health Services

We were proud to deliver care in the community for people living in Tower Hamlets and audiology services in Newham and Waltham Forest. These services – provided in people's homes as well as in a number of community settings such as GP surgeries and community health centres – had more than 700,000 patient contacts last year.

Over the last year, we worked closely with colleagues at The Royal London to prevent unnecessary hospital admissions and to help our patients leave hospital earlier. This reflected the needs of our patients who wanted their care closer to home, and helped our hospital run more efficiently.



We built strong links with multi professional community health teams and clinical teams in the hospital. For example, we worked with our colleagues in the Clinical Commissioning Group to make sure that if patients required medication at home in their last days of life, staff were able to dispense it. We also established training with colleagues in our hospitals and social care to raise awareness of pressure ulcers and how these could be prevented. This collaborative way of working helped us provide better, coordinated care to patients that led to better outcomes and a better experience, as evidenced by the positive feedback we received.

Last year, we were proud to be awarded national Vanguard status with our partners – Tower Hamlets GP Care Group Community Interest Company (representing primary care); East London NHS Foundation Trust (our local mental health trust) and London Borough of Tower Hamlets (representing our local council and social care). This partnership is known as the Tower Hamlets Together.

NHS Tower Hamlets Clinical Commissioning Group (CCG) announced in April 2016 that the new contract for community health services in Tower Hamlets had been awarded to Tower Hamlets GP Care Group Community Interest Company, the lead provider for Tower Hamlets Together.

In the new contract, we will be responsible for running children's community health services and specialist community services for adults such as cardiology, respiratory and diabetes. Our partners across Tower Hamlets Together will be responsible for providing all other community health services, and together we will develop and deliver integrated services across health and social care.

By working together, patients in Tower Hamlets will benefit from having straightforward, easy

to access, health and social care services and a positive patient experience. This new model of community care will ensure a single shared assessment and plan for patients. Services will be coordinated around the needs of the patient, rather than the patient and their carers having to navigate themselves through numerous health and social care services.

The enhanced services will be gradually phased in from 1 October 2016 when the new contract will take effect.

While many existing services will stay the same, some of the new developments will include:

1. a new single point of access for all community health services, so people aren't being passed between them. It will make sure people get the right care at the right time, and have just one assessment instead of having to repeat information and tests every time they see a GP, an occupational therapist or a chiropodist.
2. a new integrated model of care for children's community health services, bringing together professionals from across health and social care to ensure we provide the right care at the right time in the right place for children and their families.
3. a new single patient care record – so whenever healthcare professionals need to access patients' information, it will be there in one place.

A stakeholder council, made up of local patients, carers and voluntary and community groups, will work alongside the board, and help to formulate the direction of the services and monitor progress on an ongoing basis.

## Community health services for children

Our community children's nursing team provided a service to children either at home or in an educational setting. We were proud of the service we provided last year, which was recommended by 100 per cent of our families and recognised for being caring and compassionate in the 2016 Barts Health Hero Awards.

Over the past year, we worked in collaboration with our colleagues in acute wards to increase referrals to our service, which had a particularly positive impact on children with asthma who were seen within 48 hours of leaving hospital. We also worked together to develop a new enteral feeding pathway that decreased the waiting time experienced by children and their families from having a nasogastric tube to a gastronomy and reduced A&E attendances.

We focused on recruiting specialist expertise to the team, and appointed a clinical psychologist and paediatric nurse trainer. Our clinical psychologist offered support to 13 children and families who received a continuing care package as well as supported our staff. Our paediatric nurse trainer trained staff from the local authority so that they were better able to support children with complex health needs access services.

## Public health

The people living in east London are some of the most diverse and deprived in the country, putting us in the forefront of the national effort to tackle health inequalities. More than half our patients are classified black or minority ethnic, more than 60 languages are spoken in our hospitals, and there are high levels of poverty,

overcrowding, unemployment and health inequalities in our catchment areas.

We wanted to help our patients and visitors make healthy choices, to help our staff have positive health and wellbeing outcomes, and address health inequalities through providing employment and training to local communities.

### **Smoke free**

We officially went Smoke Free on all of our Trust sites on 1 October 2015. This means that smoking is no longer tolerated in hospital grounds and staff were encouraged to remind smokers that support was available to stop smoking.



We referred over 3,500 patients to stop smoking services in 2015-16, particularly from pre-operative assessment and maternity, where we tried to ensure that all expectant mums were tested for carbon monoxide for evidence of smoking – this test led to our Royal London maternity team being recognised for their good practice and innovation by the London Clinical Senate in March 2016. Over the last three years, we helped nearly 10,500 people give up smoking.

### **Promoting health screening**

We worked closely with some of our screening programmes to support their improvement and strategic development, most notably breast screening.

## **Reducing alcohol-related injuries and disease**

A quarter of people arriving at A&E do so due to alcohol-related injuries or disease. To help us screen patients for possible risk factors, we implemented the Alcohol Use Disorder Identification Tool (AUDIT) which is a series of questions to assess whether they would benefit from finding out more information about alcohol use, advice or further support from the community alcohol services team.

We trained our staff to carry out the screening and the results were incorporated within our care records service. A new alcohol care pathway is also being developed.

## **Getting physical**

Over 2,000 staff took part in on-site exercise classes across the Trust, including Zumba, yoga, circuits, boxercise and Pilates. We also held our third annual staff and families sports day in Queen Elizabeth's Olympic Park, supported by Skanska plc. and Carillion plc. Over 500 staff and their families took part and there were number of fiercely contested sporting contests, including five-a-side football, badminton, table tennis and netball, as well as more gentle activity such as walking and kids' activities.

## **Eating well**

We developed a healthy food strategy and made significant improvements in the food offered in our hospitals, including the reduction in profile



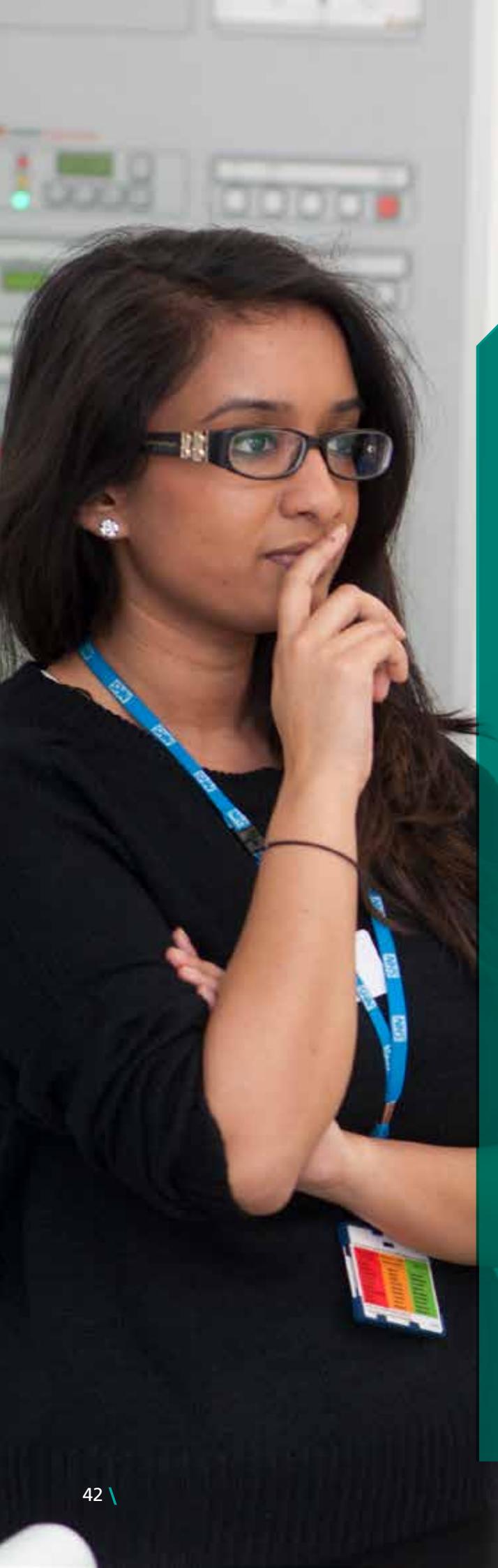
and sale of sugary drinks and healthier options at the point of sale.

## **Mental health and wellbeing**

We introduced a new mental health and wellbeing policy, which led to awareness training for managers, and stress management training for staff. We were recognised for our work in this area, winning the 'Achievement' award from the Health and Wellbeing Charter, validated by the Greater London Authority.

## **Supporting the local community**

We are committed to employing local people and over 160 local residents were supported into work through the Community Works for Health (CWfH) programme. The apprenticeship programme also continued to expand – 142 new apprentices started their training in 2015-16, including 81 new recruits to the Trust. This year also saw the full flourishing of the East London Careers Project, now working with over 40 schools.



## Our public health in numbers

**10,500 people** were helped to stop smoking in the last three years



**2,000+ staff** were supported to be more active in the workplace

**150+** the highest apprenticeship numbers of any NHS organisation in the Health Education North Central and East London (HENCEL) region.

**20+ trainees** from the Tower Hamlets Working Start scheme were supported with placements leading to employment

**30 people** participated in Project Search, a scheme to help people with learning difficulties, and they secured employment at Whipps Cross, Newham and Mile End

**130 successful candidates** from our Community Works for Health programme were celebrated at the Barts Health Awards

**800 school students** engaged in career talks through the east London health careers project; 500 were provided with work experience

**456 young people** accessed experience in health settings over summer school that supported their application to health related degrees

**Kaylie Devlin** was recognised as the Apprentice of the Year for the HENCEL area

# Innovation in healthcare

## Our Education Academy

We want our staff to have access to high quality education and training resources to help them deliver safe and compassionate care to our patients. The income we receive to deliver education across the Trust was significant last year at £80million, which was the largest contract nationally, and our second largest income line as a Trust.

Over the past year, we received excellent feedback from the student nurses, nurses, midwives, allied health professionals, medical and dental students and trainees who accessed education through the Academy. We were also formally reviewed by Health Education England who were impressed by our commitment to widening participation and encouraging local people from east London to take up careers in healthcare.

We continued to listen and engage with our external partners and colleagues to identify and resolve concerns that were raised. We received feedback from our learners in many ways, including formal forums, face-to-face, national student and GMC surveys, real time feedback, student stories and from a range of online survey channels. As a result of the feedback, we have shaped our offering to further increase learner satisfaction specifically in relation to support supervision and mentorship.

Last year we launched a new online database called WIRED to help us understand completion of statutory and mandatory training courses. This reporting tool has enabled us to promote training compliance in a transparent way and

resulted in us achieving a record high compliance rate of 91.3 per cent across the Trust. We also launched an education app to promote more than 120 resources for staff to aid their development.





## New developments for our staff

---

- Site-based education leads
- Increase in multi-professional simulated learning in the workplace
- End of life care training available to all staff
- Supporting continuing professional development and revalidation, including investment in the Nursing Times e-learning and revalidation resources for every registered nurse and midwife
- Development of clear career pathways
- Development of systems and processes to provide easily accessible data to evidence the quality of educational delivery and outcomes
- Use of technology to support virtual and interactive education



During 2016-17, we will be launching the Leadership, Management and Improvement Faculty to bring all of our learning and development from across the Trust into one place. It will shift our focus on learning in a classroom to learning on the job, and help our staff and managers know where to go to access the development they need to deliver safe and compassionate care to our patients.

## Research and development

An integral part of our work as a Trust is to advance our understanding of health conditions to improve the care we can provide to patients. In the past year, we recruited 30,000 people to clinical trials to participate in research approved by a research ethics committee – significantly more than last year.

We had the largest number of live commercial trials in the UK and a record number of patients were recruited to National Institute for Health Research (NIHR) studies. We also had five award winners in the NIHR Research Investigator Recognition awards, including two special awards to mark the 10th anniversary of the NIHR. We undertook research projects across all of our clinical specialities, including:

### **100,000 genomes project**

This national priority project continued to develop under the local leadership of Professor Lyn Chitty of Great Ormond Street Hospital, and Clinical Director of the North Thames Clinical Research Network (hosted by Barts Health). The project is challenging to deliver, but will enable new medical research by combining genomic sequence data with medical records to create a ground-breaking research resource. This is currently the largest national sequencing project of its kind in the world. We are fully involved in the programme and have begun to recruit patients in rare diseases and cancer (colorectal), with expansion into other specialities imminent.

### **CLAHRC progress**

Since we were awarded the host status for the one of the NIHR's prestigious new Collaborations for Leadership in Applied Health Research and Care (CLAHRC) in 2013, this project has moved into operational mode.

Key deliverables over the last year included innovations to improve care for people with chronic obstructive pulmonary disease, improving the identification and management of people with HIV, implementation and evaluation of a research-based guide for NHS boards to develop their quality improvement strategies (iQUASER), and identification and referral to improve safety (IRIS): improving the response to domestic violence and abuse. Our CLAHRC, under the leadership of Professor Rosalind Raine, was a UK top performer and has made huge headway in developing new healthcare models across north east London.

### **Barts Heart Centre**

In December, donations from Barts Charity enabled us to combine research and clinical care as part of the Centre's aim to save 1,000 lives each year. While helping to tackle the most pressing cardiovascular healthcare issues facing our community, the grant and outcomes of the research will have broad global relevance. The investment focused on integrating clinical care and research strategies. This built on the transfer of related University College London Hospital staff to Barts Health earlier in 2015 and underpins the ongoing collaboration between Barts Health, Queen Mary University London and University College London Partners, to create the premier translational cardiovascular institute across the affiliated hospitals within five years.

## Working with Barts Charity

Barts Charity is our dedicated charity, helping to fund extraordinary healthcare in our five hospitals and associated medical school.

The Charity provided funding for innovative research, equipment and community projects that made a significant difference to the care we provided last year. The funding from Barts Charity helped our staff go above and beyond in their treatment of patients, with all projects demonstrating clear, tangible benefits.

Barts Charity administered all charitable donations given for the benefit of our hospitals, and made sure that all funds were allocated according to our donors' wishes. The Charity didn't deduct anything for administration costs, meaning 100 per cent went directly to the donor's chosen cause. They also offered support to anyone interested in fundraising for the benefit of our hospitals, and offered places in a number of challenge events across London. In addition to the £10.2 million grant awarded to the Barts Heart Centre, the Charity awarded 50 grants to the Trust and our associated medical school.

A £6.8 million grant was awarded to build a bespoke centre for children and young people at Newham Hospital. The centre will serve both Newham's local population as well as our wider patient population. This will vastly improve facilities for children and teenagers.

Barts Charity also helped the Trust achieve a first for Europe in lung cancer diagnosis, with a £118,000 grant. New technology – 3D lung navigation bronchoscopy software – helped us detect and diagnose lung cancer at an earlier stage. Many small project grants and funding schemes provided by the Charity also helped staff on a day-to-day basis. Examples from the last year included £9,155 for a cerebral function monitoring machine to assess the condition

of newborns with suspected reduced oxygen and blood supply to their brains; £9,000 for "MotoMed" equipment, a rehabilitation aid for patients who are confined to bed-rest due to critical illness; and £2,069 for enhanced malnutrition training for staff working with older people.

In addition to these, grants were awarded across a wide range of our services – from cancer and cardiac to trauma and children's. This incorporated small- and large-scale community outreach projects, such as £250,000 for studies (from which the resource East London Genes & Health began) into advancing the understanding of human disease and human gene function to improve healthcare in our local population.

The Charity's Christmas (*Send a Smile with Santa*) and Easter (*Egbert's Eggstraordinary Challenge*) appeals were successful in fundraising for children's and elderly services, and gave our patients staying in hospital during the holiday periods a gift or Easter egg to open.

We look forward to continuing our partnership with Barts Charity next year to promote the best outcomes for our patients.

## Sustainable healthcare

Our sustainability programme saved the NHS over £9.2 million and nearly 50,000 tonnes of carbon. Our approach to sustainability focused on building trusting and lasting partnerships, breaking down barriers, sharing knowledge and celebrating success as we mobilised change. In healthcare, there has never been a more important time to do this. With resources pushed to their limits and an increasing drive for operational and financial efficiencies to be met, the ever increasing reality of population growth, and the impact climate change is having on our

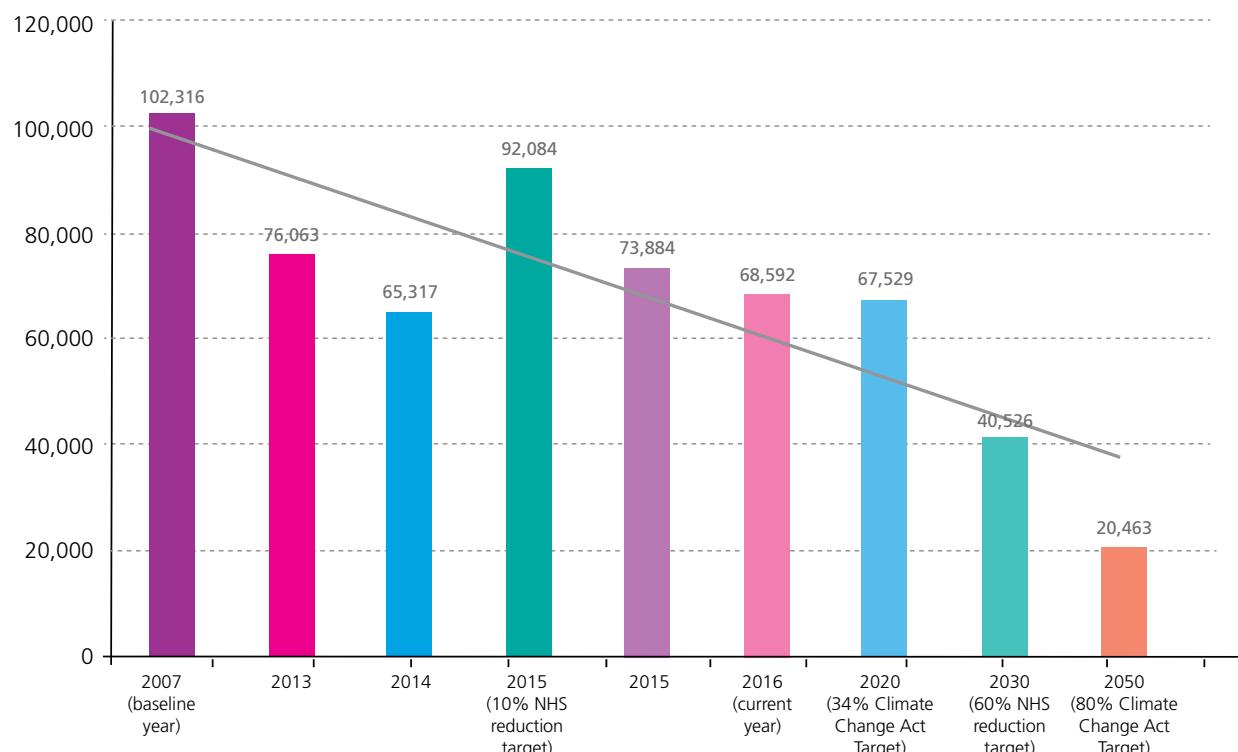
health, we need long-term, sustained change to create a health system that is fit for both today and for the future. We recognised we must actively seek to innovate, to work together, and to engage with our patients, staff and the public to start the conversations that will drive this change.

### **Carbon and energy**

This year we reduced our carbon emissions by 5,292t/CO<sub>2</sub> against last year, and by 33,724t/CO<sub>2</sub> on the 2007 baseline year. This represented

an overall reduction in emissions of 33 per cent, meeting the 2015 NHS target and indicating that we are on track to achieve the statutory Climate Change Act of 34 per cent by 2020.

#### *Reducing carbon emissions by 2050*



### **Waste**

In our partnership with Skanska, we crushed and segregated 3,500 items ready for recycling through the installation of the first reverse vending machines in a hospital. We also

developed and installed two machines in our renal units which compacted and crushed plastic waste, reducing transportation costs and carbon. During 2015-16, our waste programme saved the Trust £1.03 million.



## Waste in numbers

**181 tonnes** of cardboard **was recycled** – stacking higher than The Royal London Hospital

**We diverted 3,500 tonnes of domestic waste** away from landfill into Refuse Derived Fuel (RDF) – enough fuel to power The Royal London Hospital for four months

**2,000 pieces of equipment** were given a second life through our **circular economy programme with Globechain**, which benefitted over 9,000 people through medical relief abroad. This represented 10 per cent of our bulky waste on site.

**We trained over 3,000 front line staff** in waste management

**We reduced our sharps waste costs by 10%**

**We carried out 112,000 individual waste audits** and provided 3,500 individually tailored audit reports to departments across the Trust

**Our sharps awareness programme** helped us ensure that there were no needle stick injuries to waste portering staff – the first year this has ever happened

**The Chinese Government visited The Royal London Hospital** to learn about our waste management practices as we were seen as a global best practice exemplar

## Operation TLC

Operation TLC is a behavioural change programme that focused on creating healing environments for patients through

environmental behaviour changes. It improved the experience of our patients and saved the Trust £428,000 and 1,900 t/CO<sub>2</sub>.

## 2 YEARS OF ACHIEVEMENT



PATIENTS REPORT  
1  
3 FEWER SLEEP DISRUPTIONS

1,900 TONNES CO<sub>2</sub> SAVED PER ANNUM

TLC HAS IMPROVED THE QUALITY OF THE RELATIONSHIP BETWEEN US AND OUR PATIENTS  
NIGEL ROSE, PAEDIATRIC WARD MANAGER

ZZZZZZ ZZZ  
OVERALL PATIENT EXPERIENCE IMPROVED WHEN SLEEP IMPROVED

£ OPPORTUNITY TO SAVE £35M AND 200,000 TCO<sub>2</sub> PER ANNUM ACROSS THE NHS

38% FEWER PATIENT REQUESTS TO CHANGE ROOM TEMPERATURE



STAFF REPORT A BOOST TO TEAM SPIRIT AND COLLABORATION

STAFF REPORT FEELING PROUD TO IMPROVE PATIENT CARE

**£428,000**  
FINANCIAL SAVINGS PER ANNUM  
THAT'S ENOUGH FOR  
**18 NEW NURSES**

## Air quality in east London

Working in collaboration with The City of London, Newham, Tower Hamlets and Waltham Forest authorities, The Greater London Authority (GLA), Defra and supported by Global Action Plan, we are aiming to reduce some of the 9,500 deaths that are caused each year in London from air pollution by reducing emissions and exposure to the harmful pollutants they cause.

The programme focused on:

- Keeping patients warm and well
- Distributing air pollution maps through pharmacies and community health services
- Creation of breathing spaces
- Encouraging our staff to 'switch their trip' to a lower pollution option
- Training drivers in low emission driving behaviours.

## Telling the story



This year we created a new film and infographic to demonstrate the impact our sustainability programme has made and to inspire others to prioritise sustainability to have a similar impact across the health system in the UK.

We held our annual NHS sustainability day, which we founded five years ago. A national day of action, we travelled across the country to deliver six tailor made regional roadshows demonstrating the efficiencies and health benefits from sustainable interventions.

### Celebrating our success

We were shortlisted for ICAEW Public Sector Finance for the Future Awards for our work on sustainability. We were also shortlisted for the HSJ Awards for Improving Environmental and Social Sustainability and Fiona Daly, Associate Director of sustainability and patient transport, was shortlisted, and highly commended, as the National Air Quality Champion at the National Air Quality Awards. In conjunction with Skanska, we provided the winning bid for the British Institute of Facilities Management (BIFM) Awards for new product/service for our waste management service.



# Our performance against CQUINS in 2015-16

The table below and information here shows the income associated with each individual CQUIN for 2015-16, which of our hospitals it applied to and our projected percentage delivery for the first three quarters of 2015-16.

Overall we achieved 81 per cent of our CQUINs (Commissioning for Quality and Innovation Scheme) in 2015-16, resulting in £16.7 million of a total £20.6 million available. Achieving the CQUINs was challenging due to an increased range of national areas they covered and in some instances the level of realistic achievability.

*Our overall performance is shown here in this table:*

## Key:

**ME:** Mile End Hospital

**NUH:** Newham University Hospital

**RLH:** Royal London Hospital

**SBH:** St Bartholomew's Hospital

**WX:** Whipps Cross Hospital

## National CQUIN

Acute Kidney Injury

Dementia and Delirium

Sepsis

Urgent and Emergency Care:

- Improving A&E Diagnosis coding
- Reducing Avoidable Emergency Admissions

## Local CQUIN

Cancer

Integrated Care

Mental Capacity Act

Patient Experience

Service Alerts

## Specialised CQUIN

Cancer:

- Oncotype DX (Breast Cancer gene testing)
- Systemic Anti- Cancer Therapy

Clinical Utilisation Review Tool

Hepatitis C

HIV - reducing unnecessary monitoring

Neonatal Intensive Care

Reducing Delayed Discharges from Critical Care

## Other CQUINs

Community

Dental

Public Health

### Barts Health NHS Trust CQUIN 2015/16 Performance

	Site	15/16 value available	15/16 value anticipated	% CQUIN achievement
	NUH/RLH/WX	£1,300,057	£758,359	58%
	All	£1,300,057	£1,189,449	91%
	NUH/RLH/WX	£1,300,057	£1,018,368	78%
	NUH/RLH/WX	£1,300,057	£845,029	65%
	NUH/RLH/WX	£1,300,057	£1,105,038	85%
	All	£1,300,057	£845,037	65%
	NUH/RLH/WX	£1820,080	£1,820,062	100%
	All	£1,300,057	£1,300,057	100%
	All	£780,034	£624,028	80%
	All	£1,300,057	686,430	53%
	SBH	£750,140	£750,140	100%
	SBH	£250,047	£250,047	100%
	RLH	£1,000,186	£250,000	25%
	RLH	£1,000,186	£1,000,186	100%
	RLH	£1,000,186	£1,000,186	100%
	NUH/RLH/WX	£750,140	£493,337	66%
	All	£1,000,186	£1,000,186	100%
	ME	£1,011,070	£953,844	94%
	RLH	£557,025	£557,025	100%
	ME	£287,471	£287,471	100%
<b>Total</b>		<b>£20,607,210</b>	<b>£16,734,278</b>	<b>81%</b>

## **Areas where performance was not as high as anticipated are noted here.**

## **National CQUINs**

### **Acute Kidney Injury**

Acute Kidney Injury or AKI CQUIN is predicated on recording information on discharge summaries to aid GPs to treat patients with AKI once they're discharged from hospital care. Although 58 per cent performance was noted overall, significant improvements were made on discharge information provided throughout the year with 90 per cent of all elements recorded in the latter quarter of the year.

### **Sepsis**

This CQUIN is predicated on screening patients for sepsis and administering antibiotics within one hour for severe sepsis patients. Performance improvements were made throughout the year and a best practice model was developed at Whipps Cross and is being rolled out to all of our hospitals.

### **Improving A&E diagnosis coding**

This specifically related to improving mental health diagnosis codes recorded for patients attending A&E.

## **Local CQUINs**

### **Cancer**

The main element of the CQUIN related to safety-netting procedures to make sure patients with abnormal test results were seen rapidly. 100 per cent of this three-part CQUIN was achieved throughout the year. Performance was lower around the discharge process. Improvements were made in the number of health needs assessments produced at patients' discharge and

we are reviewing with commissioners whether the discharge summary measure in the CQUIN is judged at the most appropriate point. We followed Macmillan guidelines in respect of cancer patients' discharge, and summaries for some patients were not produced immediately as they can remain within the health system for a long period.

### **Service alerts**

Poor performance in this CQUIN related to responding to patients' complaints in a timely manner. Although there were some improvements, the benefits of new complaints reporting process adopted from September 2015 won't be seen until later in the financial year.

## **Specialised CQUINs**

### **Clinical Utilisation Review (CUR) Tool**

The CUR Tool is a predictive tool which assesses information maintained about patients' treatment and welfare to aid assessing when they may be suitable for discharge. We didn't subscribe to this tool in 2015 -16. Cerner, our patient administration system provider, is developing our ability to be able to use this in 2016 -17 and beyond.

### **Neonatal Intensive Care**

This CQUIN was predicated on babies being discharged from the NICU into community nursing when appropriate; however some babies were kept in longer as their consultant deemed they needed a longer period of specialised care. This resulted in lost CQUIN income.

# Our year ahead: 2015-16

## Summary of our priorities for 2016-17

We are half way through a journey to ensure that all of our services achieve the same high standards as those which are already nationally and internationally recognised. We took steps to make rapid improvements in the care for our patients, to enhance our operational performance, and to ensure our finances are sustainable for the future.

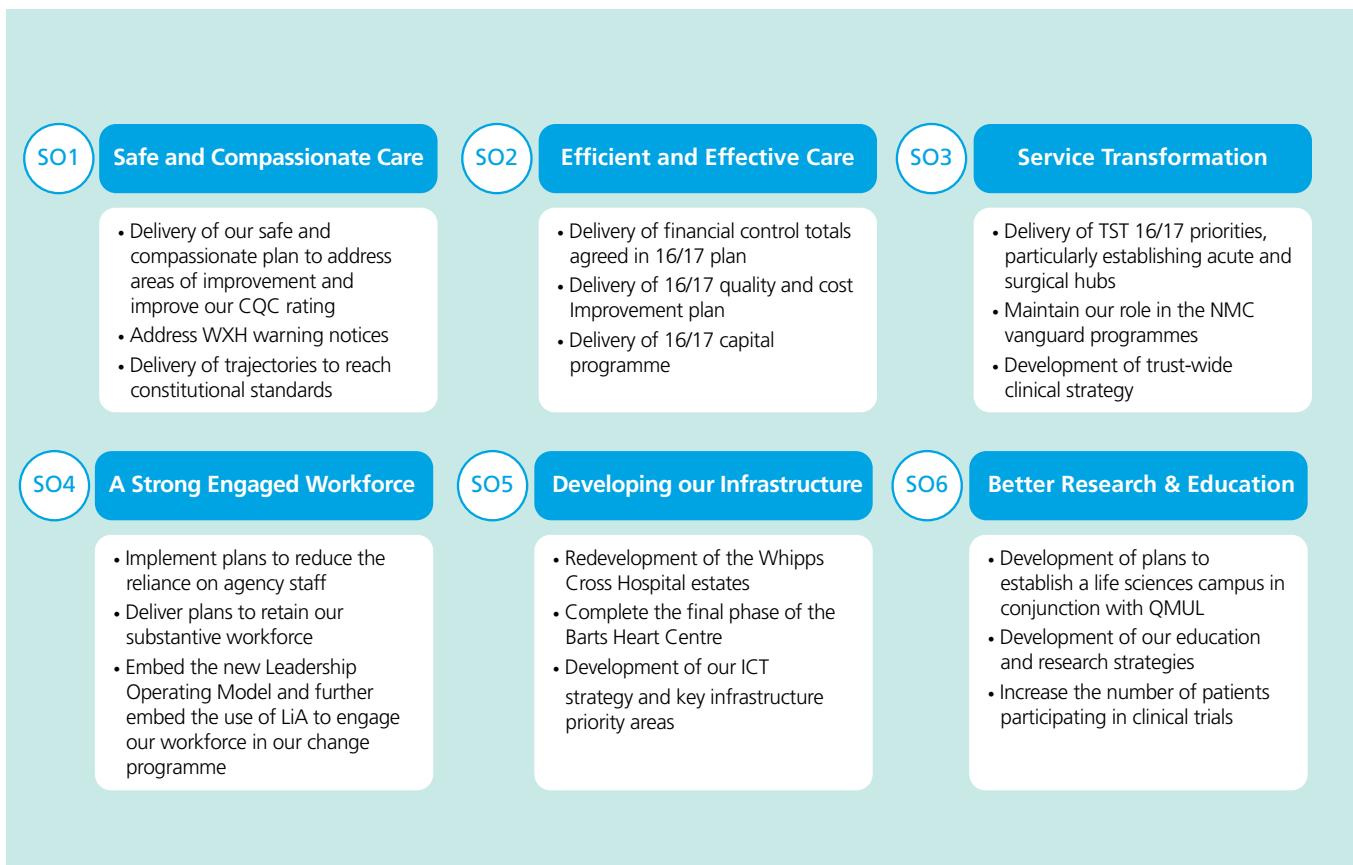
Our priorities for 2016 -17 further support the delivery of these ambitions. In collaboration with staff across the Trust and responding to the feedback from our patients and stakeholders, we are refreshing our Safe and Compassionate improvement plan with a greater focus on making improvements in our hospitals. Through the successful delivery of this plan, we aim to improve our CQC ratings from inadequate as a significant step towards exiting special measures.



## Our priorities

Our overriding priority in everything we do is to ensure the safety and quality of our services so we consistently provide safe and compassionate

care to our patients. We have adopted six strategic objectives to deliver this ambition:



Our operational plan for 2016-17, Barts Health cares, sets out how we will achieve these, by making further improvements in the quality of care for our patients, reducing waiting times and putting our finances on a firmer footing. These

areas are closely linked. Increasing efficiency, and improving our recruitment and retention of permanent staff to reduce reliance on temporary staff, will both improve the quality of care we provide to patients and reduce our costs.

## Our quality priorities

Our quality improvement plan, Safe and Compassionate, is our response to the 2015 Care Quality Commission (CQC) hospital inspection reports which resulted in the Trust being placed in special measures. Considerable progress was made to ensure that all our services achieved the same high standards as those which are already nationally and internationally recognised. We are proud of the progress we made in the past year, which is monitored and reported monthly on our website and NHS Choices.

We will shortly publish an update to Safe and Compassionate setting out a blueprint for each of our hospitals over the next 12 months. This will show how each hospital will achieve the key quality improvement objectives that we have set ourselves for the year.

1. Reduce the incidence of pressure ulcers:
  - Grade 4 – reduce by 75 per cent
  - Grade 3 – reduce by 50 per cent
  - Grade 2 – reduce by 75 per cent
2. Falls resulting in harm - 50 per cent reduction
3. Deteriorating patients
  - 50 per cent reduction in cardiac arrests across all sites
  - Sepsis 6 - 90 per cent compliance with antibiotics in sepsis in the first hour. Implementation of Sepsis 6
  - AKI – installation of a new real time AKI algorithm with automated notification to the renal service
4. Mortality governance – all deaths will receive peer review to gain learning and assess avoidability
5. Medication errors – validate and benchmark reporting methodology and occurrence and then set target for medication error reduction
6. Elimination of MRSA bacteraemias – 0 run rate by Quarter 4
7. 90 per cent duty of candour compliance by end Quarter 1

8. Statutory and mandatory training compliance is at a Trust record high, with all hospital sites in the green > 90 per cent, and overall training compliance on 31 March 2016 is 91.27 per cent.
9. Achieve site specific trajectories for patient experience – to be aligned to our new strategy.

The CQC informed us that it will re-inspect both Whipps Cross and The Royal London hospitals in July 2016. We expect our other sites to be re-inspected later this year. This will give us the opportunity to demonstrate how we have addressed the warning notices and compliance actions from the previous inspections, and taken significant steps to improve safety, reduce patient complaints, and engage staff.

The Trust has already met its target for staff compliance with statutory and mandatory training requirements, with all sites recording over 90 per cent. During the first quarter of 2016-17 we also intend to achieve 90 per cent compliance with the requirements of the duty of candour, and during the year we will set specific site trajectories for improving patient experience.

Our staff enthusiastically adopted the Listening into Action approach which empowered them to make changes to improve services for patients. We will continue to encourage local clinical teams to follow this model to put their ideas into practice, while also using it centrally to refresh our organisational values and behaviours.

## Our CQUINs for 2016-17

### Income from CQUINs

The Commissioning for Quality and Innovation scheme in 2016-17 will represent in the region of potentially £24 million income for the Trust. This is broken down into £17 million for CCG commissioned services, for both national and local schemes, and £7 million for NHS England Prescribed Specialised Services (previously known as Specialised Commissioning).

### CCG commissioned services

National schemes attracting 1.25 per cent outcomes based premium include:

1. NHS staff health and well being
2. Antimicrobial review and stewardship
3. Timely indication and treatment of sepsis

The scheme for sepsis will attract 10 per cent of the total 2.5 per cent applicable to CCG commissioned care.

A further 10 per cent proportion or 0.25 per cent CQUIN payment is in respect of the antimicrobial review. This CQUIN seeks a one per cent reduction in antibiotic usage.

The key change, however, relates to the introduction of a new three part CQUIN in respect of NHS staff health and well-being. This CQUIN is worth 0.75 per cent of the total 2.5 per cent CQUIN monies available, and represents potential income of around £5 million. The CQUIN is looking to improve outcomes in respect of:

1. Introduction of health and well being initiatives
2. Healthy food for NHS staff, visitors and patients
3. Improving uptake of flu vaccinations for frontline clinical staff

### Local schemes

Local schemes will operate for:

1. Ambulatory care
2. Delayed transfers of care
3. End of life care
4. Integrated care
5. Maternity
6. Patient safety
7. Smoking cessation

### Community Health Services

1. Integrated care

*NHS England (NHSE) Prescribed Specialised Services (Specialised Commissioning)*

Prescribed Specialised Services CQUINs are also subject to significant change in 2016-17. In 2015-16, the overall CQUIN attributable to Specialised Commissioning was 2.5 per cent. 0.1 per cent of this was topsliced to deliver Operational Delivery Networks (ODNs) in specialised areas such as critical care.

In 2016-17, ODNs are funded as a separate entity, however the remaining 2.4 per cent CQUIN has also been increased as we are a Hepatitis C ODN provider. For the first time, NHS England (NHSE) have issued a differential CQUIN with Hepatitis C ODN providers attracting 2.8 per cent CQUIN and other providers attracting only 2.0 per cent CQUIN.

Hepatitis C is the key feature of the NHSE scheme for Prescribed Specialised Services with 1.6 per cent of the 2.8 per cent CQUIN being apportioned to the operation and delivery of the Hepatitis C ODN. Hepatitis C has been subject to significant improvements in drug regimes offering marked benefit to patients and part of the Hepatitis C ODN

role is to ensure NICE guidance in respect of these new drug advances is adhered to.

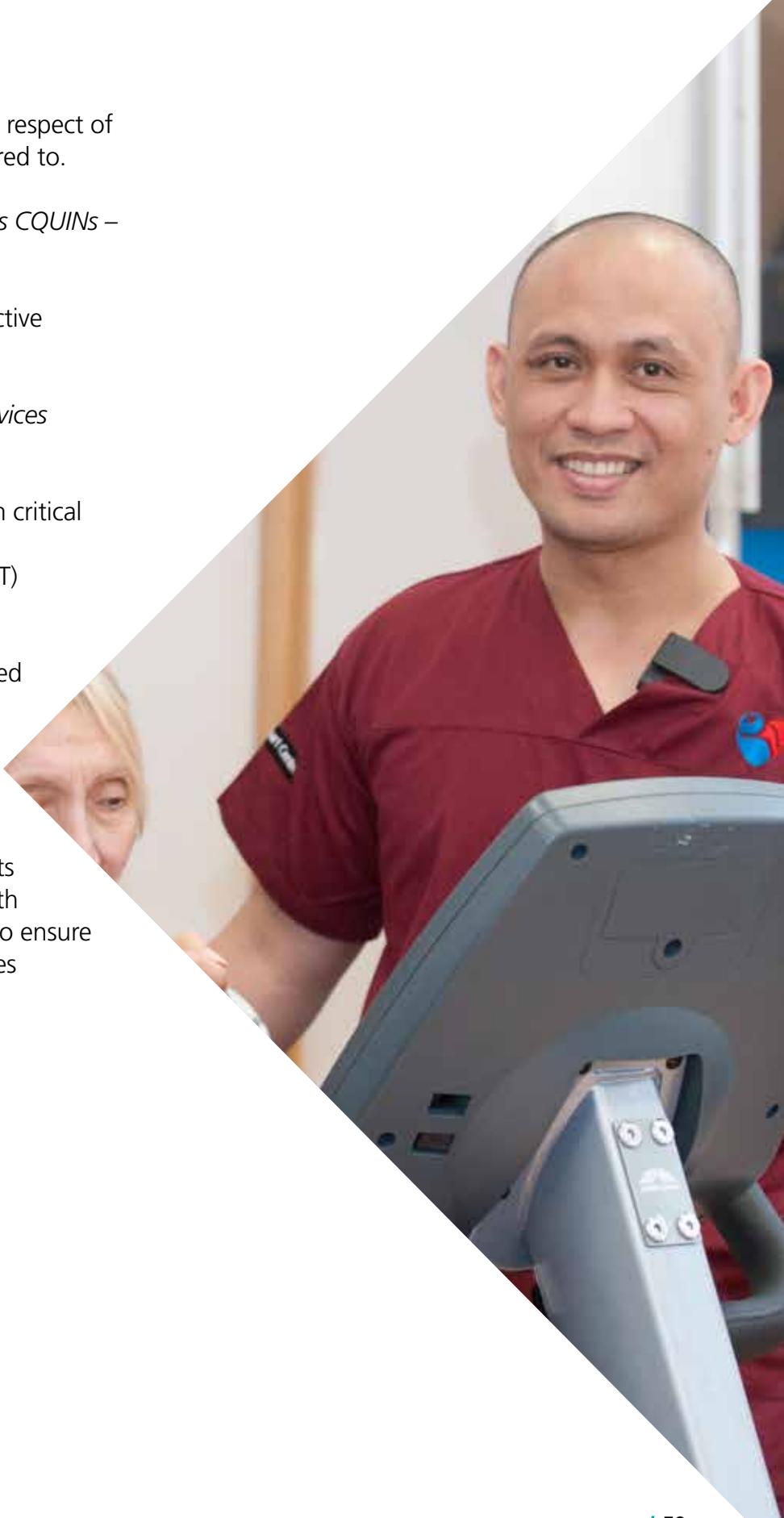
*Further Prescribed Specialised Services CQUINs – new schemes*

2. Haemoglobinopathy
3. Reducing cardiac surgery non elective inpatient waiting

*Further Prescribed Specialised Services CQUINs – existing schemes*

4. Clinical utilisation review tool
5. Reducing delayed discharges from critical care to ward care
6. Systemic anticancer therapy (SACT) chemotherapy

All CQUINs for 2016-17 have a defined link to our wider improvement journey as outlined in the Safe and Compassionate improvement plan. The achievement of the above CQUINs will ensure we continue to improve the outcomes for our patients as well as strengthening our work with partners as a wider health economy to ensure local, national and specialised priorities are met.



# Quality Assurance

## Our Quality Assurance Statement

In accordance with the Quality Account Regulations, Barts Health NHS Trust is required to include a set of prescribed assurance statements in the look back section of the Quality Account. These must cover:

- A review of services provided
- Details of participation in clinical audit and research
- Care Quality Commission regulation and registration status – included on page 4a
- Income and performance through the Commissioning for Quality and Innovation payment scheme (CQUIN)
- Data quality and Information Governance assurance

### Review of services

During 2015-16, Barts Health NHS Trust Board reviewed all the data available to it on the quality of care in 100 per cent of its NHS services, as measured by individual service lines.

These service lines cover the range of regulated activities (as specified in the Care Quality Commission's registration statement of purpose) undertaken by the Trust in the period before 1 April 2016. The income generated by the services reviewed in 2015-16 represents 100 per cent of the total income generated from the provision of NHS

services by Barts Health NHS Trust for 2015-16.

Quality was reviewed by systematic data collection against a suite of quality and operational service line metrics which inform our performance management framework and Integrated Performance Report (IPR). The Trust operates a robust system of patient safety and risk management.

Quality governance is reviewed in depth through the Trust Executive and the Quality Assurance Committee. The latter provides assurance to the Barts Health NHS Trust Board.

### Data Quality

Barts Health NHS Trust is currently ranked 15th in the London area, as represented via the HSCIC data quality dashboard, with an overall data quality performance of 97.5 per cent. This performance is 1.3 per cent above the national average of 96.2 per cent and 1.4 per cent above the London area team average of 96.1 per cent.

Barts Health submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode



Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 98.0 per cent - for admitted patient care (an overall improvement of 2.4 per cent)
- 99.2 per cent - for outpatient care (an overall improvement of 2 per cent)
- 92.9 per cent - for accident and emergency care (an overall improvement of 3.6 per cent)

In addition, to facilitate the delivery of streamlined patient care and integrated working with our commissioners and partner organisations we focused on improving our submitted performance of the recorded organisation of residence, which has increased from 22.3 per cent to 97.8 per cent and the patient's valid General Medical Practice Code, was:

- 100.0 per cent for admitted patient care
- 100.0 per cent for outpatient care
- 99.9 per cent for accident and emergency care

The Trust continued to make improvements in the accuracy and completeness of patient records by proactively reviewing and resolving:

- potential duplicate records
- missing NHS numbers
- completeness of ethic category

The Trust is no longer subject to an annual external audit of clinical coding by the Audit Commission. These are now undertaken on an ad-hoc basis. However, so that the Trust maintains a high standard of clinical coding, our internal team of accredited auditors carried out five detailed audits across the following specialties; interventional radiology, general surgery, orthopaedics, cardiology and general medical. All audits complied with Information Governance Toolkit standards. Future audits will cover other specialties.

## Information Governance Toolkit attainment levels

Barts Health Information Governance Assessment Report overall score for 2015-16 was 76 per cent and was graded satisfactory.

## Participation in clinical audit

During 2015-16 there were 39 mandatory national clinical audits and two national confidential enquiries covered NHS services that Barts Health NHS Trust provides. During that period Barts Health participated in 97 per cent of national clinical audits and 100 per cent of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Barts Health NHS Trust participated in, and for which data collection was completed during 2015-16 are listed in on pages **xx-xx** alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

To date, the reports of eight national clinical audits were reviewed by the provider in 2015-16 and Barts Health intends to take the following actions to improve the quality of healthcare provided:

### Cancer audits

- Appointed a clinical data lead and adopted use of the real time CancerStats tool.
- Appointed a new lung cancer nurse specialist.

### Inflammatory bowel disease audits

- Established patient involvement panels.
- Developed patient satisfaction survey and adopted use of iWantGreatCare system.

### Trauma research audit network

- Appointed two new trauma neurosurgeons and a consultant trauma plastic surgeon.

1,035 local clinical audits were registered by the provider in 2015-16 and Barts Health NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Development of a training programme in ICU physiotherapy.
- Additional pre-assessments in ophthalmology to reduce the risk of laser-related complications.
- Introduction of standardised outcome measures to assess pain prior to steroid injection in podiatry.
- Development of training and education around cognitive assessment in stroke patients.
- Establishment of collaborative working to improve pre-operative rehab planning for trauma patients requiring therapy.

Further details of our achievements and progress against the goals agreed for 2015-16 are provided on pages **xx-xx** of the Quality Account.

### Care Quality Commission

Barts Health NHS Trust is required to register with the Care Quality Commission and its current registration status is full registration with no conditions.

The Care Quality Commission did not take enforcement action against Barts Health NHS during 2015-16. However, Barts Health remains in special measures following publication of the CQC report on Whipps Cross in March 2015, when enforcement action was taken involving the issuing of four warning notices and four compliance notices against the Trust in relation to Whipps Cross. Furthermore, a range of compliance actions were identified for The Royal London and Newham hospitals in the CQC report published in May 2015.

More detail of the actions we have taken in relation to this is described in pages 7-36, our performance in 2015-16.

### Research and development

The number of patients receiving NHS services provided or sub-contracted by Barts Health NHS Trust in 2015-16 that were recruited during that period to participate in research approved by a research ethics committee was 30,000.

### Goals agreed with Commissioners (CQUINs)

A proportion of Barts Health NHS Trust's income in 2015-16 was conditional on achieving 18 acute and two community services quality improvement and innovation goals agreed between Barts Health NHS Trust and our local commissioners.

# Mandated indicators

The NHS and NHS Foundation organisations included in the Health and Social Care Information Centre published data, against which Barts Health is benchmarked, include those trusts that are similar to Barts Health i.e. large, multi-site trusts, as well as single-site and single speciality trusts. Caution should be exercised when drawing firm conclusions as to comparative/relative performance, as the benchmarks do not account for socio-economic factors, such as deprivation, nor do they reflect ethnic and cultural differences that impact the case mix presenting for treatment at Barts Health.

\*The palliative care indicator is a contextual indicator

## SHMI

### Definition

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to (a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.



### Data period 1 April 2015 – 31 March 2016

SHMI	Best	0.67	The Whittington Hospital NHS Trust
	2nd	0.75	Chelsea and Westminster Hospital NHS Foundation Trust
	3rd	0.76	Imperial College Healthcare NHS Trust
	8th	0.87	Barts Health NHS Trust
	Average	1.00	
	Worst	1.21	North Tees and Hartlepool NHS Foundation Trust

The SHMI figures include patients who were coded as receiving 'palliative care' at either diagnosis or specialty level:

Our quality priorities for 2016-17 on page 55 outline our objective to peer review every death to ensure we learn and assess avoidability.

Patients receiving palliative care	Best	50.9	Imperial College Healthcare NHS Trust
	Barts Health	18.6	
	Average	26.0	
	Worst	10.1	Croydon Health Services NHS Trust

More information on work we are doing to improve care for patients who are at the end of their life can be found on pages 26.

## PROMS

### Definition

The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to the Trust's patient reported outcome measures scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.

### Data period 1 April 2015 – 31 December 2015

PROMS i) groin hernia	Best	0.156	Nuffield Health, Leicester Hospital
	2nd	0.132	Bodmin NHS Treatment Centre
	3rd	0.132	South Warwickshire NHS Foundation Trust
	124th	0.064	Barts Health NHS Trust
	Average	0.087	
	Worst	0.024	University Hospitals Coventry and Warwickshire NHS Trust
PROMS ii) varicose vein surgery	Best	0.147	West Hertfordshire Hospitals NHS Trust
	2nd	0.136	Wye Valley NHS Trust
	3rd	0.135	Heart of England NHS Warwickshire
	23rd	0.096	Barts Health NHS Trust
	Average	0.098	
	Worst	0.036	Bedford Hospital NHS Trust

PROMS iii) hip replacement surgery	Best	0.524	Spire Clare Park Hospital
	2nd	0.517	St Hugh's Hospital
	3rd	0.508	BMI - Three Shires Hospital
	189th	0.414	Barts Health NHS Trust
	Average	0.436	
	Worst	0.331	Walsall Healthcare NHS Trust

PROMS iv) knee replacement surgery	Best	0.4	BMI - The Droitwich Spa Hospital
	2nd	0.395	Northern Devon Healthcare NHS Trust
	3rd	0.392	Shepton Mallet NHS Treatment Centre
	156th	0.285	Barts Health NHS Trust
	Average	0.331	
	Worst	0.215	Barking, Havering and Redbridge University Hospitals NHS Trust

\* Case mix - adjusted figures are not shown for organisations with fewer than 30 modelled records, as the underlying statistical models break down when counts are low and aggregate calculations based on small numbers may return unrepresentative results.

## Readmission to hospital within 28 days of discharge

### Definition

The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

### Data period April 2015 – November 2015

#### a) Overall

Overall	Best	3.41%	University College London Hospital
		7.35%	Barts Health NHS Trust
	Average	5.6%	
	Worst	10.05%	Barnsley

b) Readmissions age 0 to 14

Readmissions 0-14	Best	1.95%	Sheffield Teaching
		6.5%	Barts Health NHS Trust
	Average	5.3%	
	Worst	17.73%	Barnsley

b) Readmissions age 15 and over

Readmissions 15 and over	Best	3.45%	University College London Hospital
		8.2%	Barts Health NHS Trust
	Average	5.9%	
	Worst	9.92%	West Midlands

A joint audit of readmissions within 30 days of discharge is being undertaken between Barts Health and CCG colleagues. Issues and areas for improvement will be identified and overseen by the efficient and effective care workstream throughout 2016-17.

### **Responsiveness to personal needs of patients – patient experience net promoter score Definition**

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.

### **Data period – April 2016 (inpatients and outpatients)**

Recommended percentage score	Best	99.5%	Liverpool Women's NHS Foundation Trust
	2nd	98.8%	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
	3rd	98.8%	Royal Berkshire NHS Foundation Trust
	127th	92.3%	Barts Health NHS Trust
	Average	94.3%	
	Worst	78.18%	Sheffield Children's NHS Foundation Trust

Our compassionate care and patient experience section (pages 18-25) outlines the work we're doing to improve the experience of all our patients, including the launch of our new patient experience strategy and iWantGreatCare.

## VTE

### Definition

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

### Data period 1 April 2015 to 31 March 2016

Percentage of patients admitted to hospital who were risk assessed for VTE

Percentage of patients admitted to hospital who were risk assessed for VTE	Best	100%	South Essex University
	Average	96.0%	
	95th	95.7%	Barts Health NHS Trust
	Worst	79.9%	Hull East Yorkshire

## Rates of Clostridium Difficile

### Definition

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged two or over during the reporting period.

The rate per 100,000 bed days for Barts Health during 2015-16 was 10.75

(\*bed days data used not yet published from Public Health England).

**Data period 1 April 2015 to 31 March 2016**

The ranking below is based on the count of Trust-apportioned C.difficile infections.

C Diff	Best	0	Birmingham Women's Hospital
	2nd	0	Moorfields Eye Hospital
	3rd	0	Liverpool Women's Hospital
	144th	68	Barts Health NHS Trust
	Average	35.55	
	Worst	139	Leeds Teaching Hospital

In 2015-16, we were below the NHS England objective of 82 cases with 68 cases of C.difficile attributed to Barts Health. Of these 68 cases, all were assessed and only three lapses of care were identified which were addressed with local clinical teams.

## Patient safety incident reporting

### Definition

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death)

### Data period 1 April 2015 to 30 September 2015 (NRLS)

Rate per 1,000 bed days of patient safety incidents reported during 2015 (a higher rate of incident reporting is seen as positive)

Rate of patient safety incidents reported in 2015 (a higher rate of incident reporting is seen as positive)	Best	74.67	Northern Devon Healthcare
	84th	35.77	Barts Health NHS Trust
	Average	5.3%	
	Worst	18.07	United Lincolnshire Hospitals NHS Trust

## Definition

The data made available to the Trust by the Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

### Data period 1 April 2015 to 30 September 2015 (NRLS)

Percentage of patient safety incidents which resulted in severe harm or death	Best	0%	Wye Valley NHS Trust
	77th	0.4%	Barts Health NHS Trust
	Average	0.4%	
	Worst	2.9%	South Warwickshire NHS Foundation Trust

You can read more about the work we've done to improve patient safety and our Sign up to Safety campaign in our safe and effective care section on pages 10 to 17.

## Friends and Family Test – Staff

### Definition

Friends and Family Test - Question Number 12d – Staff – The data made available by National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' for each acute and acute specialist trust who took part in the staff survey.

### Data period 2015

FFT– Staff Question 12	Best	3.48	Moorfields Eye Hospital
	2nd	3.39	Homerton University Hospital NHS Foundation Trust
	3rd	3.39	West Middlesex University Hospital NHS Trust
	68th	3.09	Moorfields Eye Hospital NHS Foundation Trust
	Average	3.06	
	Worst	2.70	Pennine Acute Hospitals NHS Trust

## Friends and Family Test – Patient

### Definition

The data made available by National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E (types 1 and 2).

### Data period 1 April 2015 to 31 March 2016

FFT Patient A&E	Best	43.2%	Royal Free London NHS Foundation Trust
	2nd	33%	Gateshead Health NHS Foundation Trust
	3rd	29.4%	University Hospitals of Morecambe Bay NHS Foundation Trust
	137th	1.8%	Barts Health NHS Trust
	Average	14.1%	
	Worst	1.4%	Bradford Teaching Hospitals NHS Foundation Trust

### Data period 1 April 2015 to 31 March 2016

FFT Patient Inpatient	Best	57.3%	Papworth Hospital NHS Foundation Trust
	2nd	55.6 %	Royal National Orthopaedic Hospital NHS Trust
	3rd	51.6 %	Moorfields Eye Hospital
		18%	Barts Health NHS Trust
	Average	30%	
	Worst	8%	Norfolk and Norwich University Hospitals NHS Foundation Trust

Our compassionate care and patient experience section (pages 18 to 25) outlines the work we're doing to improve the experience of all our patients including our new patient experience strategy and iWantGreatCare.



## Participation in Mandatory Quality Account National Clinical Audit Projects 2015-16

Audit Title	National Clinical Audit supplier	CAG	Inclusion criteria - data submitted in 2015/16
Acute coronary syndrome or Acute myocardial infarction	MINAP	Cardiovascular	<p>Any acute coronary syndrome, including non-ST-elevation myocardial infarction and ST-elevation myocardial infarction.</p> <p>All consecutive patients. 1 January - 31 December 2014</p>
Bowel cancer	Health and Social Care Information Centre	Surgery and Cancer	All patients diagnosed from 1 April 2014 - 31 March 2015 undergoing major surgery.
Cardiac Rhythm Management	Heart Rhythm UK, NICOR	Cardiovascular	<p>Classes of devices included for 2015 calendar year are: Pacemakers (PM) for bradycardia (abnormally slow heart rates) and Implantable defibrillators (ICD) for life threatening ventricular arrhythmias which may otherwise cause sudden cardiac death.</p> <p>All EP ablation procedures in calendar year 2013 (excluding diagnostic EP studies).</p>
Case Mix Programme	ICNARC Case mix programme	Surgery	All critical care patients in 2015/16 financial year. Audit of patient outcomes from adult general critical care units (intensive care and combined intensive care/high dependency units)
Child Health Clinical Outcome Review Programme	NCEPOD	Children's	
Congenital heart disease (Paediatric cardiac surgery) (CHD)	CHD		All cardiac or intrathoracic great vessel procedures carried out in patients under the age of 16 years, and all adult congenital cardiac procedures performed for a cardiac defect present from birth.

Number of participating sites/number of eligible sites		Site coverage - number of cases submitted in 2015/16					
		Newham	Whipps Cross	Royal London	St Bartholomew's	Mile End	
4/4		Participating					Not eligible
3/3		Submitted as Barts Health for NUH, SBH and WCH					Not eligible
2/2		Not eligible	Participating	Not eligible	Participating	Not eligible	
3/3		Participating			Not eligible		
		Participating			Not eligible		
Cardiovascular		Not eligible					

Audit Title	National Clinical Audit supplier	CAG	Inclusion criteria - data submitted in 2015/16
Coronary angioplasty otherwise known as Audit of Percutaneous Coronary Interventional Procedures (PCI)	NICOR: National Institute of Cardiovascular Outcomes Research (also BCIS)	Cardiovascular	All PCI patients in the 2012 calendar year.
Diabetes (Adult) ND(A)	NDA	ECAM	All patient diagnosed with diabetes and seen in in and outpatient care from 1 October 2013 to 31 December 2013
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Children's	Patients that have been seen at paediatric diabetes clinics from 1 April 2012 to 31 March 2013 up to and including 24 years of age.  <b>PREM:</b> Families who attend OPD from 2 September 2013 to 31 January 2014.
Elective surgery (National PROMs Programme)	HSCIC	Surgery	All groin hernia, varicose veins, hip fracture and knee fracture patients.
Falls and Fragility Fractures Audit Programme (FFFAP), including Hip Fracture Database	Royal College of Physicians	ECAM	All falls and hip fractures reported in the Hip Fracture Database.
Inflammatory bowel disease (IBD) Includes Paediatric Inflammatory Bowel Disease Services	Royal College of Physicians	ECAM and Children's	50 consecutive prospectively identified admissions for ulcerative colitis from 1 January to 31 December.
Lung cancer	Health and Social Care Information Centre	Cancer	Patients first seen from 1 January 2012 to 31 December 2012.
Severe trauma	TARN	ECAM	All trauma patients from 1 April 2013 to 31 March 2014.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	MBRRACE-UK	Women's and Children's	Maternal deaths, stillbirths and infant deaths from 1 January 2013.

Number of participating sites/number of eligible sites	Site coverage - number of cases submitted in 2015/16		
2/2	Not required to participate - patients referred to other sites	Participating	Not eligible
2/3		Participating	Not eligible
3/3		Participating	Not eligible
3/3		Participating	Not eligible
3/3		Participating	Not eligible
4/4		Participating	Not eligible
4/4		Participating	Not eligible
3/3		Participating	Not eligible
3/3		Participating	Not eligible

Audit Title	National Clinical Audit supplier	CAG	Inclusion criteria - data submitted in 2015/16
Adult cardiac surgery audit (ACS)	ACS (Society of Cardiothoracic Surgeons)	Cardiovascular	Patients undergoing two major types of cardiac surgery aortic valve surgery and coronary bypass surgery from 1 April 2012 to 31 March 2013 to be confirmed.
National Audit of Dementia	Royal College of Psychiatrists	ECAM	TBC
National Cardiac Arrest Audit (NCAA)	ICNARC	ECAM	All individuals (excluding neonates) receiving chest compressions and/or defibrillation and attended by the hospital-based resuscitation team (or equivalent) in response to the 2222 from 1 April 2013 to 31 March 2013.
Chronic Obstructive Pulmonary Disease (COPD)	Royal College of Physicians	ECAM	Snapshot audits of admission to hospital from 1 February to 30 April 2014 with COPD exacerbation and outcomes at 30 and 90 days.
National Comparative Audit of Blood Transfusion	NHS Blood and Transplant	CSS	
Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Centre for Mental Health and Risk, University of Manchester	Not applicable	Mental health services are provided by East London NHS Foundation Trust and North East London NHS Trust, not Barts Health.
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Surgery	All patients over the age of 18 year having a general surgical emergency laparotomy from 1 January 2014 to 31 November 2015.
Heart failure (HF)	NICOR: National Institute of Cardiovascular Outcomes Research	Cardiovascular	All heart failure patients from 1 April 2012 to 31 March 2013

Number of participating sites/number of eligible sites	Site coverage - number of cases submitted in 2015/16		
1/1	Not required to participate - patients are referred to other sites	Participating	Not eligible
National audit to begin 2015/16	Participating		
5/5	Participating		Not Participating as sample too small to be included (<2 per annum)
3/3	Participating		Not eligible
CSS	Participating		
	Not eligible		
3/3	Participating		Not eligible
4/4	Participating		Not eligible - no A&E department

Audit Title	National Clinical Audit supplier	CAG	Inclusion criteria - data submitted in 2015/16
Hip, knee, shoulder and ankle replacements	National Joint Registry	Surgery	All hip, knee and ankle replacements from 1 April 2014 to 31 March 2015.
National Prostate Cancer Audit	Royal College of Surgeons	Cancer	All patients newly diagnosed with prostate cancer from 1st April 2014
National Vascular Registry	Royal College of Surgeons	Surgery	Patients undergoing vascular procedures including; Abdominal Aortic Aneurysm (AAA) surgery, Infrainguinal Bypass, Amputation or Carotid surgery
Neonatal intensive and special care (NNAP)	Royal College of Paediatrics and Child Health	Children's	All babies admitted to the neonatal unit in 2013, including term babies.
Non-Invasive Ventilation	British Thoracic Society	ECAM	All patients treated with Non-Invasive Ventilation during the audit period
Oesophago-gastric cancer	Health and Social Care Information Centre	Cancer	Patients diagnosed in the first and second years of the continuing audit (01 April 2012 to 31 March 2013) including patients with oesophageal high-grade glandular dysplasia (HGD)
Paediatric Asthma	British Thoracic Society	Children's	
Paediatric Intensive care	PICANet	Children's	All children and young people admitted to the paediatric intensive care unit from 1 January 2012 to 31 December 2014.
Prescribing Observatory for Mental Health (POMH)	POMH	Not applicable	Mental health services are provided by East London NHS Foundation Trust and North East London NHS Trust, not Barts Health.
Renal replacement therapy	Renal Registry	ECAM	All patients starting renal replacement therapy (RRT) in 2013

Number of participating sites/number of eligible sites	Site coverage - number of cases submitted in 2015/16		
3/3	Participating		Not eligible
3/3	Participating		Not eligible
1/1	Not required to participate - all patients referred to RLH	Participating	Not eligible
3/3	Participating		Not eligible
No data collection in 2014/15	Participating		Not eligible
3/3	Submitted as Barts Health for NUH, SBH and WSH		Not eligible
3/3	Participating		Not eligible
1/1	Not eligible	Participating	Not eligible
	Not eligible		
1/1	Not eligible	Ongoing Participation (100% submitted)	Not eligible

Audit Title	National Clinical Audit supplier	CAG	Inclusion criteria - data submitted in 2015/16
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	ECAM	<p><b>Inclusion criteria:</b> Adult patients past their 16th birthday, undergoing procedural sedation at all levels (minimal, conscious, moderate, dissociative and deep).</p> <p><b>Exclude:</b> Patients aged 15 or under. Patients receiving: * Entonox (50 per cent nitrous oxide/oxygen) only *Opiates only * Entonox and opiates in combination</p>
Pulmonary hypertension audit	HSCIC	Not applicable	Pulmonary hypertension centres only. Barts Health is not a pulmonary hypertension centre.
Rheumatoid and early inflammatory arthritis	British Rheumatology Society	ECAM	All patients with rheumatoid and early inflammatory arthritis from 1 February 2014. Data entry includes three months follow up.
Sentinel Stroke National Audit Programme	Royal College of Physicians	ECAM	All stroke patients from April 2013 to March 2014 in their first three days in hospital.
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	ECAM	
UK Parkinson's Audit (previously known as National Parkinson's Audit)	UK Parkinson's Audit (previously known as National Parkinson's Audit)	ECAM	

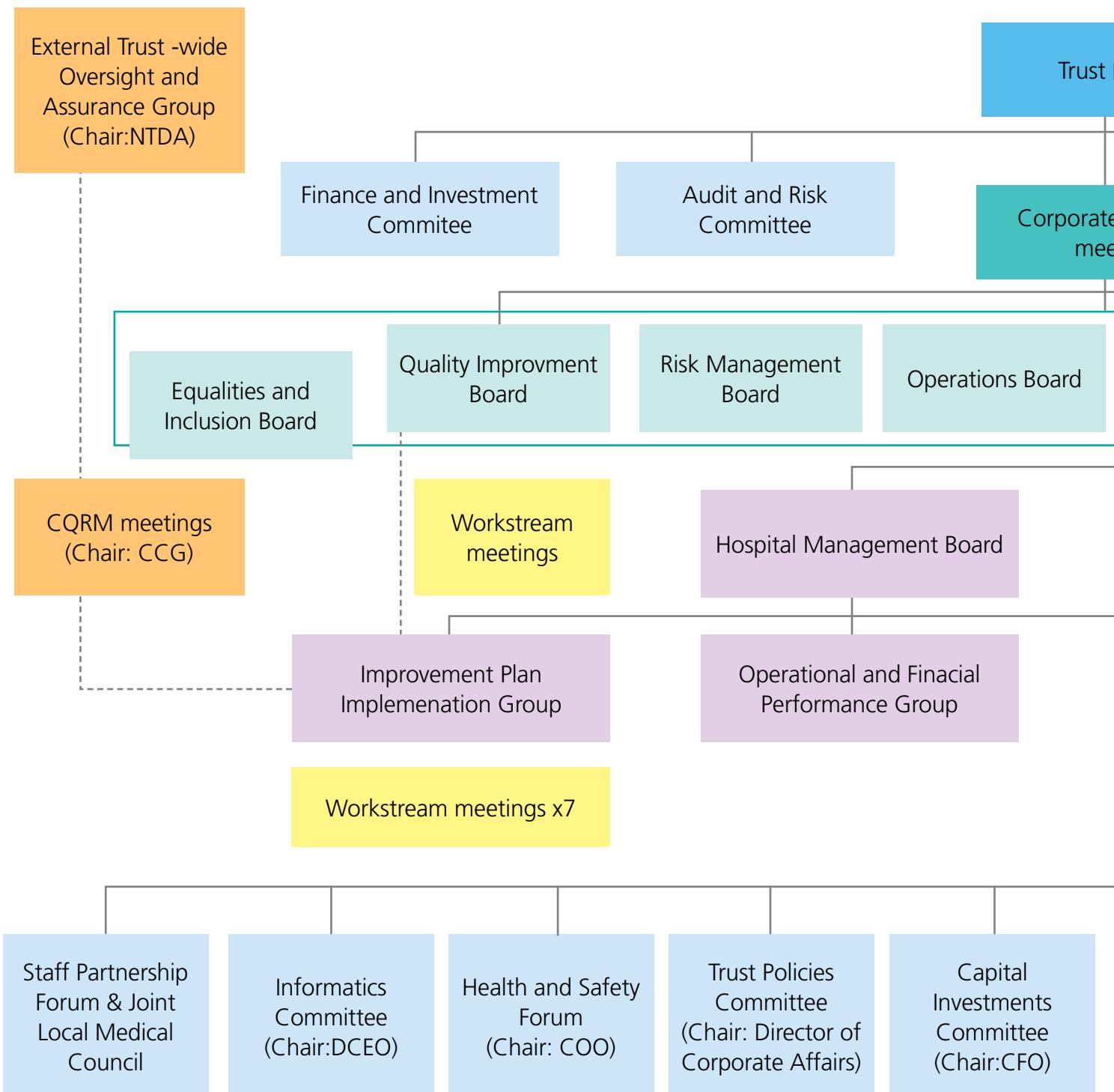
Number of participating sites/number of eligible sites	Site coverage - number of cases submitted in 2015/16			
	98 cases	36 cases	50 cases	Not eligible
	Not eligible			
3/3 Organisational questionnaires submitted 2/2	Not eligible	Not Participating	Not eligible	Not Participating
3/3	Q1: 34 cases Q2: 38 cases Q3: 34 cases Q4: 31 cases	Q1: 39 cases Q2: 58 cases Q3: 43 cases Q4: 33 cases	HASU Q1: 202 HASU Q2: 191 HASU Q3: 174 HASU Q4: 153 to date	Not eligible
3/3	Not eligible		108/112 (96 per cent)	Not eligible
3/3	Participating			Not eligible Participating

Audit Title	National Clinical Audit supplier	CAG	Inclusion criteria - data submitted in 2015/16
Vital signs in Children (care in Emergency Departments)	Royal College of Emergency Medicine	ECAM	<p><b>Inclusion criteria:</b> Children (patients less than 16 years of age) who present to the ED with a medical illness, including rashes and abdominal pain.</p> <p>By medical illness, we mean presentations unrelated to trauma. The child may be ambulatory or non-ambulatory.</p> <p><b>Exclude:</b> Adult patients aged 16 and over. Trauma patients presenting with injuries.</p>
VTE risk in lower limb immobilisation (care in Emergency Departments)	Royal College of Physicians	ECAM	<p><b>Inclusion criteria:</b> Patients 17 years of age and above who present to an ED or an Minor Injuries Unit that is part of the ED with a lower limb injury and are discharged with temporary immobilisation of the limb using a plaster cast.</p> <p><b>Exclude:</b> *Any patient under the age of 17 years. * Patients who are admitted to a ward as an inpatient (excluding observation and short stay wards under the jurisdiction of the ED). *Patients on warfarin, related New Oral Anticoagulants (NOACs) or heparin. * Patients with lower limbs immobilised by other means e.g. air cast boot, cricket splint etc.</p>

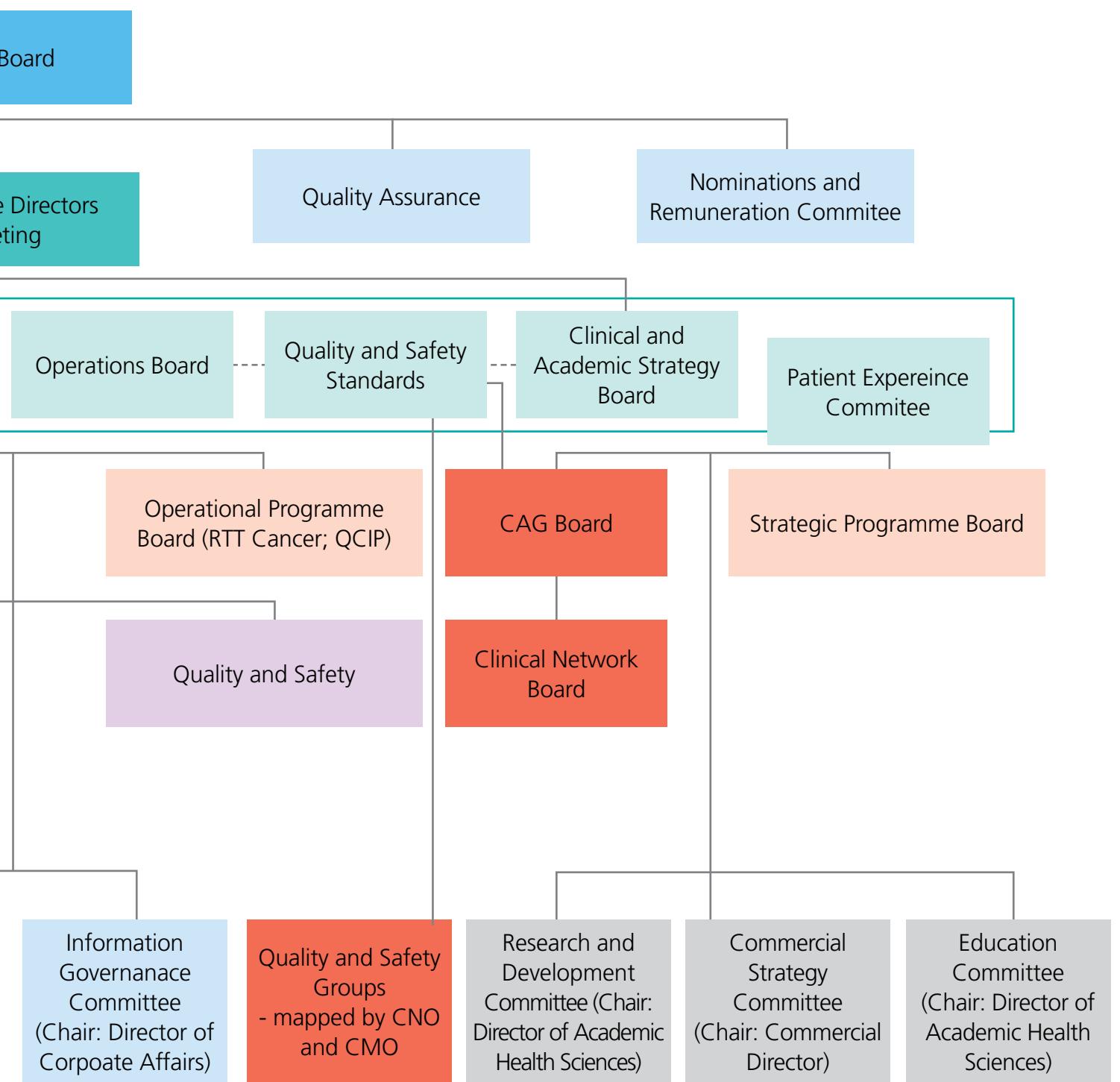
Number of participating sites/number of eligible sites	Site coverage - number of cases submitted in 2015/16		
3/3	100 cases		Not eligible
3/3	Not eligible	100 cases	Not eligible

# Appendices

## Appendix 1:



# Barts Health NHS Trust Governance structure: April 2016



## Appendix 2:

### Appendix 2: Feedback and reports from our stakeholders

In April 2016, we sent a draft version of the Quality Account to a number of local stakeholders for their scrutiny, input and comment. The Account was sent to:

- The Chairs and Chief Officers of our local Clinical Commissioning Groups
- The Chairs of the health scrutiny committees for our local authorities
- Our local Healthwatches.

Formal written responses follow from these organisations:

1. Tower Hamlets Clinical Commissioning Group on behalf of the collaborative commissioning arrangements for Barts Health NHS Trust
2. The Chair of the Inner North East London Joint Health Overview and Scrutiny Committee
3. The Chair of the Tower Hamlets Health Scrutiny Committee
4. The Chair of the Waltham Forest Council Health Scrutiny Committee
5. Healthwatch for The City of London
6. Tower Hamlets Healthwatch

Internally, the draft Quality Account was presented to the Trust's Quality Assurance Committee, a sub-committee of the Board, the Trust Board and the Trust executive team during April, May and June 2016.



## **Healthwatch City of London response to the Barts Health Quality Account 2015-16**

Healthwatch City of London is pleased to have the opportunity to comment on this quality account from Barts Health for 2015/16. The last year has been one of significant change for Barts Health whilst in special measures following the CQC reports of March 2015 and the changes in senior management have led to a review of the approach taken across the Trust.

We have been pleased to take part in the programme of quarterly meetings with Alwen Williams, Chief Executive of Bart's Health Trust. Staff, Board Members and volunteers have continued to attend this and additional meetings and events to support development of the new Patient Engagement and Experience Strategy which has now been approved at Board level. The strategy has been co-designed with patient organisations, of which Healthwatch City of London has taken a key role.

The efforts being taken to make the premises more user friendly for those with dementia is welcome although City members were surprised that a 'Dementia Buddies' system for activities is not already in place in such a large trust.

The reliance on Friends and Family Test results is of concern as patients may be reluctant to say if care or service is poor. The new 'IWantGreatCare' will also encourage individual nurses to obtain individual feedback from patients which will result in a lack of anonymity. It is welcomed that there is a variety of ways of collecting patient experience and these should be averaged out instead of highlighting the results from one source as too often happens. Care should be taken that patients do not feel pressurised into providing real time feedback when they are feeling unwell and may be vulnerable.

One of the major areas of complaint from patients is transport and the inefficiencies experienced although there is little said of this apart from a sentence on page 15. Whilst the volume of complaints is referenced in the report there is no focus on what learnings have come from the complaints, how they have been dealt with and what the outcomes have been. More evidence of learning would help to build service user trust in Barts Health.

There is acknowledgement in the Quality Account that 'outpatients' is an area of difficulty especially in relation to patients making contact by telephone. There is little reference to the difficulties that many patients have in navigating the whole outpatient system such as not all staff knowing their reception and clinic area and the major problems with IT where the many different IT systems are unable to talk to each other.

The initiatives described on p12-15 include:

- Ward Dashboards
- Dementia Buddy Pack and 'Forget Me Not' form
- Patient Experience Groups
- 'iWantGreatCare' real-time feedback.

These refer to the collation of information. What is unclear is the benchmarking bar, the critical success factors, which highlight and calibrate improvement.

Members would also like to see all tables showing results of patient experience (or other) surveys (see page 13 for example) include the number of respondents as is standard convention.

In terms of the 'Supporting the Local Community' (page 27) Healthwatch members and City residents have experienced this directly through involvement with a two week training programme co-ordinated by Barts Health and came away with a very positive impression. However, more could be done to publicise the training programmes to the local community in Tower Hamlets and the areas around The Royal London.

## **London Borough of Waltham Forest response to the Barts Health NHS Trust Quality Account for 2015-16**

Thank you for submitting the 2015/16 Quality Account to Waltham Forest Councils for scrutiny.

In March 2015 an important inspection report was produced by the Care Quality Commission (CQC) on Whipps Cross University Hospital, a facility used by many of our residents, which outlined a number of serious concerns about the hospital.

The Health Committee has been grateful for your willingness to attend regularly and provide updates about progress made in implementing the Performance Improvement Plan that was published in September 2015. However, councillors and residents continue to be concerned about the poor clinical and financial performance at Whipps Cross Hospital and the wider Barts Health NHS Trust as highlighted in the CQC report last year.

We understand that Whipps Cross Hospital is due to be revisited by the CQC, and commenting on the Quality Account would have been easier had this already taken place. However, we would like to make the following points in reference to whether the Account is a "fair reflection" of the services provided by Barts Health:

### **1. Overview of our performance (p5)**

We remain extremely concerned about the poor financial performance at the Trust and the impact this could have on care and public confidence in your ability to deliver the high standard of care they expect. Despite attempts to make efficiency savings, the financial position is continuing to worsen. We hope that the turnaround programme improves productivity and the

financial position of the Trust, and that next year's Quality Account will present an improving picture.

We have also noted that you are still not in a position to report "how many patients are waiting longer than 18 weeks for treatment because of problems with data quality." The Committee were informed of this at the January 2016 meeting you attended, and this was also raised in the Committee's response to last year's Quality Account. We would again urge you to look to resolve this as quickly as possible as it is a key way for external partners and the public to judge performance at the hospital.

### **2. Leadership and organisational development (p21)**

We welcome the recruitment of a new senior management team, and in particular the local leadership that has been placed at Whipps Cross Hospital. We hope that the managers that are permanently recruited into these positions have the capacity to deliver the improvements we all hope for and bring stability to the hospital.

However, we have noted that staff engagement remains an issue, with an increase in the number of incidents of bullying, harassment or abuse from colleagues, an increase in discrimination at work, and a reduction in promotion of equal opportunities for career progression. This is an issue that was highlighted in the CQC inspection report, in correspondence sent by the Committee in response to last year's draft Account. We have also raised this with you when you came before the Committee in January 2016.

Elsewhere in the draft account, and when you have to come to the Committee, you have made much of the increase in

recruitment of nurses, and you have noted that "by the end of February 2016, 82.2 per cent of our workforce were permanent, a growth of 60 whole time equivalent staff in post."

We are pleased that you have again acknowledged the issues highlighted by your staff survey, which need to be tackled urgently in order that you can ensure that the new staff can be retained. We would also suggest that the priorities for 2016 –17 set out on p. 36 be amended to reference the work you intend on carrying out in this area.

We would also note that residents and councillors believe that priority must be given to the construction of a new hospital at Whipps Cross, which can have a significant and beneficial impact on the way that care is delivered. We are aware of the discussions that have been ongoing with the CCG and the Council and the positive working relationship that has been established.

Finally, we would be grateful if next year you could think about timing the preparation of the Quality Account to coincide with a meeting of the Health Scrutiny Committee so that we have an opportunity to question you about the draft Account before providing a formal written response.

### **Changes required to the document**

Although there is considerable work to be done, we accept the Quality Account and welcome the focus on improvement at the Trust.

### **Summary statement of Waltham Forest's opinion on the Account**

Please incorporate the following paragraph as the view of Waltham Forest Scrutiny on the report:

*"Waltham Forest Council acknowledges that Barts Health has faced a number of serious challenges since the Trust was created in 2012. The most recent report by CQC raised a number of serious concerns about Whipps Cross University Hospital which was subsequently rated as 'inadequate' by the health regulator. We are encouraged that the Trust has acknowledged where improvements are needed, and the progress made over the course of the year through the Performance Improvement Plan, which has set out comprehensive actions in response to the CQC Inspection. However, we remain extremely concerned by the financial situation at the Trust and its potential impact on the standard of the care the Trust wants to deliver, as well as continuing concerns about staffing culture within the Trust. Finally, we are pleased that the Trust is working closely with the CCG and Council on proposals for the construction of a new hospital which will better meet the needs of residents."*

Yours sincerely

**Anna Mbachu**  
Councillor

## **Inner North East London Joint Health Overview and Scrutiny Committee response to Barts Health NHS Trust's Quality Account 2015-16**

Further to the request dated 19 April, I am replying on behalf of INEL JHOSC to provide comments on your draft Quality Account for 2015/16.

The report is an accurate description of the Trust's performance against your quality indicators and we would like to thank the engagement team and senior officers for their continued positive engagement with scrutiny.

We will not comment here in any detail on the individual hospitals as we are aware that you have contacted the key HOSCs for comments.

Overall the Committee is pleased with the steady progress which has been made, considering that it is just one year since the Trust was placed in Special Measures. However, the comparison data provided in the Quality Account shows that in some areas there is still a lot to be done to improve performance.

We do acknowledge however the particular challenges for Barts Health, serving a population with high levels of deprivation. It is also important to acknowledge the successes, such as The Royal London's Trauma Centre having a survival rate which is twice the national average, and the new Barts Heart Centre, now the largest cardiovascular centre in the UK and treating more heart patients, faster and with better health outcomes than before.

We welcome too that you have appointed a Deputy Chief Executive responsible for quality and the returning of the responsibility for the operational delivery of high quality care to each hospital site, with each hospital having its own Managing Directors.

The size of your deficit, currently at £135 million, remains a concern but we note too that a significant part of this is fines and penalties for not meeting national indicators.

We note with concern your comment that the merging of separate systems and data sets from the three previous NHS Trusts had led to the failure to adequately capture and code activity and as a consequence the Trust has received less income than it is entitled to. We would urge your Board to make improving Data Quality a key priority for 2016/17.

We are pleased to note the following key improvements:

- a. Reducing, at Whipps Cross, non-clinical cancellations by 40 per cent, training four out of five staff on techniques that were previously lacking and raising nurse staffing levels.
- b. Having a renewed focus on safety by introducing safety champions to embed safe care.
- c. Ensuring that now that you are again meeting all nine national cancer standards, that every effort is made to maintain them.
- d. That progress has been made on reducing the waiting lists for elective care within the 18 week referral-to-treatment standard and that the trajectory on this is now moving in the right direction.
- e. That staff are now "at the centre of change" and that senior management are now listening to them and ensuring that middle managers are more empowered to use their own initiative.
- f. That you have implemented new 'dementia-friendly' wards which are already having an impact on quality of care.
- g. That you have localised your complaints handling to the individual hospital sites
- h. That you are acting on Prof Duncan Lewis's recommendation on tackling ill-treatment experienced at work by your staff e.g. bullying.

- i. That while the number of enquiries and concerns reported to PALS has increased, better handling of these has meant a steady reduction in the number of formal complaints.

We do wish to raise the following concerns however:

- a. That you are still not reporting how many patients are waiting longer than 18 weeks for treatment because of problems with data quality.
- b. That your high bed-occupancy rate is affecting your ability to admit, treat and move patients because of a shortage of beds and that not enough progress appears to have been made on this CQC finding.
- c. That you are not meeting targets for theatre cancellations due to lack of bed availability in the wards.

We note that you succeeded in achieving 81 per cent of your CQUINS (Commissioning for Quality and Innovation Scheme), which is to be commended. This brought in £16.7 million in additional income but we share your concern about the level of "realistic achievability" of some of these. We note you are aiming to exit special measures by April 2017 by scoring 'good' in all domains and we wish you well with that aspiration.

We look forward to hearing more about the Trust's action plans over the coming year.

Yours sincerely

**Cllr Ann Munn**

Chair – Inner North East London Joint Health Overview and Scrutiny Committee

cc Members of INEL JHOSC



## **Tower Hamlets Health Scrutiny Panel response to Barts Health NHS Trust's Quality Account 2015-16**

Further to your request dated 19 April, I am replying on behalf of the Tower Hamlets Health Scrutiny Panel (HSP) to provide comments on your draft Quality Account for 2015/16.

In preparing this response I am mindful of the fact that the Inner North East Joint Health Overview and Scrutiny Committee (INEL JHOSC) has already provided a response. In principle the Health Scrutiny Panel supports the views expressed in that response.

Our comments outlined below specifically address The Royal London Hospital and specific scrutiny activities that the panel has carried out relating to Barts Health NHS Trust. These are:

- A presentation by Barts Health NHS Trust on its response to the CQC inspection (published in May 2015)
- A report and presentation on advocacy services in health (also involving the Tower Hamlets Clinical Commissioning Group and East London Foundation Trust)
- A review of maternity services at The Royal London Hospital

We echo the concern that INEL JHOSC raised about the problems that the Trust has encountered in merging three separate systems and data sets and recommend that your Board make improving data quality a key priority for 2016/17. We noted in our review of maternity services at The Royal London Hospital that there were some significant changes about data quality and consistency of patient information and how the Trust captures patient experience data which makes it difficult to build a comprehensive picture of overall patient experience of the service. Therefore the review recommended Barts Health NHS Trust improves

the way that data on patient experience is collated and finds a way of bringing together data from various sources that can be analysed at a sufficient level of granularity, for example ethnicity, age group and site specific.

We welcome the commitment of the Trust to put frontline staff at the heart of decision making, change management and fixing problems. This is a step in the right direction and something that we had identified as an area of improvement in our review of maternity services at The Royal London Hospital. We look forward to hearing more about how the Trust is progressing its improvement plan in this regard over the course of 2016/17.

In September 2015, we heard about Barts Health NHS Trust's response to the CQC inspection (May 2015). The CQC report had raised concerns around staffing ratios and capacity. We are pleased to see that these have been addressed and that the Trust is now operating at designated 'safe' staffing levels. We would also like the Quality Account to address how the Trust is looking at future resource levels given that the local population is projected to increase rapidly in the next few years.

The Panel's work on the review of maternity services showed a renewed emphasis on a culture of openness and honesty within the organisation and hope to see evidence of how this is being embedded in departments across The Royal London Hospital over the coming year. We recognise that the change in leadership at the Trust is having an impact on turning the culture around and look forward to seeing this progress further in 2016/17.

In their presentation on health advocacy and interpreting services at the Panel meeting in December 2015, Barts Health and the TH CCG highlighted the importance of accurate and clear communications about symptoms and condition

management, nothing that patients have a right to receive information communicated in a language and format that they understand. The Panel noted that some harder to reach groups, particularly the Somali community, were not aware of the service offered and consequently were experiencing inequalities in terms of access to health information and health outcomes. We recognise the importance of advocacy in helping patients to make their needs clear and understood, and would like to see more attention being given to the most marginalised communities in this respect, as a key dimension of delivering compassionate care.

We are pleased to note the following positive points that have been evidence through our interactions with Barts Health NHS Trust over the past year:

- a. The cultural transformation agenda that is being implemented by the new leadership team. We welcome the progress around 'Listening into Action' as a way to empower frontline staff and ensure that learning is captured and informs policy and practice development.
- b. The new Patient Experience Strategy with a stated objective to listen to patients and capture feedback in a timely way alongside the introduction of 'iwantgreatcare' which should enable the Trust to capture and examine 'live' patient experience feedback.
- c. Recruitment and retention of skilled and qualified staff to meet designated safe staffing levels. Staff retention levels are also improving and we also note the commitment to reduce reliance on costly agency staff.

We note that 85.4% of staff are permanent and this should help to deliver consistency and continuity of care that is so important to patients. Linked to this, it is encouraging to see that steps are being taken to ensure that the workforce represents the local population in that women and staff from BME groups are developing their careers and progressing to more senior roles.

- d. That complaints handling has been devolved

to local sites. We would like to see further assurance around analysis of complaints at individual service level.

- e. That the new co-located midwifery led birthing centre at The Royal London Hospital is due to open in the summer and will provide an additional choice for local women and also increase the capacity at the hospital significantly as it can accommodate 1,500 births each year which will reduce stresses on the existing maternity wards.

However, we share the concerns raised by INEL JHOSC and particularly highlight the following:

- a. The financial deficit of £135 million for the Trust which is the largest in the history of the NHS. We note that a large proportion of this is due to penalties from not having met quality and national indicators previously. We hope to see the new leadership team chart a course to greater financial stability over the coming year.
- b. That the aforementioned problem with integrating systems and data means that there are continued problems in terms of the accuracy of reporting on people who wait over 18 weeks for treatment.
- c. That whilst you are explicitly tackling bullying, there is still more progress required in ensuring that compassionate care is offered to all patients regardless of background or circumstances. This came through in our maternity review where we heard a number of examples of poor care which fell short of the standards of compassion that the Trust aspires to.

We are looking forward to working with the Trust to address some of the actions outlined in our review, and to being updated on the progress of improvement plans that the Trust has developed over the coming year.

**Yours sincerely,**

**Cllr Amina Ali**

Chair, Health Scrutiny Panel,  
London Borough of Tower Hamlets

## **WEL Clinical Commissioning Collaborative Commissioner Statement for 2015-16 Quality Account**

NHS Tower Hamlets Clinical Commissioning Group (CCG), NHS Newham CCG and NHS Waltham Forest CCG, welcome the opportunity to review the Barts Health NHS Trust Quality Account to provide this statement.

We understand the challenges that have faced Barts Health over the past 12 months following the Care Quality Commission reports published in January 2015 and the requirements this has placed on the new corporate management team and all existing staff across all of the Barts Health sites. Furthermore, the new ways of working across the Trust following the implementation of the new Leadership Operating Model that was launched in September 2016. The leadership model is fully supported by the CCG's and look forward to this enabling better staff support and drive to ensure delivery of quality care to our patients.

### **Review of Performance 2015 - 2016**

We welcome the presentation of the performance in line with the Trusts Improvement Plan which includes information on most of the priorities as highlighted in the Quality Accounts 2014-15, although it would be beneficial for the reader to have clearer information that demonstrates levels of achievement against these priorities by year on year comparison:

1. Harm free care
2. Improved mortality
3. Right care right place
4. Trajectory to achieve being in the top 70 per cent in the National Inpatient Survey by 2017-18
5. Listening to staff feedback

We have recognised the improvement in the culture of reporting incidents and are keen to see the number of outstanding incidents on

Datix being reduced at a much faster pace moving forward. We have also recognised that cross site learning is beginning to take place following incidents but feel this needs to be more embedded across the organisation, there also needs to be clear actions to demonstrate how the Trust will become compliant with the Statutory Duty of Candour. We believe that the incident reporting section should include commentary on the number of Never Events that occurred across Barts Health and reference to the action plan in place.

Performance against the Friends and Family Test in terms of response rates needs to improve across all sites. We are optimistic that the iWantGreatCare programme will enable this to happen in 2016-17.

We would have welcomed the inclusion of the extremely positive work undertaken at the Newham University Hospital site in the reduction of Hospital Acquired Pressure Ulcers. The number of pressure ulcers reported from April to August in 2015 (five months) were 68 in total. From September 2015 to December 2015 the total number of pressure ulcers has reduced to 27.

We are pleased to see that the Trust has undertaken a number audit and surveys and improvements have been made. The CCG's would welcome feedback during 2016-17 in relation to the learning from audits currently underway and the efficacy of actions taken in response.

### **Priorities for 2016 - 2017**

We note the Trust's intention to 'exit special measures' by April 2017 by scoring 'good in all domains and support the six priorities of:

- Safe and Compassionate Care
- Efficient and Effective Care
- Service Transformation
- A Strong Engaged Workforce

- Developing our Infrastructure
- Better Research and Education

Furthermore, we welcome the nine listed Quality Priorities and look forward to reviewing and monitoring the plans which the Trust develop to ensure they deliver these priorities.

Having reviewed the mandated content and format as outlined in the NHS England Quality Accounts guidance, we strongly recommend the following areas are included in the final published Quality Account.

- Information relating to Adults and Children's Safeguarding specifically how they are adhering to the intercollegiate guidance.
- To report on all mandated quality indicators with demonstration of improvement actions.
- More detail as to what the Trust has been doing as a direct result of patient feedback both formal and informal (e.g. NHS Choices, patient opinion).
- Evidence the Trust Board has reviewed and engaged in cross cutting initiatives which link to quality improvement and embedding quality improvement in the organisation management/clinical systems – use of clinical dashboards, scorecards, real time feedback.
- Service line information including information specific to community health services'
- What others say – statements from CQC and other stakeholders i.e. Healthwatch.
- More site specific data as recommended for multi-site providers.
- More information on community services.
- Balance of qualitative and quantitative information (case studies).
- Subsequent explanation of performance against these standards.
- Detailed information relating to litigation numbers and costs.
- Detailed updates from each site on how

they have delivered against the 2015-2016 Trust quality improvement plans.

In line with the Francis Report recommendations we will continue to actively monitor and hold Barts Health NHS Trust to account for the quality improvements required for the population we serve.

We are committed to working with Barts Health NHS Trust and take our responsibility to improve the quality of services provided to patients very seriously. We look forward to seeing an even greater connection between the Trusts Improvement Plan and future quality improvements in 2016-17.

**Dr Anwar Khan**

Chair  
Waltham Forest CCG

**Terry Huff**

Chief Officer  
Waltham Forest CCG

**Dr Sam Everington**

Chair  
Tower Hamlets CCG

**Jane Milligan**

Chief Officer  
Tower Hamlets CCG

**Dr Prakash Chandra**

Chair  
Newham CCG

**Steve Gilvin**

Chief Officer  
Newham CCG

## Statement from Healthwatch

### Tower Hamlets response to Barts Health NHS Trust's Quality Account 2015-16

This Quality Account was considered by members of Healthwatch Tower Hamlets. We are encouraged by the Trust's commitment to putting patients first and the recognition that patient stories, complaints and surveys provide unique learning opportunities for improving the quality of care.

We were reassured that the concerns we raised in last year's Quality Statement were reflected in the Care Quality Commission reports and the Trust. Although this has been a challenging year for the Trust, it has led to the development of a comprehensive improvement programme that is monitored through regular site based Clinical Quality Review Meetings with capacity for Healthwatch input.

The Trust has acted to address concerns that we raised last year and have greatly strengthened their patient experience data, the capacity to track this in real time, overtime and to make clearer the changes made as a result.

The Trust has been more open and has shared with us their PALS, complaints and Friends and Family Test data. We have been able to use this information together with feedback from our own outreach and patient engagement activities to identify the following issues in relation to patient experience.

1. **Staff** – more to do with poor attitude rather than quality or adequate numbers with a perceived over reliance on temporary staff.
2. **Access** – poor administrative systems and processes leading to delayed, wrong, impossible to change or never arranged appointments, widespread inaccuracies in correspondence, postponed and cancelled appointments. Unreliable patient transport in terms of timing and ability to book causing serious disruption to treatment.

3. **Information** and poor communication with patients and between the hospital and GPs.
4. **Environment** – poor signage, confusing lift system, difficult wheelchair access.
5. **Discharge** – happening too quickly without medication in place and without patient, family/carers adequately prepared. Not clear the need to be admitted in the first place.
6. An **inconsistency across wards** with some wards well led where patients feel safe and well cared for while the ward next door the opposite is the case.

A prerequisite for better engagement is better information and communication and realistic expectations on both sides. Often it is as simple as being nice, smiling, explaining what they might expect and being honest if things go wrong. We are still concerned about the extremely slow progress in developing the Barts Health Patient Forum and the hospital panels.

The development of a Royal London Hospital site based management team has allowed us to take a more proactive partnership approach to gathering and using patient feedback to drive forward service improvements specifically in the areas of nutrition, discharge and cancer. The Trust have supported us to open a new Healthwatch Hub on The Royal London site that has enabled us to undertake outreach and engagement with patients and to better utilise volunteers.

With a growing emphasis on integrated care and care in the community we feel greater emphasis should be placed on building better relationships with the wider community. A large element of patient care is delivered by family and informal carers and they need to be better engaged. Staff are also often members of the local community. If we want the whole health system to work better we must engage with the people who use it and not look at the hospital in isolation.

or as a building rather than a service. The new management and Board is making progress in this regard but we are yet to see any evidence regarding Board and community events or access to Non Executive Directors in the assurance process.

The Learning into Action programme seems to have had led to staff initiated improvements, is there an opportunity to take the learning from this and adopt a similar process with patients and the wider community? There is also an opportunity for the Trust to use contract and procurement procedures to ensure that the opportunities presented by the localism and social value act is fully implemented and benefits patient engagement and the wider community.

Responses to our enquires and Enter and View Visit reports have generally been positive and constructive and have led to a recognisable impact but there is still inconsistency across the site with some staff being very welcoming and understanding the role of patient representatives, to other situations where staff had no time, and in some instances had no understanding of why patient representatives were there or what value having a patient perspective had on improving services. An emphasis from the Trust that patient engagement is important and useful at all levels would still be beneficial.

We appreciate that the document itself is not written for patients but it is not clear what it means for patients. An executive summary that is patient facing with key measures to follow – diagrams, illustrations and visual aids highlighting what you have improved this year and what you intend to do next year - would go a long way to creating trust. Our members, however, feel that the performance information contained in the report is reliable and accurate and the Quality Account presents a balanced picture.

We look forward to working together with the Trust and the community to improve the quality of services at our local hospitals.

Yours sincerely

**Dianne Barham**

Chief Executive  
Healthwatch Tower Hamlets

## Statement from our auditors, Grant Thornton UK LLP

We are required to perform an independent assurance engagement in respect of Barts Health NHS Trust's Quality Account for the year ended 31 March 2016 ('the Quality Account') and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ('the Regulations').

### Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Rate of Clostridium Difficile infections
- Percentage of patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as 'the indicators'.

### Respective responsibilities of directors and auditors

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the

Quality Account is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ('the Guidance'); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to May 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated June 2016;
- feedback from Local Healthwatch dated May 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 2014-15
- feedback from London Borough of Tower Hamlets Health Scrutiny Committee and London Borough of Waltham Forest Health Scrutiny Committee as other named stakeholders involved in the sign off of the Quality Account, dated June 2016;
- the latest national patient survey dated February 2016;
- the latest national staff survey dated 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016;
- the annual governance statement dated 1 June 2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated May 2016

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Barts Health NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they

have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Barts Health NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

### **Assurance work performed**

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in

materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Barts Health NHS Trust.

## **Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP  
Melton Street  
London NW1 2EP

30 June 2016

# Corporate Governance Report



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

## The Trust Board

The Trust Board is a unitary board accountable for setting the Trust's strategic direction, vision and values, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the local community. The Board consists of the chairman, chief executive, four executive directors and seven non-executive directors (NEDs) all with voting rights, plus four other executive directors who attend board meetings in a non-voting capacity. As at 1 April 2016, there was one non-executive director vacancy. The number of NEDs is one higher than most NHS trusts, reflecting the size and complexity of Barts Health's agenda as the largest trust in England. Others may be invited to attend board meetings for specific items as agreed with the chairman.

The Trust Board meet regularly in public so that it can discharge its duties (the Board met 11 times in public during 2015-16, not including the Annual General Meeting). The Trust Board take responsibility for the quality and safety of healthcare services, education, training and research. Day-to-day responsibility for implementing the Trust's strategy and delivering operational requirements is delegated through the chief executive to the executive directors and their teams. Key duties of the board are set out in the Trust's Standing Orders and Standing Financial Instructions, which are reviewed every two years.

### Board Appointments

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

### Independence of NEDs

One of the NEDs is nominated by Queen Mary University of London. Excluding this NED position, there are six NEDs and five executive directors (in line with Monitor's Code of Governance recommendations). Alastair Camp is the senior independent director and vice chairman of the Trust. NEDs are generally appointed for an initial four-year term, with the chairman monitoring the composition of the board, its skills and knowledge in the light of any NED changes or potential reappointment of NEDs for second terms of office.



## Board members – biographies of board members (as at 1 April 2016)



**Mr John Bacon (chairman)** has over 30 years' experience working in the NHS at regional and national level. John is also and will continue as chair of Community Health Partnerships, an independent company wholly owned by the Department of Health which works with NHS bodies to plan and utilise the community-based estate more efficiently. Previously, John was chair of Sussex Partnership NHS Foundation Trust for seven years.



**Ms Alwen Williams (Chief Executive)** has been a manager in the NHS since 1980, working in primary care, community and acute services, commissioning and joint planning. She became chief executive of Tower Hamlets Primary Care Trusts (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.



**Mr Alastair Camp (non-executive director)** became an associate non-executive director with NHS Tower Hamlets in 2008, before becoming chair of the Primary Care Trust and then vice-chairman of NHS East London and the City until March 2012. His business career has included 34 years with Barclays plc, during which he led businesses in the UK and overseas. These included appointments as managing director (Caribbean & 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 trustee of the Institute of Financial Services. He holds a Masters Degree in Business Administration and is a fellow of the Chartered Institute of Bankers. Alastair is also the Trust Board's vice-chairman and senior independent director.



**Mr Gautam Dalal (non-executive director)** is a chartered accountant and a former senior audit partner at KPMG London. From 2000 to 2003 he was chairman and chief executive of KPMG's practice in India, which he helped to establish. He was formerly a non-executive director of Barts and The London NHS Trust from September 2010 to March 2012. He is also a trustee of The National Gallery, where he chairs the Finance and Audit Committee, a member of the Governing Body and Audit Committee of the School of Oriental and African Studies, University of London and Board member of AMREF UK, the African health development organisation. He is a non-executive director of ZincOx Resources plc and the Law Society. Previously he was a founder board member of the UK India Business Council and a member of the Asian Business Association Committee of the London Chamber of Commerce.



**Professor Steve Thornton (non-executive director)** is vice-principal and executive dean (Health) of Barts and The London School of Medicine and Dentistry and assumed his role as non-

executive director in February 2016. Previously he had held the position of pro vice chancellor and executive dean of medicine at the University of Exeter. Prior to this he has held positions at the universities of Newcastle, Cambridge, Warwick and (as dean) the Peninsula College of Medicine and Dentistry. Professor Thornton is a clinical scientist whose speciality is obstetrics and gynaecology.



**Dr Thoreya Swage (non-executive director)** has several years experience in the NHS both as a clinician in psychiatry and a senior manager in various NHS purchasing organisations

covering the acute sector as well as primary care development. Her previous NHS executive post was as executive director of a health authority with a remit to develop primary care services including GP commissioning and GP fundholding. Since 1997 Thoreya has run a successful management consultancy business during which time she has developed particular expertise in the field of service reviews and redesign, strategic development, clinical governance, commissioning and procurement with the NHS and independent sector, and education and training. During 2006-2007 she was deputy medical director at the commercial directorate at the Department of Health with the responsibility to set up the clinical governance processes for the National Independent Sector Treatment Programme. She has taught at King's College, London and has researched and written a number of published articles. Thoreya is also a non-executive director at Frimley Health NHS Foundation Trust.



**Karen West (non-executive director)** has over 25 years' experience of working within large, complex organisations across the private, not-for-profit and public sectors in the

sport, leisure and regeneration industry. She has held a range of senior strategic leadership roles in London and the South East, including Sport England, local authorities, London Development Agency and the London Legacy Development Company where she was the head of sport and health. She recently established her own leisure consultancy and continues to deliver programmes in east London where she was born and has lived for most of her life. Through her end to end involvement from bid stage to the legacy of the London 2012 Games, Karen has been key to the design and delivery of the regeneration of east London. She chaired the 2014 World Diving Series Board, was a board member of the 2014 NEC Wheelchair Tennis, 2016 European Swimming, 2015 European Hockey and 2016 UCI World Track cycling championships. Other previous board roles include; vice chair of Pro Active South London, board member of East London Sports Partnership and Creating Leisure Limited for the Parkwood Leisure contracts in Southend and Barnstaple. As a former board member for the six growth boroughs "Supporting Healthier Children Programme", Karen developed a particular passion in using regeneration momentum to improve health outcomes for the residents of east London.



**Tracey Fletcher**  
**(non-executive director)**  
has over 25 years experience of working as a senior executive and non-executive director within the communities that

Barts Health serves. She is strongly committed to building the capacity of organisations and communities as reflected in her past executive roles in charitable and housing agencies working to address social and health inequalities. This has included her role as chief executive of the Attlee Foundation leading social policy research and direct delivery of provisions for communities and young people in Tower Hamlets, director of communities and neighbourhoods at Poplar HARCA housing association in Tower Hamlets, development director at Forest YMCA leading initiatives around healthy living, mental health support for rough sleepers and homeless young people. She currently works as a charity consultant specialising in supporting front line organisations with a particular focus on organisations serving minority ethnic communities to improve their governance, delivery and sustainability. She has a Masters in Management Studies and combines this with her professional experience and passion for bringing positive change to communities in her other non-executive roles as the lead trustee for governance with the Dame Kelly Holmes Trust and Chair of DigiBridge CIC – social enterprise.



**Dr Tim Peachey**  
**(deputy chief executive)** is a consultant in anaesthesia, previously seconded part-time to Barts Health to support the Trust's improvement programme

(in his capacity as the NHS Trust Development Authority's associate medical director). Tim's former roles at the Royal Free London NHS Foundation Trust included chief clinical information officer and he has previously held posts as clinical director, medical director, divisional director and interim chief executive of Barnet and Chase Farm Hospitals NHS Trust, on secondment, in the 18 months prior to its acquisition by the Royal Free. As deputy chief executive, Dr Tim Peachey will have board-level responsibility for information and ICT, corporate governance and communications, and the delivery of the Trust's quality improvement plan.



**Ms Caroline Alexander**  
**(chief nurse)** has significant nursing leadership experience at director level across a breadth of portfolios - healthcare provision, commissioning and system leadership. She was director of nursing and therapies for Tower Hamlets PCT and then director of nursing and quality for NHS ELC then NHS NEL clusters of primary care trusts. Caroline was regional chief nurse for NHS England in London for three years before taking up her current post of chief nursing officer for Barts Health. Caroline graduated as a nurse in 1987 from Edinburgh University (BSc/RGN) and has an MSc in Nursing Studies from South Bank University. Caroline was a 2008 Florence Nightingale Leadership Scholar. She is a visiting professor at Bucks New University.



**Professor Alistair Chesser  
(chief medical officer)**  
trained as a medical student at Cambridge and The Royal London Hospital, undertaking his junior doctor training at St

Bartholomew's, Whips Cross and The Royal London. He then did a period of research in 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 most recently as the clinical academic group director for emergency care and acute medicine at Barts Health since 2012.



**Ms Chrisha Alagaratnam  
(chief financial officer)**  
was formerly interim chief executive at Epsom and St Helier University Hospitals NHS Trust and has worked in the NHS for 20 years. As

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



**Mr Michael Pantlin (director of human resources)** joined Barts Health NHS Trust on 1 October 2012 from the Royal Surrey County Hospital NHS Foundation Trust. Previously he was

with the Royal Bank of Scotland in commercial and retail banking sectors across England and Wales. Prior to this, Michael headed HR for the specialist brands of the Thomson Travel Group. Originally, during his professional training, Michael spent some time working at the Mildmay Hospital, which specialises in palliative care for HIV/AIDS. He moved to the private sector knowing one day he wanted to return to a similar organisation.



**Mr Ian Walker (director of corporate affairs and trust secretary)** began his career in the civil service as an economist at HM Treasury and led the Treasury and

Department of Health team supporting Sir Derek Wanless in his review of the long-term funding of the NHS which reported to the chancellor of the exchequer in 2002. This experience reinforced Ian's passion for the NHS and in 2003 he joined Barts and The London as director of corporate services and trust secretary. Ian was appointed as director of corporate affairs and trust secretary for Barts Health NHS Trust in February 2012. His responsibilities include corporate governance and Board secretariat, communications, information governance, policy development, foundation trust membership, corporate events, and the Trust's archives and museums.



**Ms Jacqueline Totterdell (chief operating officer)** is an immensely experienced NHS leader, having previously been chief executive of West Middlesex University NHS Trust, helping to

steer the organisation through to its merger with Chelsea and Westminster Hospital NHS Foundation Trust. She has an impressive track record of delivering performance improvement in challenged trusts, and was previously chief operating officer at The Hillingdon Hospital NHS Trust before moving on to be chief executive at Southend University Hospital NHS Foundation Trust for almost five years.



**Mr Ralph Coulbeck (director of strategy)** began his career on the NHS Management Training Scheme and has worked in the NHS, parliament and government. He was previously director

of strategy at the NHS Trust Development Authority and also worked as chief adviser to the NHS chief executive Sir David Nicholson. Ralph Coulbeck was appointed director of strategy for the Trust in April 2016.

## Trust Board and Board Committees

The terms of reference and membership for the Trust Board and all board committees are published on the Trust's website and summarise key duties of each committee. The Trust board will elect 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: in 2015-16 the Trust board established a quality improvement committee and an access standards group (which were subsequently integrated with the quality assurance committee in March 2016). The approved board committee structure and current chairs as at 6 April 2016 are shown below in Chart 1.

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

### Trust Board

Chair:  
**John Bacon**



### Quality Assurance Committee

Chair:  
**Thoreya Swage**



### Audit and Risk Committee

Chair:  
**Gautam Dalal**



### Finance and Investment Committee

Chair:  
**Alastair Camp**



### Nominations and Remuneration Committee

Chair:  
**John Bacon**



## Audit and risk committee

The following are key duties:

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

The chair of the audit and risk committee is a chartered accountant with a strong background in corporate finance and audit. Membership is in line with good practice recommendations and a self-assessment of the committee's performance is conducted annually.

## Quality Assurance Committee

The quality assurance committee is a standing 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 supports the audit and risk committee through providing dedicated time and resources to review, for example, clinical aspects of assurance work carried out by internal audit and the clinical audit functions. There is a shared membership of the audit and risk committee and the quality assurance committee and the chair of the quality assurance committee has relevant clinical experience and qualifications.

The terms of reference include a remit to examine on the board's behalf key aspects of operational delivery, given its close relationship to the quality agenda. During 2015-16, the quality assurance committee was supported in this work through a sub-committee (the access standards group) with a specific focus on performance against national access standards for emergency care, cancer services and 18 weeks referral to treatment time; while a quality improvement committee provided a dedicated forum for review of the implementation of the Trust's improvement plan.

### **Nominations and Remuneration Committee**

The Trust's nominations and remuneration committee comprises the chairman and all NEDs. The chief executive and the director of human resources usually attend meetings. The committee has delegated authority from the Trust board to appoint and remove the chief executive and, together with the chief executive, to appoint and remove other executive directors. Appointments to non-executive director posts are approved externally by NHS Improvement, which also sets the remuneration and terms and conditions for chairs and NEDs of NHS trusts. Appointment, removal, remuneration, allowances and terms and conditions of office for executive directors (and the structure of remuneration, allowances and terms and conditions for other defined senior officers) and any changes to these terms is determined by the nominations and remuneration committee with due regard to performance and national guidance.

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

### **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.

### **Attendance - Attendance by members of Board committees, 2015-16**

\*The below figures indicate the number of meetings attended by the relevant member/total number of meetings held



Board member	Trust board part 1	Trust board part 2	Audit and risk committee	Quality assurance committee	Remuneration and nomination committees	Finance and investment committee	improvement committee – time limited group
John Bacon	6/6* (100%)	6/6 (100%)			2/2 (100%)		
Alastair Camp	10/11 (91%)	10/11 (91%)	2/2 (100%)	8/9 (89%)	3/5 (60%)		
Thoreya Swage	11/11 (100%)	11/11 (100%)	2/2 (100%)	9/9 (100%)	4/5 (80%)		4/8 (50%)
Gautam Dalal	(10/11) (91%)	9/11 (82%)	4/4 (100%)	7/9 (78%)	4/5 (80%)	12/13 (92%)	
Steve Thornton	(1/2) 50%	2/2 (100%)			0/0 (n/a)		
Anne Whitaker	11/11 (100%)	10/11 (91%)	3/4 (75%)		5/5 (100%)	12/13 (92%)	8/8 (100%)
Karen West	4/5 (80%)	4/5 (80%)			1/1 (100%)	4/4 (100%)	
Tracey Fletcher	5/5 (100%)	5/5 (100%)		2/2 (100%)	0/1 (0%)		4/4 (100%)
Philip Wright	5/5 (100%)	5/5 (100%)	4/4 (100%)	1/3 (33%)	3/3 (100%)	5/7 (71%)	
Richard Trembath	2/5 (40%)	2/5 (40%)		1/3 (33%)	3/4 (75%)		
Mike Curtis	2/4 (50%)	3/4 (75%)			0/1 0%		
Alwen Williams	9/9 (100%)	9/9 (100%)				11/11 (100%)	7/8 (88%)
Chrisha Alagaratnam	9/9 (100%)	9/9 (100%)				12/12 (100%)	
Jan Stevens	9/11 (82%)	9/11 (82%)					5/8 (63%)
Alistair Chesser	2/2 (100%)	2/2 (100%)					0/1 (0%)
Tim Peachey	2/3 (67%)	2/3 (67%)				3/4 (75%)	3/3 (100%)
Michael Pantlin	10/11 (91%)	10/11 (91%)				10/13 (77%)	5/8 (63%)
Jacqueline Totterdell	5/5 (100%)	4/5 (80%)					
Ian Walker	11/11 (100%)	11/11 (100%)					
Jo Martin	5/6 (83%)	5/6 (83%)					
Peter Morris	2/2 (100%)	2/2 (100%)				2/2 (100%)	
Steve Ryan	4/4 (100%)	4/4 (100%)					1/2 (50%)
Frances O'Callaghan	5/6 (83%)	6/6 (100%)				6/8 (75%)	
Ian Miller	1/3 (33%)	1/3 (33%)				1/3 (33%)	

## **Board effectiveness**

Under the leadership of a new chair and chief executive, a significant number of substantive appointments have been made to both executive and non-executive director roles to strengthen the effectiveness of the Trust board and in support of the new leadership operating model. As the new team has come together, the Trust has been working with an external partner to put in place a board development programme for implementation during 2016/17.

## **Trust board appraisals**

The process for appraisals has been established with the Chair of NHS Improvement conducting appraisals for 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. Appraisals of executive and non-executive director performance for 2015-16 are scheduled for completion by the end of the first quarter of 2016-17. 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; and expenses**

The 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. Fit and proper persons regulations

in line with national fit and proper persons regulations, there is a requirement for directors to provide evidence to support their fitness to practice and for organisations to satisfy themselves in this regard. The Trust office (on behalf of the chairman) maintains records of the following for each executive director and non-executive director:

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

The Trust publishes a report detailing all non-executive director and executive director expenses on its website on a six-monthly basis, following submission to the audit and risk committee.

## **Risk management and systems of control**

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

## **Board assurance framework**

The board assurance framework sets out the principal risks to achievement of the Trust's objectives, while the annual governance statement (included in Appendix 1) provides a year-end assessment of the Trust's systems of control and key issues that materialised during the year, thereby informing plans for 2016-17. The following were identified as the principal risks to the Trust objectives (scores shown are risk scores as at 31 March 2016) in the board assurance framework (BAF).

Board assurance framework - risk entry	31 March 2016 Risk Score
A failure to learn from never events, serious incidents and complaints adversely impacts on quality and safety.	5x4=20
High vacancy rates in some areas result in increased reliance on temporary staffing, and reduced ability to address demand increases.	5x3=15
Failure to embed and evidence progress against CQC warning notice and compliance actions results in enforcement or other regulatory actions.	5x3=15
Lack of a robust infection prevention culture impairs performance and patient safety.	4x3=12
A failure to deliver 18 weeks referral to treatment time recovery plans risks patient harm.	5x4=20
Failure to address patient flow and capacity issues impacts on emergency care access and patient experience.	4x5=20
Performance against the financial plan for 2015-16 is impaired by (i) a failure to significantly reduce agency staffing usage; (ii) failure to improve patient flow, increase theatre productivity and reduce length of stay; (iii) insufficient income.	5x4=20
PFI costs (outside the scope of the Trust's savings programme) impact on long term financial sustainability.	4x5=20
Capital funding constraints prevent adequate investment in medical equipment and estates improvements, including fire safety and other backlog maintenance.	4x4=16
A failure to effectively engage staff and develop the organisational culture results in concerns not being effectively reported, inconsistent compliance with best practice, inability to attract / retain the best talent and deliver major change programmes.	4x4=16
Lack of a robust embedded data quality framework impairs decision-making and use of resources.	4x4=16
ICT infrastructure does not adequately support staff to deliver safe and timely care.	4x4=16
A failure to identify and communicate a clinical strategy with staff and partners impacts on site plans and agreeing sustainable models of care.	4x3=12
Not meeting educational standards in line with expectations of education commissioners	4x3=12

### Lead Committee roles

- Audit and Risk Committee
- Quality Assurance Committee
- Finance & Investment Committee

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

The above entries describe the principal risks to the Trust's operational, clinical quality, financial, workforce, strategic and academic objectives. The Trust's ability to mitigate board assurance framework risk scores downwards towards target risk scores remained limited during 2015-16. Four board assurance framework entries were sufficiently addressed to reduce risks to meet their target risk score enabling their removal. However, a number of high risk scores perpetuated with some increases in risk score during the year reflecting increased operational and financial pressures and some weaknesses in controls identified during the year. The number of BAF entries with a risk score of 16 or 20 remained high throughout the year reflecting the organisation's continued high risk profile. In light of the risks faced (in part due to the wider health economy climate and need to embed effective structures in a relatively newly merged organisation), it is anticipated that the Trust's strategic risk appetite will be low going into 2016-17.

### Risk register and overarching risk management system

During the year work has continued to strengthen and improve risk management systems and processes across the organisation. CQC inspections in 2014-15 had indicated that risk management systems and processes were not fully embedded or transparent at a hospital-level and, as a consequence, not working effectively. The implementation of the new leadership operating model (LOM) has responded to this by introducing greater site-based leadership. While there has been a period of transition to the new structures, site leadership teams have made progress embedding risk management processes across their services and have introduced new governance arrangements for the review of their risks. The Trust risk management committee has met regularly throughout the year and maintains corporate oversight of risk in the organisation. At each meeting the committee reviews the Trust's high level risks and receives a quarterly metrics report that details site and directorate performance.



In addition to new site-based governance arrangements for the management of risk, we implemented a programme of risk management training in 2015-16. This comprised drop-in sessions at our major hospitals which were well attended and well evaluated. We will continue to offer training in 2016-17 and will examine how we can target those staff most involved in risk management. Another key achievement during the year has been the provision of timely management information in relation to risk to support them to manage this more effectively.

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

A new Trust risk manager will take up their position in early 2016-17 and help to determine a work programme for the coming year.



# Annual Governance Statement 2015-16

## Appendix 1: Barts Health NHS Trust

### 1. Scope of responsibility

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

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

As chief executive I am accountable to the Trust board. I am also accountable, via the NHS accounting officer, to Parliament for the stewardship of resources within the Trust.

### 2. Governance framework of the organisation

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

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2015-16 was a year of significant challenges on the back of the Trust being rated as 'inadequate' by the Care Quality Commission (CQC) and being placed in special measures by the then NHS Trust Development Authority. Substantive recruitment has been undertaken to a large number of senior leadership roles in the organisation, a new leadership operating model has been implemented with a greater focus on site leadership, an ambitious quality improvement plan has been agreed to address the concerns raised by the CQC and a revised governance structure has been put in place. These are described in more detail below and further in the Trust's annual report.

#### Trust Board and committee structure

The Trust Board has met on a monthly basis. Voting members comprise the chair, seven non-executive directors and five corporate directors (including the chief executive). Other corporate directors are members of the Board in a non-voting capacity, as has been one associate non-executive director (until 31 March 2016).

There have been significant changes to Board membership during 2015-16, with a number of positions being filled on an interim basis for at least part of the year. A new chair took up post in August 2015 and I was appointed

substantively as chief executive in October 2015 having taken on the role in June 2015 on an interim basis.

New substantive appointments have been made to the executive posts of deputy chief executive, chief medical officer, chief nursing officer, chief finance officer and director of strategy during the second half of the year and all had taken up post by 1 April 2016. The substantive appointment of a chief operating officer is expected to be confirmed in the first quarter of 2016-17.

Three new non-executive directors (including the Queen Mary University of London representative) joined the board during the second half of the year. As at 1 April 2016, there is one non-executive director vacancy following a long-standing non-executive director reaching the end of her term of office and deciding not to seek re-appointment.

The role of the Trust board is to govern the organisation effectively and in so doing to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care.

Trust board meetings are held in public and the papers are available on the Trust website. The board regularly reviews performance against national standards and regulatory requirements via an integrated performance report and a summary of performance against these priorities in 2015-16 is included in the Trust's annual report. The board places a strong emphasis on the quality and safety of patient care and, in addition to performance reports, regularly hears directly from patients, carers and staff including through patient and staff stories and ward and department visits.

The Trust board approved the 2014-15 Barts Health quality account in June 2015, further

to review by the quality assurance committee. The accuracy of the Trust's quality account is assured through internal review and data checking processes as part of the Trust's data quality arrangements. The Trust's external auditors undertook an audit of the 2014-15 quality account and the findings are being taken into account for the production of the 2015-16 quality account which is due to be agreed by the board in June 2016.

The Trust undertook the first phase of a planned board development programme, supported by an expert external provider, during the final quarter of 2015-16, following substantive appointments to the majority of vacant posts. The second phase, which involves the development and delivery of a comprehensive board development programme, is being planned during the first quarter of 2016-17.

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, the Director of Corporate Affairs and Trust Secretary has assessed the arrangements for the discharge of statutory functions. No gaps in legal compliance have been identified. However, concerns were identified around the middle of the year related to compliance with contract award and waiver requirements as set out in the Trust's Standing Orders and Standing Financial Instructions. A full report was provided to the Trust board and action was taken by the executive to ensure compliance going forward. Internal audit was also commissioned to undertake a review and the final report and recommendations, expected in early 2016-17, will be discussed by the audit and risk committee.

The new chair of the Trust undertook a review of the board committee structure following his appointment and the outcome was approved by the board in October 2015. During the course of the year, the separate remuneration and nominations committees were merged into a single committee. The former public health and equalities committee became an executive-led committee, while two time-limited committees were established during the year: the quality improvement committee to provide assurance on the implementation

of the Trust's quality improvement plan (see below); and an access standards group as a sub-group of the quality assurance committee to provide specific assurance on compliance with national performance standards. Both of these time-limited groups were incorporated into the quality assurance committee with effect from 1 April 2016.

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

### **Audit and risk committee**

The audit and risk committee has overall responsibility for independently monitoring, reviewing and reporting to the Trust board on all aspects of governance, risk management and internal control. It is supported in this role by the quality assurance committee.

### **Quality assurance committee**

The quality assurance committee monitors, reviews and reports on the quality of services provided by the Trust. This includes the review of governance, risk management and internal control systems to ensure the delivery of safe, high quality, patient centred care; quality indicators flagged as of concern through escalation reporting or as requested by the Trust board; and progress in implementing action plans to address shortcomings in the quality of services, should they be identified.

### **Quality improvement committee**

The quality improvement committee, which was established in June 2015 (and met monthly until it was incorporated into the quality assurance committee in April 2016), oversees the effective and timely implementation of the Trust's quality improvement plan in response to the findings of the CQC inspection reports published in spring 2015.

### **Nominations and remuneration committee**

The nominations and remuneration committee has delegated authority from the Trust board to appoint and remove the chief executive and, together with the chief executive, to appoint and remove the other executive directors. It also determines the overall remuneration policy of the Trust; sets the remuneration, allowances and other terms and conditions of office for the Trust's executive directors; and recommends and monitors the structure of remuneration for senior managers.

### **Finance and investment committee**

The finance and investment committee undertakes on behalf of the Trust board objective scrutiny of the Trust's financial plans, investment policy and major investment decisions. The Committee reviews the Trust's monthly financial performance and identifies the key issues and risks requiring discussion or decision by the Trust board. During the year, there has been a significant focus on the Trust's financial turnaround programme, monthly reporting on implementation of cost improvement plans and review of business cases relating to the Trust's estate.

During the year, the chairs of board committees reported on their discussions and drew issues to the attention of the Trust board as appropriate through minutes, written exception reports to each board meeting and an annual report arrangement.

For example, in 2015-16, the audit and risk committee focused on the effectiveness of risk management arrangements (including

identification and escalation of risks), data quality supporting key information systems, and the effectiveness of controls in relation to payroll, bank and agency use and pre-employment checks.

The quality assurance committee provided assurance to the Trust board on quality and safety of patient care, with a focus on improving learning from never events, serious incidents and complaints.

### **Attendance at Trust board and principal board committees**

<b>Committee</b>	<b>Number of meetings held</b>	<b>Average attendance rate in 2015-16</b>
Trust board (parts 1 and 2)	22	93%
Audit and risk committee	4	94%
Quality assurance committee	9	80%
Quality improvement committee	7	74%
Nominations and remuneration committee	5	78%
Finance and investment committee	13	81%

A more detailed breakdown of attendance records by individual Trust board members is provided in the Trust's annual report.

A revised executive and site governance structure has also been put in place to support the new leadership operating model.



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

As designated accountable officer, I have overall accountability for risk management in the Trust. During 2015-16, the chief nursing officer has led on risk management issues at Board level.

#### Risk management framework

The Trust has a comprehensive risk management strategy and policy and is available to all staff on the Trust's intranet site. It is also accessible on the Trust's website.

The strategy and policy describes the Trust's overall risk management strategy, responsibilities for risk at each level of the organisation, the risk management process and the Trust's risk identification, evaluation and control system. The latter includes the 5x5 (impact x likelihood) risk matrix used to evaluate risks in the Trust.

A new leadership operating model for the Trust was implemented from September 2015, with sites taking over primary responsibility for day-to-day operations from the Clinical Academic Groups (CAGs). While the overall framework for risk management has not changed significantly, the leadership focus shifted mid-year from CAGs to sites. The leadership framework for risk management is summarised below:

- The audit and risk committee meets four times a year and oversees the overall performance of the risk management system. It provides assurance to the Trust board that effective governance, risk management and internal control systems are in place across the Trust's activities, including the development of the board assurance framework and how this is informed by the high risk register. As noted above, a board-level quality assurance

committee meets on a monthly basis and monitors, reviews and reports on the quality of services provided by the Trust. It provides assurance to the audit and risk committee and the Trust board that effective arrangements are in place to ensure that the Trust's services deliver safe, high quality, patient-centred care. Key risks are highlighted to and reviewed by the Trust board both as part of its regular monitoring of performance and in the context of specific issues that arise.

- The Trust's risk management committee, which is chaired by the chief executive, provides executive oversight of risk management issues. The risk management committee meets monthly and is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust and providing assurance to the audit and risk committee that this is the case.
- The risk management committee reviews the Trust's risk register on an ongoing basis. All new risks with a proposed score of 15 and above (classified as 'high') are reviewed by the risk management committee. The committee has also undertaken a rolling review of clinical academic group (and latterly hospital site) and corporate directorate risks with a score of 12 ('medium') and above and those risks with high consequence but low likelihood. The risk management committee reviews all risk register entries with a score of 20 or above at each meeting.
- The risk management team within the nursing and governance directorate 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.

- The director of corporate affairs is the Trust's senior information risk owner (SIRO). Working closely with the chief nursing officer as the executive director-lead for risk and the chief medical officer as Caldicott Guardian, the SIRO has been responsible for taking ownership of information risk at board level and advising the chief executive accordingly.
- For each of the Trust's CAGs/sites, the director of nursing and governance leads on governance and risk issues and is responsible for coordinating risk management processes within the CAG/site, including management of the local risk register. CAG/site boards have responsibility for monitoring, managing and where necessary escalating risks on their risk registers. Risk training has been undertaken with CAGs and sites during the year to help strengthen risk identification, evaluation and monitoring.

Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. This begins at corporate induction which all staff attend. There is clear guidance on the type of courses that staff need to attend and the frequency of attendance required. Attendance at mandatory risk management training courses is monitored and feedback given to CAGs/sites and corporate directorates via a central monitoring database which allows corrective action to be taken by management teams as required and we are aiming to improve attendance rates. Drop-in risk management training sessions were held at each of the main sites to support the new leadership operating model.

### **Board assurance framework**

The board assurance framework is reviewed by the risk management committee at each meeting and formally reviewed by the Trust board at least three times a year. Risks on the assurance framework are assigned

both a lead executive director and a lead Trust board assurance committee and the respective committees review at each of their meetings progress against those risks assigned to the committee.

The principal risks on the Trust's board assurance framework as approved by the board at the end of 2015-16 are summarised at Appendix 1. The board assurance framework is based around the Trust's strategic objectives and is mapped to the Care Quality Commission fundamental standards of quality and safety. It identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls. It also details some gaps in control and assurance in relation to the risks, including strategic objectives related to quality of care, service delivery, workforce, finance, infrastructure and information systems, together with actions to address them. The actions include identifying additional resources, putting in place new systems, processes, operating procedures and monitoring arrangements, strengthening project and programme management, and effective working with partner organisations.

The board assurance framework is updated through both a 'top down' assessment by directors of key risks and a 'bottom up' review of high and significant risks on the Trust's risk register.

The 2015-16 internal audit report on the board assurance framework, in draft at the point of producing this annual governance statement, carries an interim limited assurance. The report assigns a reasonable assurance rating to the design of the board assurance framework but a limited assurance rating to its application. Action will be taken by the Trust executive to address the recommendations identified in the audit report once it has been finalised.

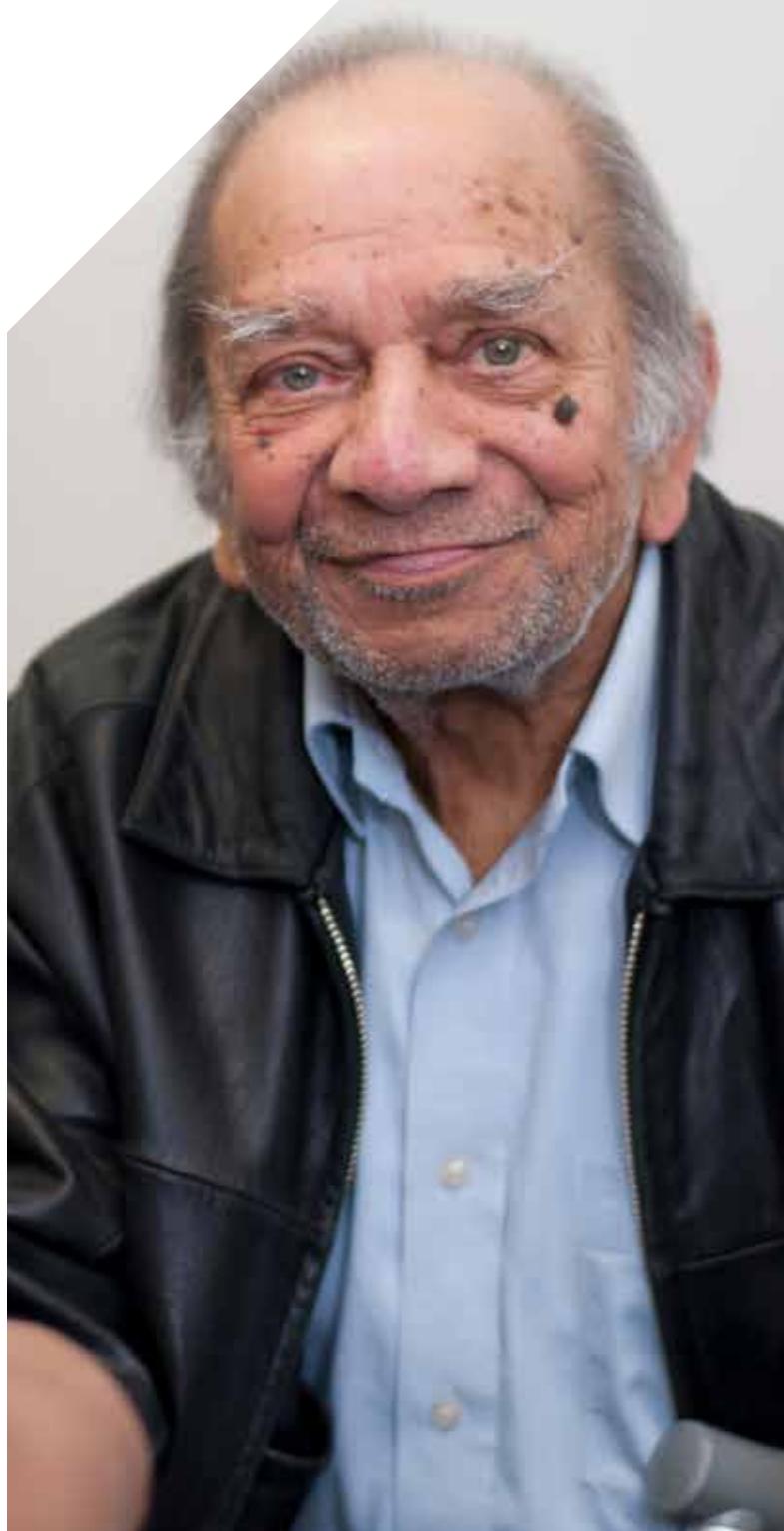
## Counter fraud

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

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

## External assurance

The Care Quality Commission's quality report on Barts Health, published in May 2015, concluded that risk management systems and processes were not fully embedded and risk registers were poorly applied in some clinical areas which led to some risks not being identified, recorded and managed or escalated. As part of the new leadership operating model implemented in September 2015, site leadership teams have been given a clear role through their hospital management boards and quality and safety groups to ensure that risks are being appropriately identified, mitigated and escalated.





## **Stakeholder involvement in risk**

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

### **Patients and the public**

- The work of the Trust's patient advice and liaison service and specific patient representative groups.
- The work of the local Healthwatchs, overview and scrutiny committees and health and wellbeing boards.
- Monthly 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.
- Regular events for patient and public members of the Trust's prospective foundation trust.
- An extensive volunteering programme across hospital sites.
- The national patient survey programme and the results of real time feedback on wards and departments.

### **Staff**

- The adoption of the 'Listening into Action' approach to staff engagement and staff-led change during 2015-16.
- A strong focus on encouraging staff to raise concerns and the web-based speak in confidence system.
- Ward conversations.
- Executive and senior staff visits to wards and departments.
- The annual staff survey and monthly staff 'Pulse' surveys.
- Monthly staff briefings on every site led by the managing director.
- Non-executive director ward visits.
- Chairman's lunch events.
- Team meetings and the use of the team briefing system.
- Staff representation on key committees and groups.

## Partners

- Establishment of partner-led oversight and assurance groups at Trust-wide and site levels related to the implementation of the Trust's quality improvement plan as part of the special measures regime.
- Regular performance discussions with commissioners and the NHS Trust Development Authority (NTDA).
- Stakeholder membership of Trust committees and working groups.
- Joint strategic planning with healthcare and academic partners, including the NHS Trust Development Authority, NHS England, CCGs, Barts and The London School of Medicine and Dentistry, City University and UCL Partners.

## Compliance issues

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

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

The Trust has undertaken a climate change risk assessment and developed an adaptation plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

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

## Information governance

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

The Trust has implemented the national information governance assurance programme, with a specific focus on the handling of person identifiable data. A data transfer database is in place, person identifiable data flows are reviewed and arrangements are in place to ensure their security, and the risk register has been reviewed to ensure that it appropriately reflects information governance risks. The processes and controls in place have been monitored by the Trust's information governance committee. The Trust recorded six serious untoward data security breaches during the year which have been reported to the Information Commissioner's Office (ICO). Details are provided in Section 4.



## Update on significant control issues in 2014-15

The Trust identified a number of significant control issues in its annual governance statement for 2014-15:

- Data security, national performance and CQC standards and financial performance are covered in Section 4.
- The control issues identified in 2014-15 related to implementation difficulties with the patient records system at Whipps Cross, a new patient transport contract and the move to a new Trust-wide bank and agency system were largely addressed in that year. External reviews were undertaken to learn the implementation lessons for future change programmes.



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

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

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of internal audit's work. The head of internal audit opinion for 2015-16 concludes that for the systems that have been reviewed reasonable assurance can be given that controls are generally sound and operating effectively. However, it notes that there are defects in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.

My review has 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.
- The findings of the inspections of Whipps Cross University, Newham University and The Royal London hospitals by the Care Quality Commission (CQC) between November 2014 and January 2015, as detailed in the inspection reports published in March and May 2015.
- The Trust's ongoing assessment of compliance with the CQC's essential standards of quality and safety.
- The work of internal audit through the year. Details of the internal audit reports completed during 2015-16 and the level

of assurance provided are set out in the Head of Internal Audit Opinion. [9] reports provided significant or reasonable assurance while [5] provided limited assurance. [None] of the finalised audit reports contain findings that internal audit regard as significant control issues requiring disclosure in this annual governance statement.

- The outcomes of the Trust's clinical audit programme, the effectiveness of which has improved during the course of the year.
- The results of external audit's work on the Trust's annual accounts and local tailored performance management reviews.
- Patient and staff surveys and feedback and other sources of external scrutiny and accreditation including clinical peer review arrangements.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the risk management committee and the audit and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Key roles have been as follows:

- The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the integrated performance report and detailed financial and quality and safety reports, and through Board and committee reporting on progress against other strategic objectives.
- The audit and risk committee has overseen the effectiveness of the risk management arrangements. The audit and risk committee has placed a focus this year on workforce arrangements including employment checks and temporary staffing controls.
- The risk management committee has reviewed the Trust's risk register and the board assurance framework and monitored key clinical and non-clinical risks highlighted

by Trust committees and individual managers.

- Executive managers have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.
- Both internal and external audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

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

### **CQC essential standards of quality and safety**

Barts Health is registered with the Care Quality Commission (CQC) without conditions. As described in the 2014-15 annual governance statement, the Trust was placed in special measures in March 2015 in response to a CQC inspection which rated Whipps Cross University Hospital as 'inadequate' and imposed four warning notices, combined with Trust-wide challenges in meeting national waiting time standards and the financial position. Subsequent inspection reports published in May 2015 also rated The Royal London and Newham University hospitals as 'inadequate' and the Trust was given an 'inadequate' rating overall.

A comprehensive quality improvement plan, Safe and Compassionate, was developed and approved by the Trust board in September 2015. A major programme of work has been undertaken during the second half of 2015-16 to start to implement the quality improvement plan and deliver improvements for our patients and staff. Good progress is being made, underpinned by our new leadership operating model and improved staff engagement through Listening into Action, but there is much more to do. Further details are set out in the annual report and quality account.

## Senior leadership positions

As described above, there was heavy reliance on interim appointments to senior leadership positions for much of the year, including at corporate director and site management team levels. This inevitably created uncertainty and slowed progress in delivery of the Trust's improvement plans. However, the Trust ended 2015-16 in a significantly stronger position following permanent recruitment to the majority of senior leadership roles, providing a stronger platform for delivery in 2016-17.

## Never events

The Trust reported 15 never events during 2015-16. This is a significant matter of concern to the executive and the Trust board and extensive work is being undertaken to implement a comprehensive action plan, working through site leadership teams and newly appointed clinical leaders. The quality assurance committee on behalf of the board is monitoring closely the delivery of the action plan.

## National performance standards

The Trust underachieved on the national standards for emergency care waiting times and MRSA infections. Action plans have been put in place to improve performance and are monitored regularly by the Trust board and the access standards group (the quality assurance committee from April 2016) as part of the performance reporting framework.

## 18 weeks referral to treatment data quality

The Trust suspended national reporting of 18 weeks RTT performance in autumn 2014 due to data quality issues resulting from significant difficulties associated with the implementation of the Cerner Millennium electronic patient record system at Whipps Cross and compounded by the failure of an RTT validation database. An extensive action plan has been agreed with partners and is on track to address the data quality issues and move to re-commencing

reporting during 2016-17. A broader data quality review is also being taken within the Trust.

## Financial performance

The Trust recorded a financial deficit of £134.9 million in 2015-16, in line with the control total set at the beginning of the year. Fines and penalties for underperformance against national standards, continued high levels of temporary staffing use and under-achievement of cost improvement plans (CIPs) were key drivers of the deficit. A major programme of financial recovery is in train to improve the financial position in 2016-17 and deliver a control total of £82.7 million.

## Data security

During the year, there were six serious untoward incidents involving personal data which were reported to the information commissioner in accordance with national guidance. The ICO decided not to take any further action in relation to all six of the incidents.

Three of the cases related to personal information being provided to another party in error, one related to personal information being lost while being transported off site, one related to a technical security failing and one was potential inappropriate access to personal identifiable information.

All incidents were fully investigated and the resulting recommendations implemented. The Trust continues to take steps to ensure the secure management of patient and staff information. This has been facilitated through enhancements to our information security systems and processes, embedding clear policies and procedures in our staff's daily work and ensuring that staff receive appropriate information governance training. As at the end of March 2016, over 90% of staff had received information governance training and passed a test of comprehension in the past 12 months.

## Conclusion

My review has established that Barts Health NHS Trust has a reasonable system of internal controls that supports the achievement of the trusts policies, aims and objectives. Those significant control issues that have been identified in this review have associated plans to ensure that these have been or are being resolved. During 2016-17 we will further embed our new leadership operating model and supporting governance arrangements at corporate and site levels to further strengthen the Trust's systems and processes for controls and assurance, and support the delivery of the Trust's quality and financial improvement plans.

### **Alwen Williams**

Chief Executive  
Barts Health NHS Trust

1 June 2016



## Appendix 1: board assurance framework - principal risks at March 2016

Board assurance framework - risk entry	31 March 2016 Risk Score
A failure to learn from never events, serious incidents and complaints adversely impacts on quality and safety.	5x4=20
High vacancy rates in some areas result in increased reliance on temporary staffing, and reduced ability to address demand increases.	5x3=15
Failure to embed and evidence progress against CQC warning notice and compliance actions results in enforcement or other regulatory actions	5x3=15
Lack of a robust infection prevention culture impairs performance and patient safety	4x3=12
A failure to deliver 18 weeks referral to treatment time recovery plans risks patient harm	5x4=20
Failure to address patient flow and capacity issues impacts on emergency care access and patient experience	4x5=20
Performance against the financial plan for 2015-16 is impaired by (i) a failure to significantly reduce agency staffing usage; (ii) failure to improve patient flow, increase theatre productivity and reduce length of stay; (iii) insufficient income.	5x4=20
PFI costs (outside the scope of the Trust's savings programme) impact on long term financial sustainability	4x5=20
Capital funding constraints prevent adequate investment in medical equipment and estates improvements, including fire safety and other backlog maintenance	4x4=16
A failure to effectively engage staff and develop the organisational culture results in concerns not being effectively reported, inconsistent compliance with best practice, inability to attract / retain the best talent and deliver major change programmes.	4x4=16
Lack of a robust embedded data quality framework impairs decision-making and use of resources.	4x4=16
ICT infrastructure does not adequately support staff to deliver safe and timely care	4x4=16
A failure to identify and communicate a clinical strategy with staff and partners impacts on site plans and agreeing sustainable models of care.	4x3=12
Not meeting educational standards in line with expectations of education commissioners	4x3=12

### Lead Committee roles

- Audit and Risk Committee
- Quality Assurance Committee
- Finance & Investment Committee

# Staff Policies and Benefits

Key human resources policies are held on the Trust's website (and intranet). These include the human rights, equality and diversity policy and recruitment and selection policy which set out the process for ensuring fair employment, training and career development opportunities for individuals with protected characteristics.

## Remuneration Policy

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. The Secretary of State for Health determines nationally the Remuneration of the Chairman and Non-Executive Directors, with terms of appointment and renewal for the Chairman and Non-Executive Directors determined by the NHS Trust Development Authority. Remuneration for Executive Board members is determined by the Remuneration Committee (as outlined in the relevant section of this report).

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) is determined by the Nomination and Remuneration Committee. Amendments are determined annually by the Committee with due regard to national remuneration guidance. Executive director performance against organisational and individual objectives is monitored through the formal appraisal process.



## Salaries and Allowances (subject to audit)

Name and title	2015/16					(f) TOTAL (a to e) (bands of £5,000)
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	
	£000	£00	£000	£000	£000	£000
Mr Philip Wright, Acting Chair (until 31.07.15)	5 to 10	0	0	0	0	5 to 10
Mr John Bacon, Chair (from 01.08.15) [3]	25 to 30	0	0	0	0	25 to 30
Mr Alastair Camp, Non Executive Director and Vice Chair	5 to 10	0	0	0	0	5 to 10
Mr Gautam Dalal, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Prof Richard Trembath, Non Executive Director (until 12.09.15)	0 to 5	0	0	0	0	0 to 5
Prof Mike Curtis, Non Executive Director (from 13.09.15 until 31.01.16) [3]	0 to 5	0	0	0	0	0 to 5
Prof Steve Thornton, Non Executive Director (from 01.02.16) [3]	0 to 5	0	0	0	0	0 to 5
Ms Anne Whitaker, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Dr Thoreya Swage, Non Executive Director [1]	5 to 10	17	0	0	0	5 to 10
Ms Tracey Fletcher, Non Executive Director (from 26.10.15) [3]	0 to 5	0	0	0	0	0 to 5
Ms Karen West, Non Executive Director [3]	0 to 5	0	0	0	0	0 to 5
Ms Angela Greatley, Associate Non Executive Director (from 01.05.15) [3]	5 to 10	0	0	0	0	5 to 10
Mr Paul Brickell, Associate Non Executive Director (until 01.11.15) [3]	0 to 5	0	0	0	0	0 to 5
Mr Peter Morris, Chief Executive (until 31.05.15)	45 to 50	0	0	0	0	45 to 50
Ms Alwen Williams, Chief Executive from 21.10.15 (Interim Chief Executive from 01.06.15 until 20.10.15) [3] [4]	225 to 230	0	0	0	0	225 to 230
Dr Tim Peachey, Deputy Chief Executive (from 13.01.16) [3]	40 to 45	0	0	0	0	40 to 45
Ms Jacqueline Totterdell, Interim Chief Operating Officer (from 26.10.15) [3] [4]	75 to 80	0	0	0	0	75 to 80
Mr Ian Miller, Interim Chief Financial Officer (until 14.06.15) [2]	190 to 195	0	0	0	0	190 to 195
Ms Chrisha Alagaratnam, Chief Financial Officer from 01.03.16 (Interim Director of Director of Delivery & Improvement from 05.05.15 until 14.06.15, and Interim Chief Financial Officer from 15.06.15 until 29.02.16) [3] [4]	155 to 160	0	0	0	0	155 to 160
Dr Steve Ryan, Chief Medical Officer (until 19.07.15)	60 to 65	0	0	0	20 to 22.5	85 to 90
Prof Alistair Chesser, Chief Medical Officer from 03.02.16 (Director, Emergency Care and Acute Medicine Clinical Academic Group until 02.02.16)	190 to 195	0	0	0	170 to 172.5	365 to 370
Ms Jan Stevens, Interim Chief Nurse	175 to 180	0	0	0	425 to 427.5	600 to 605
Mr Michael Pantlin, Director of Workforce Development	165 to 170	0	0	0	0	165 to 170
Prof Joanne Martin, Director of Academic Health Sciences (Interim Chief Medical Officer from 20.07.15 until 02.02.16)	110 to 115	0	0	0	0	110 to 115
Ms Frances O'Callaghan, Director of Strategy (until 31.10.15)	90 to 95	0	0	0	17.5 to 20	110 to 115
Mr Ian Walker, Director of Corporate Affairs and Trust Secretary	120 to 125	0	0	0	60 to 62.5	180 to 185
Sir Stephen O'Brien, Chairman (until 31.03.16) [7]						
Mrs Tessa Green, Non Executive Director (until 31.01.2015) [7]						

Name and title	2015/16					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Mr Mark Ogden, Chief Financial Officer (until 31.01.2015) [1] [7]						
Prof Kay Riley, Chief Nurse (until 20.02.2015) [7]						
Mr Luke Readman, Chief Information Officer (until 01.09.2014) [7]						
Mr Mark Cubbon, Director of Delivery (until 23.04.2014) [7]						
Ms Karen Breen, Director of Delivery and Improvement (from 01.09.2014) [6][7]						
Mr Ajit Abraham, Director, Surgery and Cancer Clinical Academic Group (from 01.10.2014) [5] [6] [7]						
Dr Jane Hawdon, Director, Women's and Children's Health Clinical Academic Group (from 01.10.2014) [5] [6] [7]						
Mr Tony Halton, Director, Clinical Support Services Clinical Academic Group (from 01.10.2014) [6] [7]						
Dr Charles Knight, Director, Cardiovascular Clinical Academic Group (from 01.10.2014) [5] [6] [7]						



## Salaries and Allowances (subject to audit)

Name and title	2015/16					(f) TOTAL (a to e) (bands of £5,000)
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	
	£000	£00	£000	£000	£000	£000
Mr Philip Wright, Acting Chair (until 31.07.15)	5 to 10	0	0	0	0	5 to 10
Mr John Bacon, Chair (from 01.08.15) [3]						
Mr Alastair Camp, Non Executive Director and Vice Chair	5 to 10	0	0	0	0	5 to 10
Mr Gautam Dalal, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Prof Richard Trembath, Non Executive Director (until 12.09.15)	5 to 10	0	0	0	0	5 to 10
Prof Mike Curtis, Non Executive Director (from 13.09.15 until 31.01.16) [3]						
Prof Steve Thornton, Non Executive Director (from 01.02.16) [3]						
Ms Anne Whitaker, Non Executive Director	5 to 10	0	0	0	0	5 to 10
Dr Thoreya Swage, Non Executive Director [1]	5 to 10	16	0	0	0	5 to 10
Ms Tracey Fletcher, Non Executive Director (from 26.10.15) [3]						
Ms Karen West, Non Executive Director (from 26.10.15) [3]						
Ms Angela Greatley, Associate Non Executive Director (from 01.05.15) [3]						
Mr Paul Brickell, Associate Non Executive Director (until 01.11.15) [3]						
Mr Peter Morris, Chief Executive (until 31.05.15)	275 to 280	0	0	0	0	275 to 280
Ms Alwen Williams, Chief Executive from 21.10.15 (Interim Chief Executive from 01.06.15 until 20.10.15) [3] [4]						
Dr Tim Peachey, Deputy Chief Executive (from 13.01.16) [3]						
Ms Jacqueline Totterdell, Interim Chief Operating Officer (from 26.10.15) [3] [4]						
Mr Ian Miller, Interim Chief Financial Officer (until 14.06.15) [2]	75 to 80	0	0	0	0	75 to 80
Ms Chrisha Alagaratnam, Chief Financial Officer from 01.03.16 (Interim Director of Director of Delivery & Improvement from 05.05.15 until 14.06.15, and Interim Chief Financial Officer from 15.06.15 until 29.02.16) [3] [4]						
Dr Steve Ryan, Chief Medical Officer (until 19.07.15)	210 to 215	0	0	0	2.5 to 5	210 to 215
Prof Alistair Chesser, Chief Medical Officer from 03.02.16 (Director, Emergency Care and Acute Medicine Clinical Academic Group until 02.02.16)	95 to 100	0	0	0	0	95 to 100
Ms Jan Stevens, Interim Chief Nurse	10 to 15	0	0	0	0	10 to 15
Mr Michael Pantlin, Director of Workforce Development	145 to 150	0	0	0	0	145 to 150
Prof Joanne Martin, Director of Academic Health Sciences (Interim Chief Medical Officer from 20.07.15 until 02.02.16)	110 to 115	0	0	0	0	110 to 115
Ms Frances O'Callaghan, Director of Strategy (until 31.10.15)	160 to 165	0	0	0	52.5 to 55	215 to 220
Mr Ian Walker, Director of Corporate Affairs and Trust Secretary	105 to 110	0	0	0	20 to 22.5	125 to 130
Sir Stephen O'Brien, Chairman (until 31.03.16) [7]	20 to 25	0	0	0	0	20 to 25
Mrs Tessa Green, Non Executive Director (until 31.01.2015) [7]	5 to 10	0	0	0	0	5 to 10

Name and title	2015/16					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Mr Mark Ogden, Chief Financial Officer (until 31.01.2015) [1] [7]	175 to 180	300	0	0	25 to 27.5	230 to 235
Prof Kay Riley, Chief Nurse (until 20.02.2015) [7]	150 to 155	0	0	0	0	150 to 155
Mr Luke Readman, Chief Information Officer (until 01.09.2014) [7]	65 to 70	0	0	0	0	65 to 70
Mr Mark Cubbon, Director of Delivery (until 23.04.2014) [7]	5 to 10	0	0	0	77.5 to 80	85 to 90
Ms Karen Breen, Director of Delivery and Improvement (from 01.09.2014) [6][7]	95 to 100	0	0	0	0	95 to 100
Mr Ajit Abraham, Director, Surgery and Cancer Clinical Academic Group (from 01.10.2014) [5] [6] [7]	85 to 90	0	0	0	0	85 to 90
Dr Jane Hawdon, Director, Women's and Children's Health Clinical Academic Group (from 01.10.2014) [5] [6] [7]	100 to 105	0	0	0	0	100 to 105
Mr Tony Halton, Director, Clinical Support Services Clinical Academic Group (from 01.10.2014) [6] [7]	75 to 80	0	0	0	0	75 to 80
Dr Charles Knight, Director, Cardiovascular Clinical Academic Group (from 01.10.2014) [5] [6] [7]	95 to 100	0	0	0	0	95 to 100

[1] Expense payments (taxable benefits): This relates to miscellaneous travel and parking expenses.

[2] For comparative purposes this is the equivalent salary payment net of VAT and employer national Insurance. Overall, the Trust has incurred costs of up to £329.7k plus VAT, with Maxentius and Co. for some consultancy fees, and for the period that Ian Miller was Chief Financial Officer of the Trust (from 1st February 2015 to 14th June 2015). Ian Miller is a director of the Maxentius and Co..

[3] Individual was not in Director post with the Trust at 31 March 2015; comparative figures not available

[4] All pension related benefit cannot be calculated; comparative figure not available as at 31st March 2015

[5] Performance pay and bonuses: This relates to clinical excellence award.

[6] Not classified as a Board post 2015/16

[7] Included solely to reflect Board arrangements for the prior period; the listed individual has not been a Board member for any part of the 2015/16 reporting period.

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

Composition of the Board by Gender	Headcount	%
Female	11	42%
Male	15	58%
Total	26	100%

## Pension Benefits (subject to audit)

Name and title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age	(c) Total accrued pension at pension age	(d) Lump sum at pension age related to accrued value	(e) Cash Equivalent Transfer Value at 1 April 2015	(f) Real increase in Cash Equivalent Transfer Value at Transfer	(g) Cash Equivalent Transfer Value at 31 March 2016	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Peter Morris, Chief Executive (until 31.05.15)	[2]	[2]	[2]	[2]	[2]	[2]	[2]	0
Ms Alwen Williams, Chief Executive from 21.10.15 (Interim Chief Executive from 01.06.15 until 20.10.15)	[1]	[1]	80 to 85	240 to 245	[1]	[1]	1,779	0
Dr Tim Peachey, Deputy Chief Executive (from 13.01.16)	[2]	[2]	[2]	[2]	[2]	[2]	[2]	0
Ms Jacqueline Totterdell, Interim Chief Operating Officer (from 26.10.15)	[1]	[1]	65 to 70	195 to 200	[1]	[1]	1,197	0
Mr Ian Miller, Interim Chief Financial Officer (until 14.06.15)	[2]	[2]	[2]	[2]	[2]	[2]	[2]	0
Ms Christa Alagaratham, Chief Financial Officer from 03.02.16 (Interim Chief Financial Officer from 15.06.15 until 02.02.16)	[1]	[1]	45 to 50	140 to 145	[1]	[1]	789	0
Dr Steve Ryan, Chief Medical Officer (until 19.07.15)	0 to 2.5	2.5 to 5	85 to 90	255 to 260	1,845	48	1,915	0
Prof Alistair Chesser, Chief Medical Officer from 03.02.16 (Director, Emergency Care and Acute Medicine Clinical Academic Group until 02.02.16)	7.5 to 10	25 to 27.5	50 to 55	160 to 165	821	157	988	0
Ms Ian Stevens, Interim Chief Nurse	17.5 to 20	57.5 to 60	70 to 75	220 to 225	1,141	436	1,591	0
Mr Michael Pantin, Director of Workforce Development	[2]	[2]	[2]	[2]	[2]	[2]	[2]	0
Prof Joanne Martin, Director of Academic Health Sciences (Interim Chief Medical Officer from 20.07.15 until 02.02.16)	[2]	[2]	[2]	[2]	[2]	[2]	[2]	0
Ms Frances O'Callaghan, Director of Strategy (until 31.10.15)	0 to 2.5	0 to -2.5	40 to 45	125 to 130	639	21	667	0
Mr Ian Walker, Director of Corporate Affairs and Trust Secretary	2.5 to 5	2.5 to 5	15 to 20	35 to 40	179	43	224	0

[1] Individual was not in Director post with the Trust at 31 March 2015, comparative figures not available  
[2] Individual is not an active member of the NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The above table shows payments made directly by the Trust to the relevant NHS Pensions Scheme as described.

Actuarial assumptions - The calculation of Cash Equivalent Transfer Values ("CETVs") requires a set of actuarial assumptions such as expected inflation and life expectancy. For the purposes of calculating CETVs, these assumptions are set by the Government Actuary's Department ("GAD"), and then distributed to administrators as actuarial factors which incorporate these assumptions into a single factor for a certain tranche of pension for an individual of a given age and gender. NHS Pensions use the most recent set of actuarial factors produced by GAD.

## Compensation for loss of office (subject to audit)

In 2015/16 there was one early retirement for the efficiency of the service (three in 2014/15), at a cost of £425k (£260k in 2014/15).

## Off-payroll Engagements

**For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:**

	Number
Number of existing engagements as of 31 March 2016	27
Of which, the number that have existed:	
for less than one year at the time of reporting	11
for between one and two years at the time of reporting	13
for between 2 and 3 years at the time of reporting	3
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

**For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:**

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	22
Number of new engagements which include contractual clauses giving the Barts Health NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	22
Number for whom assurance has been requested	0
Of which:	
assurance has been received	
assurance has not been received	
engagements terminated as a result of assurance not being received	

**For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015**

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	26

## Exit Packages (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies
		£s
Less than £10,000	14	73,125
£10,000 - £25,000	3	63,161
£25,001 - £50,000	4	167,808
£50,001 - £100,000		
£100,001 - £150,000		
£150,001 - £200,000*	1	170,234
>£200,000	1	425,747
Total	23	900,075

\* Where a director of the Trust receives an exit package, additional details are provided. The payment within the £150,001 to £200,000 banding of £170,234, is a payment to Peter Morris (Chief Executive to 31st May 2015)

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.

## Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Barts Health NHS Trust in the financial year 2015/16 was £225k to £230k (2014/15, £275k to £280k). \*\* This was 5.7 times (2014/15, 7) the median remuneration of the workforce, which was £40k (2014/15 £40k).

In 2015/16, no employees received remuneration in excess of the highest paid director (this was the same in 2014/15). Remuneration ranged from the bands \*\* £15k-£20k to £225k-£230k (2014/15 £15k-£20k to £275k-£280k)

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

\*\* The ratio of the highest paid director to the median remuneration has reduced from 7 times (2014-15) to 5.7 times (2015-16) as a result of the appointment of a new chief executive during the year and remuneration was only calculated for the period in post. The remuneration band range has also reduced in (2015-16) compared to (2014-15) for the same reason.

Sickness absence data	2015/16	2014/45
	Number	Number
Total days lost	100,883	95,750
Total staff years	13,758	13,056
Averages working days lost	7.33	7.33

In line with guidance issued by the Department of Health, the sickness absence data is reported on a calendar year basis.

Early Retirements on ill health grounds	2015/16	2014/15
	Number	Number
Number of persons retired early on ill health grounds	1	11
	£000s	£000s
Total additional pensions liabilities accrued in the year	199	606

## Senior manager numbers by band

Salary bands	Number of senior managers
Less than £5,000	6
£5,000 - £10,000	6
£25,001 - £30,000	1
£40,001 - £45,000	1
£45,001 - £50,000	1
£60,001 - £65,000	1
£75,001 - £80,000	1
£90,001 - £95,000	1
£110,001 - £115,000	1
£120,001 - £125,000	1
£155,001 - £160,000	1
£165,001 - £170,000	1
£175,001 - £180,000	1
£190,001 - £195,000	2
£225,001 - £230,000	1
Total	26

## Interests - Directors

Name	Organisation	Description	Start Date (if not whole year)	End Date (if not whole year)
Mr John Bacon	Community Health Partnerships	Chairman	30/07/2015	
Mr Alastair Camp	Institute of Financial Services	Chairman, IFS pension fund		
	North West London Local Justice	Magistrate		
Dr Thoreya Swage	Thoreya Swage Ltd	Director		
	Frimley Health NHS Foundation Trust	Non-Executive Director	15/05/2015	
	Clinical Panel Ltd	Member		
	RD Capital Partners LLP	Honorary Advisor	28/10/2015	
Mr Gautam Dalal	AMREF International	Board Member, Chair of Finance Committee		
	AMREF UK	Board Member		
	AMREF UK	Chair		15/03/2016
	National Gallery	Trustee, Chair of Finance Committee, Chair of Audit Committee		
	SOAS (School of Oriental and African Studies)	"Member of Governing Body Honorary Treasurer"		
	ZincOx Resources Plc	NED		
	Law Society Group	Chair of Audit Committee	01/12/2015	
Ms Karen West	Newham CCG	Partner acts as a lay member	12/10/2015	
Ms Tracey Fletcher	Digibrige CIC	Chair		
	Voluntary Action Waltham Forest		01/01/2015	
	Significant Seams CIC			
	Dame Kelly Holmes Trust	Trustee / Director		
	Tracey Fletcher Consulting	Director - Consulting to Enterprises and Charities		
Ms Alwen Williams	No interests declared			
Dr Tim Peachey	No interests declared			
Ms Chrisha Alagaratnam	No interests declared			
Professor Alistair Chesser	No interests declared			
Mr Ian Walker	No interests declared			
Mr Michael Pantlin	No interests declared			
Ms Jacqueline Totterdell	NHS IMAS	Partner (unpaid)		
Ms Caroline Alexander	Buckinghamshire New University	Honorary Visiting Professor		

Name	Organisation	Description	Start Date (if not whole year)	End Date (if not whole year)
Ms Anne Whitaker	WHR Consulting Ltd			
	RSE Ltd	Trading subsidiary of Roedean School		
	Markel Syndicate Management Ltd			
	Markel International Insurance Company Ltd	Markel International is an insurance company which is a subsidiary of a US listed insurance group. They also write insurance through a Lloyds Syndicate.		
	Markel Europe PLC		30/06/2015	
	IPSA	Board Member		
	Aphrodite Property Company Ltd			
	Hitachi Capital UK Ltd	Appointment pending confirmation as at 31/03/16	21/03/2016	
Professor Richard Trembath	William Harvey Institute	Director		
	Global Medical Excellence Consultancy	Consultancy advice		
	Pfizer	Consultancy advice		
	Queen Mary University of London	Vice Principal, Health (primary employer)		
Ms Angela Greatley	Tavistock and Portman NHS Foundation Trust		Chair	06/05/2015      31/10/2015
Professor Michael Curtis	_No Interests Declared			
Professor Steve Thornton	Queen Mary University of London	Vice Principal, Health (primary employer)		
	Ferring Pharmacy	Consultancy advice		
	Hologic	Consultancy advice		
	Glaxo SmithKline	Consultancy advice		
Mr Philip Wright	Digital Theatre	Chairman		
	Allia	Director		
	Better Food Foundation	Chairman		
	Goldsmith's College, University of London	Council Member		
	PricewaterhouseCoopers	Partner		
	Retail Charity Bonds PLC	Director		
	Common Purpose	Trustee		

Name	Organisation	Description	Start Date (if not whole year)	End Date (if not whole year)
Ms Janice Stevens	Prince's Trust	Ambassador and mentor	19/03/2015	
Ms Frances O'Callaghan	Frances O'Callaghan Ltd	Director		
Professor Jo Martin	Queen Mary University of London	Employee		
	PricewaterhouseCoopers	Spouse is employed as a Partner		30/06/2016
	Amref Health Africa	Advisor (unpaid)	13/03/2016	
	NHS England	Appointed as the National Clinical Director of Pathology		31/03/2016
	Mulberry School	Trustee		
	Barts Charity	Spouse is chairman wef 01/04/2016	14/03/2016	
	Bio Moti Ltd	Director of start up company for drug delivery technology development.		
	ehealthpd.com	Development of Apps		
Mr Peter Moris	Skanska	Close family member (son) holds an employment contract	16/12/2014	
Mr Ian Miller	No interests declared			
Mr Paul Brickell	East London NHS LIFT Company			
	Trinity Buoy Wharf	Trustee		
	SS Robin Trust	Trustee	01/01/2015	
	London Legacy Development Corporation	Executive Director for Regeneration and Community Partnerships		
	East Village Trust	Trustee		
Dr Steve Ryan	St Paul's Way	Governor		



## Staff numbers (subject to audit)

The average staff numbers included below have been converted to full time equivalents to allow comparison to the financial figures for employee benefits reported in the Trust's accounts. The gender analysis is reported on an absolute basis irrespective of how many hours an individual works.

	2015/16				2014/15			
	Total	Permanently employed	Internal bank	Agency and other	Total	Permanently Employed	Internal bank	Agency and other
<b>Average</b>								
Medical and dental	2,392	2,211	-	181	2,383	2,222	-	161
Administration and estates	3,617	2,922	432	263	3,353	2,890	304	159
Healthcare assistants and other support staff	688	688	-	-	542	530	-	12
Nursing, midwifery and health visiting staff	5,879	4,445	889	545	5,475	4,369	651	455
Nursing, midwifery and health learners	813	813	-	-	866	866	-	-
Scientific, therapeutic and technical staff	1,819	1,569	134	116	1,785	1,604	98	83
Healthcare Science Staff	609	586	17	6	542	518	12	12
Other	7	6	-	1	14	6	-	8
<b>Total</b>	<b>15,824</b>	<b>13,240</b>	<b>1,472</b>	<b>1,112</b>	<b>14,960</b>	<b>13,005</b>	<b>1,065</b>	<b>890</b>
Of the above - staff engaged on capital projects	1	-			1	14	3	-
								11

## Staff composition (as at 31st March 2016)

Gender	Headcount	%
Female	11,208	74%
Male	3,876	26%
<b>Total</b>	<b>15,084</b>	<b>100%</b>

## Consultancy expenditure

Operating expenses	2015/16	2014/15
	£000s	£000s
Consultancy services	7,055	19,571



# Annual Accounts 2015/16



## Foreword

Financially, 2015/16 has been a very challenging year for Barts Health. The Trust has approached these challenges positively, ensuring that cost improvements were clinically effective and appropriate, and that the quality of services was not impacted upon in a detrimental way.

Throughout 2015/16, the Trust has been forecasting that it would end the year with a £134.9m deficit, and the Trust did achieve this planned deficit position. This was achieved through a combination of Cost Improvement Programmes (CIPs) focusing on greater efficiencies without adversely affecting the quality of services to patients.

In addition, for 2015/16 there were two significant one-off transactions that supported the Trust in achieving its financial plan target. The Trust sold the London Chest Hospital for £49.6m, generating a profit of £30m, and, in addition, in-year management of the capital investment programme also supported the Trust's financial plan and this resulted in an additional £15m of healthcare income from the Department of Health.

The Trust has continued to focus on improving the delivery of high quality services, and in 2015/16 increased expenditure by around 10.3% from a 2014/15 level of £1,394m to £1,538m in this financial year.

During the year, the Trust delivered £60.2m of cost improvements, and although this was below the target of £75m, this is still equivalent to 4.5% of income. Each element of the cost improvement programme went

through a quality impact assessment process to ensure clinical sign-off for all of the efficiency improvements made by the Trust.

During the year, the Trust delivered £60.2m of cost improvements, and although this was below the target of £75m, this is still equivalent to 4.5% of income. Each element of the cost improvement programme went through a quality impact assessment process to ensure clinical sign-off for all of the efficiency improvements made by the Trust.

The challenges faced in 2015/16 will continue into next year albeit with a reduced level of planned deficit.

Looking forward, it is important that we continue to strive for quality improvements and we are playing an active role in the local health economy in shaping the overall joint "Sustainability and Transformation Plan" helping to ensure that health and care services are built around the needs of our local populations and at the same time ensuring value for money.

We plan to deliver significant savings through our cost improvement programme (£75m) in 2016/17. In addition the Trust is currently reviewing its capital programme to ensure a focused level of investment in key areas that enhance the patient experience.

**Chrisha Alagaratnam**  
Chief Financial Officer

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority.

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 with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

I confirm that, 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 trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.



**Alwen Williams**  
Chief Executive



Date

## Statement of Directors' Responsibilities in Respect of the Accounts

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

In preparing those accounts, directors are required to:

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



**Alwen Williams**  
Chief Executive



**Chrisha Alagaratnam**  
Chief Financial Officer

Date

Date

1<sup>st</sup> June 2016

1<sup>st</sup> June 2016

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

We have audited the financial statements of Barts Health NHS Trust (the "Trust") for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

This report is made solely to the Directors of Barts Health NHS Trust, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. 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 Trust and the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

## **Respective responsibilities of Directors, the Accountable Officer and auditor**

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. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act. 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.

## **Scope of the audit of the financial statements**

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies, we consider the implications for our report.

## **Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

## **Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of Barts Health NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

## **Opinion on other matters**

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the audited financial statements.

## Matters on which we are required to report by exception

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve 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.

On 25 May 2016, we referred a matter to the Secretary of State under section 30 of the Act in relation to Barts Health NHS Trust's breach of its capital resource limit for the year ended 31 March 2016.

We report to you if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

## Basis for adverse conclusion

In considering the Trust's arrangements for securing economy, efficiency and effectiveness we identified the following matters:

- The Trust incurred a deficit of £134.9 million in 2015/16, which is in line with its plan. In addition, the Trust's medium term financial plan shows a forecast deficit of £82.7 million for 2016/17. This is dependent on the Trust achieving their cost improvement programme of £75 million, the tariff inflation of £30million included within the budget is fully delivered, and the Trust identifies £30 million additional savings and fully delivers them in the remaining ten months of the financial year.
- The deterioration in the Trust's financial outturn for 2015/16 compared to the previous year was due to increases in staff costs due to reliance on agency and bank

staff, non achievement of the planned Cost Improvement Programmes of £75 million and falls in other operating income such as research and development and high cost non tariff support (project diamond funding) which was expected. The Trust also suffered a shortfall on budgeted patient treatment income mainly due to the slower than expected take up on cardiac activity at the St Bartholomews site. In addition, the Trust has identified significant weaknesses in its arrangements for capturing patient activity and billing healthcare income, which have resulted in understating the amount recouped from commissioners in 2015/16.

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

- The Care Quality Commission (CQC) review of the Trust's Whipps Cross University Hospital in November 2014 rated services provided by the hospital as inadequate. The CQC also inspected the Trust's Royal London Hospital and Newham General Hospital in February 2015, and rated both hospitals as inadequate. The CQC has rated the Trust as inadequate overall, highlighting significant concerns in safety, effectiveness, responsiveness and leadership. Due to the level of concerns raised across the Trust, the NHS Trust Development Agency (NTDA) placed the Trust in special measures on 16 March 2015. The Trust has not yet been subject to reinspection by the CQC .

This is evidence of weaknesses in arrangements for acting in the public interest through demonstrating and applying the principles of good governance; and for deploying the workforce effectively to deliver the Trust's strategic priorities.

### **Adverse conclusion**

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, because of the significance of the matters described in the basis for adverse conclusion paragraph, we are not satisfied that, in all significant respects, Barts Health NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the following matters where we are required to report by exception if:

- in our opinion the governance statement does not comply with guidance issued by the NHS Trust Development Authority; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the Trust under section 24 of the Act.

### **Certificate**

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

Paul Grady  
for and on behalf of Grant Thornton UK LLP,  
Appointed Auditor  
Grant Thornton House  
Melton Street  
London NW1 2EP

1 June 2016





# Statement of Comprehensive Income for year ended 31 March 2016

	Note	2015/16 £000s	2014/15 £000s
Gross employee benefits	9.1	(836,322)	(765,034)
Other operating costs	7	(701,223)	(609,604)
Revenue from patient care activities	4	1,160,457	1,086,180
Other operating revenue	5	182,137	214,471
<b>Operating deficit</b>		<b>(194,951)</b>	(73,987)
Investment revenue	11	183	134
Other gains	12	30,116	1,646
Finance costs	13	(57,695)	(55,378)
<b>Deficit for the financial year</b>		<b>(222,347)</b>	(127,585)
Public dividend capital dividends payable		(1,259)	(6,088)
<b>Retained deficit for the year</b>		<b>(223,606)</b>	(133,673)
<b>Other Comprehensive Income</b>		<b>2015/16 £000s</b>	2014/15 £000s
Impairments and reversals taken to the revaluation reserve		0	(1,857)
Net (loss) / gain on revaluation of property, plant & equipment		(47,123)	63,093
<b>Total other comprehensive income</b>		<b>(47,123)</b>	61,236
<b>Total comprehensive income for the year</b>		<b>(270,729)</b>	(72,437)
<b>Financial performance for the year</b>			
Retained deficit for the year		(223,606)	(133,673)
IFRIC 12 adjustment (including IFRIC 12 impairments)	16	59,424	38,660
Impairments (excluding IFRIC 12 impairments)	16	26,821	6,364
Adjustments in respect of donated gov't grant asset reserve elimination		2,480	9,007
<b>Adjusted retained deficit</b>		<b>(134,881)</b>	(79,642)

The notes on pages 153 to 198 form part of this account.

A Trust's reported NHS financial performance position is derived from its retained surplus / (deficit), but adjusted for the following:

- a) Impairments to non-current assets.
- b) Incremental revenue expenditure relating to the change in the treatment of donated assets and government granted assets following the accounting policy change outlined in the Treasury FREM for 2011/12.

## Statement of Financial Position as at 31st March 2016

	Note	31 March 2016 £000s	31 March 2015 £000s
<b>Non-current assets:</b>			
Property, plant and equipment	14	<b>1,279,439</b>	1,360,674
Intangible assets	15	<b>1,228</b>	1,372
Investment property	17	<b>0</b>	2,086
Trade and other receivables	20.1	<b>3,125</b>	11,153
<b>Total non-current assets</b>		<b>1,283,792</b>	1,375,285
<b>Current assets:</b>			
Inventories	19	<b>21,870</b>	18,501
Trade and other receivables	20.1	<b>132,556</b>	157,079
Cash and cash equivalents	21	<b>3,217</b>	3,109
<b>Total current assets</b>		<b>157,643</b>	178,689
<b>Total assets</b>		<b>1,441,435</b>	1,553,974
<b>Current liabilities</b>			
Trade and other payables	22	<b>(185,334)</b>	(176,591)
Provisions	26	<b>(4,162)</b>	(8,419)
Borrowings	23	<b>(22,015)</b>	(19,546)
DH revenue support loan	23	<b>0</b>	(4,240)
DH capital loan	23	<b>(2,806)</b>	(808)
Total current liabilities		<b>(214,317)</b>	(209,604)
<b>Net liabilities</b>		<b>(56,674)</b>	(30,915)
<b>Total assets less current liabilities</b>		<b>1,227,118</b>	1,344,370
<b>Non-current liabilities</b>			
Provisions	26	<b>(13,017)</b>	(15,469)
Borrowings	23	<b>(1,074,213)</b>	(1,034,400)
DH revenue support loan	23	<b>(129,800)</b>	0
DH capital loan	23	<b>(4,829)</b>	(7,634)
<b>Total non-current liabilities</b>		<b>(1,221,859)</b>	(1,057,503)
<b>Total assets employed:</b>		<b>5,259</b>	286,867
<b>FINANCED BY:</b>			
Public dividend capital		<b>306,535</b>	317,413
Retained earnings		<b>(474,953)</b>	(257,369)
Revaluation reserve		<b>173,677</b>	226,823
<b>Total taxpayers' equity</b>		<b>5,259</b>	286,867

The notes on pages 12 to 51 form part of this account.

The financial statements on pages 8 to 11 were approved by the Board on 1st June 2016 and signed on its behalf by

*Alwen Williams*

**Alwen Williams**  
Chief Executive

*1<sup>st</sup> June 2016*

Date

## Statement of Changes in Taxpayers' Equity For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	31 March 2015 Total reserves
	£000s	£000s	£000s	£000s
<b>Balance at 1 April 2015</b>	<b>317,413</b>	<b>(257,369)</b>	<b>226,823</b>	<b>286,867</b>
<b>Changes in taxpayers' equity for 2015/16</b>				
Retained deficit for the year		(223,606)		(223,606)
Net loss on revaluation of property, plant, equipment			(47,123)	(47,123)
Transfers between reserves		6,023	(6,023)	0
Permanent PDC received - cash	4,122			4,122
Permanent PDC repaid in year	(15,000)			(15,000)
Other movements	0	(1)	0	(1)
<b>Net recognised expense for the year</b>	<b>(10,878)</b>	<b>(217,584)</b>	<b>(53,146)</b>	<b>(281,608)</b>
<b>Balance at 31 March 2016</b>	<b>306,535</b>	<b>(474,953)</b>	<b>173,677</b>	<b>5,259</b>
<b>Balance at 1 April 2014</b>	<b>215,920</b>	<b>(124,057)</b>	<b>165,949</b>	<b>257,812</b>
<b>Changes in taxpayers' equity for the year ended 31 March 2015</b>				
Retained surplus/(deficit) for the year		(133,673)		(133,673)
Net gain on revaluation of property, plant, equipment			63,093	63,093
Impairments and reversals			(1,857)	(1,857)
Transfers between reserves		361	(361)	0
New PDC received - cash	161,493			161,493
New PDC repaid in year	(60,000)			(60,000)
Other movements	0	0	(1)	(1)
<b>Net recognised revenue/(expense) for the year</b>	<b>101,493</b>	<b>(133,312)</b>	<b>60,874</b>	<b>29,055</b>
<b>Balance at 31 March 2015</b>	<b>317,413</b>	<b>(257,369)</b>	<b>226,823</b>	<b>286,867</b>

## Statement of Cash Flows for the Year ended 31 March 2016

	Note	2015/16 £000s	2014/15 £000s
<b>Cash flows from operating activities</b>			
Operating deficit		(194,951)	(73,987)
Depreciation and amortisation		53,016	61,281
Impairments and reversals		86,245	45,024
Donated assets received credited to revenue but non-cash		(2,499)	(1,839)
Interest paid		(57,469)	(54,499)
Dividend paid		(5,163)	(7,886)
Increase in inventories		(3,369)	(1,610)
Decrease / (increase) in trade and other receivables		28,639	(10,443)
Increase/(decrease) in trade and other payables		20,739	(19,535)
Provisions utilised		(4,826)	(7,750)
Decrease in movement in non cash provisions		(2,026)	(938)
<b>Net cash outflow from operating activities</b>		<b>(81,664)</b>	<b>(72,182)</b>
<b>Cash flows from investing activities</b>			
Interest received		183	134
Payments for property, plant and equipment		(61,595)	(44,756)
Payments for intangible assets		(186)	(79)
Proceeds of disposal of assets held for sale (PPE)		49,432	9,618
<b>Net cash outflow from investing activities</b>		<b>(12,166)</b>	<b>(35,083)</b>
<b>Net cash outflow before Financing</b>		<b>(93,830)</b>	<b>(107,265)</b>
<b>Cash flows from financing activities</b>			
Public dividend capital received		4,122	161,493
Public dividend capital repaid		(15,000)	(60,000)
Loans received from DH - new capital investment loans		0	3,995
Loans received from DH - new revenue support loans		219,900	0
Loans repaid to DH - capital investment loans - repayment of principal		(808)	(1,008)
Loans repaid to DH - working capital loans/revenue support loans		(94,340)	(4,240)
Capital element of payments for finance leases and On-SoFP PFI		(19,936)	(20,344)
<b>Net cash inflow from financing activities</b>		<b>93,938</b>	<b>79,896</b>
<b>Net Increase / (decrease) in cash and cash equivalents</b>		<b>108</b>	<b>(27,369)</b>
<b>Cash and cash equivalents at beginning of the period</b>		<b>3,109</b>	<b>30,478</b>
<b>Cash and cash equivalents at year end</b>	21	<b>3,217</b>	<b>3,109</b>

# Notes to the Accounts

## 1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015/16 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1

#### **Accounting convention**

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

### 1.2

#### **Acquisitions and discontinued operations**

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

### 1.3

#### **Movement of assets within the DH Group**

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

### 1.4

#### **Charitable Funds**

Under the provisions of IFRS 10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. Therefore NHS trusts are required to include charitable funds, over which they have control, in their accounts. However the Barts Charity is independent of the Trust and therefore consolidation is not required.

## 1.5

### Critical accounting judgements and key sources of estimation uncertainty

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

#### 1.5.1

##### Critical judgements in applying accounting policies

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

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

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

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

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

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

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

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

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

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

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

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

### **1.5.2**

#### **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

#### **Revenue - Note 1.6 and Note 4 and 5**

The basis of calculation for partially completed spells is detailed in note 1.6.

#### **Asset Lives – Note 1.11**

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

The minimum and maximum estimated economic lives of each class of asset are disclosed in note 1.11, and the carrying values of property, plant and equipment and intangible assets in note 14.1 respectively.

#### **Land and Buildings Valuations – Note 14.1**

All land and buildings are restated at current value by way of annual professional valuations carried out by an independent external valuer.

#### **Provision for Impairment of Receivables – Note 20.3**

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



### 1.5.3

#### Going Concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust has submitted a financial plan for 2016/17 to NHS Improvement which delivers a £82.7 million deficit after delivery of a £75 million savings programme which has been agreed by the Trust Board and is embedded in the budget. The Trust board have recognised that this is a highly demanding plan, which is subject to a high degree of risk, and dependent upon the full delivery of cost reduction targets, realisation of recurrent savings, and the adherence to agreed budgets

The plan includes a requirement for up to £199.3 million of cash support from the Department of Health to maintain the Trust's cash flows in 2016/17.

The Directors have received confirmation from NHS Improvement that it is reasonable for the Directors of Barts Health NHS Trust to assume that NHS Improvement will make sufficient cash financing available to the organisation over the next 12 month period such that the organisation is able to meet its current liabilities, and on this basis fully supports the view that the Trust's accounts are prepared on a going concern basis.

## 1.6

### Revenue

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

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred. Care delivered under the maternity pathway payment system may span more than one financial year, the Trust apportions the income across financial years based on the progression through the pathway.

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

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

## 1.7

### Employee Benefits

#### Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

#### Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

## 1.8

### Other expenses

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

## 1.9

### Property, plant and equipment

#### Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items that form part of the initial equipping and setting-up cost of a new building, ward or unit, or a major refurbishment of an existing building, ward or unit, irrespective of their individual or collective cost.

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

#### Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at current value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

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

### **Subsequent expenditure**

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

## **1.10**

### **Intangible assets**

#### **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at current value. Software that is integral to the operating of hardware, for

example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

#### **Measurement**

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

Following initial recognition, intangible assets are carried at current value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for current value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

**1.11****Depreciation, amortisation and impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had

there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Economic Lives of Non-Current Assets	Min Life Years	Max Life Years
<b>Intangible Assets</b>		
Software Licences	2	5
<b>Property, Plant and Equipment</b>		
Buildings exc Dwellings	2	72
Dwellings	11	73
Plant & Machinery	5	24
Transport Equipment	2	7
Information Technology	5	12
Furniture and Fittings	10	25

**1.12****Donated assets**

Donated non-current assets are capitalised at their current value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

**1.13****Government grants**

Government grant funded assets are capitalised at their current value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

**1.14****Leases**

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

### The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at current value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

### The NHS trust as lessor

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

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

### 1.15

#### **Private Finance Initiative (PFI) transactions**

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the current value of services received;
- b) Payment for the PFI asset, including finance costs; and
- c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

#### **Services received**

The current value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

#### **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at current value in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

### PFI liability

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 current 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 on an annual basis, using the Department of Health PFI model as an estimate of the level of lifecycle replacement, and are measured initially at their current 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 finance lease liability or prepayment is recognised respectively.

Where the current 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 current 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 the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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

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

### Other assets contributed by the NHS trust to the operator

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



## 1.16

### Inventories

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

## 1.17

### 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 NHS trust's cash management.



## 1.18

### Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present

value of those cash flows using HM Treasury's discount rate of -0.8% in real terms (1.37% for employee early departure obligations).

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

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

## 1.19

### Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 26.

## 1.20

### Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority 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 as and when they become due.

## 1.21

### Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

## 1.22

### Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

## 1.23

### Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

#### [Financial assets at fair value through profit and loss](#)

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

### Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

### Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

### Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as

a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

## 1.24

### Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

## Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets; and
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

## Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

## Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

## 1.25

### 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.

## 1.26

### Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

## 1.27

### 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. Details of third party assets are given in Note 36 to the accounts.

## 1.28

### Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. 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. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (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.

### **1.29**

#### **Losses and Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

### **1.30**

#### **Research and Development**

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.



**1.31****Accounting Standards that have been issued but have not yet been adopted**

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

**2 Operating segments**

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

	2015/16 £000s	2014/15 £000s
Income	1,342,594	1,319,964
Segment deficit	(223,606)	(133,673)
Segment net assets	5,259	286,867

**3 Income generation activities**

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



#### 4 Revenue from patient care activities

	2015/16 £000s	2014/15 £000s
NHS Trusts	0	19
NHS England	<b>406,158</b>	371,049
Clinical Commissioning Groups	<b>695,668</b>	677,548
Foundation Trusts	<b>11,080</b>	7,726
NHS Other (including Public Health England and Prop Co)	0	63
Additional income for delivery of healthcare services	<b>15,000</b>	0
Non-NHS:		
Local Authorities	<b>18,706</b>	18,874
Private patients	<b>1,980</b>	1,978
Overseas patients (non-reciprocal)	<b>6,754</b>	2,941
Injury costs recovery	<b>4,998</b>	5,819
Other	<b>113</b>	163
<b>Total revenue from patient care activities</b>	<b>1,160,457</b>	1,086,180

## 5 Other operating revenue

	2015/16 £000s	2014/15 £000s
Education, training and research	<b>132,508</b>	133,248
Charitable and other contributions to revenue expenditure - NHS	<b>112</b>	98
Receipt of donations for capital acquisitions - Charity	<b>2,499</b>	1,839
Receipt of Government grants for capital acquisitions	<b>286</b>	0
Non-patient care services to other bodies	<b>8,995</b>	7,422
Income generation (Other fees and charges)	<b>2,530</b>	2,702
Rental revenue from operating leases	<b>1,490</b>	656
Other revenue		
Winter and operation resilience	<b>4,000</b>	4,159
Transitional PFI support	<b>2,945</b>	12,300
Turnaround support	<b>1,000</b>	0
High cost (non tariff) support - project diamond	<b>0</b>	18,200
Other	<b>25,772</b>	33,847
<b>Total other operating revenue</b>	<b>182,137</b>	214,471
<b>Total operating revenue</b>	<b>1,342,594</b>	1,300,651

## 6 Overseas visitors disclosure

	2015/16 £000s	2014/15 £000s
Income recognised during 2015/16 (invoiced amounts and accruals)	<b>6,754</b>	2,941
Cash payments received in-year (re receivables at 31 March 2015)	<b>877</b>	437
Cash payments received in-year (iro invoices issued 2014/15)	<b>571</b>	686
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	<b>0</b>	0
Amounts added to provision for impairment of receivables (iro invoices issued 2014/15)	<b>5,828</b>	2,214
Amounts written off in-year (irrespective of year of recognition)	<b>1,214</b>	268

## 7 Operating expenses

	31 March 2016 £000s	31 March 2015 £000s
<b>Services from NHS bodies*</b>		
Services from other NHS Trusts	1,246	121
Services from CCGs/NHS England	62	0
Services from other NHS bodies	511	0
Services from NHS Foundation Trusts	2,000	1,780
<b>Clinical services</b>		
Supplies and services - clinical	281,738	231,660
Clinical negligence	34,568	22,700
Purchase of healthcare from non-NHS bodies	7,744	641
<b>Non executives</b>		
Trust Chair and Non-executive Directors	85	69
<b>Non clinical services</b>		
Supplies and services - general	39,719	12,344
Premises	53,866	65,214
Establishment	8,533	10,763
Transport	16,927	16,799
Business rates paid to local authorities	12,854	11,816
Service charges - on-SOFP PFI's & other service concession arrangements	66,292	69,872
<b>Depreciation, amortisation and impairments (property)</b>		
Depreciation	52,667	60,852
Amortisation	349	429
Impairments and reversals of property, plant and equipment	86,245	45,024
<b>Other</b>		
Research and development (excluding staff costs)	24,618	22,269
Consultancy services	7,055	19,571
Education and training	3,196	3,582
Legal Fees	1,708	1,427
Hospitality	1	102
Insurance	454	409
Impairments and reversals of receivables	(7,139)	2,573
Audit fees	180	240
Other auditor's remuneration	12	26
Change in discount rate	(85)	606
Other	5,817	8,715
<b>Total operating expenses (excluding employee benefits)</b>	<b>701,223</b>	<b>609,604</b>
<b>Employee benefits</b>		
Employee benefits excluding board members	834,230	762,343
Board members	2,092	2,691
<b>Total employee benefits</b>	<b>836,322</b>	<b>765,034</b>
<b>Total operating expenses</b>	<b>1,537,545</b>	<b>1,374,638</b>

\*Services from NHS bodies" does not include expenditure which falls into a category below

## 8 Operating Leases

The Trust leases a number of buildings. Terms or renewal and purchase options vary between individual leases.

### 8.1

#### Barts Health NHS Trust as lessee

	Buildings £000s	Other £000s	Total £000s	2014/15 £000s
<b>Payments recognised as an expense</b>				
Minimum lease payments			<b>4,162</b>	6,174
Contingent rents			<b>0</b>	0
Sub-lease payments			<b>0</b>	0
<b>Total</b>			<b>4,162</b>	<b>6,174</b>
<b>Payable:</b>				
No later than one year	4,101	265	<b>4,366</b>	4,633
Between one and five years	15,225	342	<b>15,567</b>	12,186
After five years	3,441	0	<b>3,441</b>	3,605
<b>Total</b>	<b>22,767</b>	<b>607</b>	<b>23,374</b>	<b>20,424</b>
Total future sublease payments expected to be received:			<b>0</b>	<b>0</b>

### 8.2

#### Barts Health NHS Trust as lessor

A small number of operating leases exist, whereby the Trust leases space in its premises to third party users. The income for these appears under Rental Revenue below

	2015/16 £000s	2014/15 £000s
<b>Recognised as revenue</b>		
Rental revenue	<b>1,490</b>	656
Contingent rents	<b>0</b>	0
<b>Total</b>	<b>1,490</b>	<b>656</b>
<b>Receivable:</b>		
No later than one year	<b>590</b>	552
Between one and five years	<b>1,639</b>	1,511
After five years	<b>4,026</b>	4,356
<b>Total</b>	<b>6,255</b>	<b>6,419</b>

## 9 Employee benefits and staff numbers

### 9.1

#### Employee benefits

Employee benefits - gross expenditure	2015/16				2014/15			
	Total	Permanently employed	Internal Bank	Agency & Other	Total	Permanently employed	Internal Bank	Agency & Other
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	<b>718,813</b>	571,860	56,846	90,107	655,278	524,127	42,832	88,319
Social security costs	<b>52,707</b>	52,707	0	0	49,344	49,344	0	0
Employer Contributions to NHS BSA - Pensions	<b>64,369</b>	64,369	0	0	58,692	58,692	0	0
Termination benefits	<b>566</b>	566	0	0	2,794	2,794	0	0
<b>Total employee benefits</b>	<b>836,455</b>	<b>689,502</b>	<b>56,846</b>	<b>90,107</b>	766,108	634,957	42,832	88,319
<b>Employee costs capitalised</b>	<b>133</b>	0	0	133	1,074	217	0	857
<b>Gross employee benefits excluding capitalised costs</b>	<b>836,322</b>	<b>689,502</b>	<b>56,846</b>	<b>89,974</b>	765,034	634,740	42,832	87,462

### 9.2

#### Staff numbers

Average staff numbers	2015/16				2014/15			
	Total	Permanently employed	Internal Bank	Agency & Other	Total	Permanently employed	Internal Bank	Agency & Other
Medical and dental	<b>2,392</b>	2,211	0	181	2,383	2,222	0	161
Administration and estates	<b>3,617</b>	2,922	432	263	3,353	2,890	304	159
Healthcare assistants and other support staff	<b>688</b>	688	0	0	542	530	0	12
Nursing, midwifery and health visiting staff	<b>5,879</b>	4,445	889	545	5,475	4,369	651	455
Nursing, midwifery and health visiting learners	<b>813</b>	813	0	0	866	866	0	0
Scientific, therapeutic and technical staff	<b>1,819</b>	1,569	134	116	1,773	1,604	98	71
Healthcare Science Staff	<b>609</b>	586	17	6	554	518	12	24
Other	<b>7</b>	6	0	1	14	6	0	8
<b>Total</b>	<b>15,824</b>	<b>13,240</b>	<b>1,472</b>	<b>1,112</b>	<b>14,960</b>	<b>13,005</b>	<b>1,065</b>	<b>890</b>
Of the above - staff engaged on capital projects	1	0	0	1	14	3	0	11

## 9.3

### Staff Sickness absence and ill health retirements

	2015/16	2014/15
	Number	Number
Total days lost	<b>100,883</b>	95,750
Total staff years	<b>13,758</b>	13,056
<b>Average working days lost</b>	<b>7.3</b>	<b>7.3</b>

	2015/16	2014/15
	Number	Number
Number of persons retired early on ill health grounds	<b>1</b>	11
	<b>£000s</b>	£000s
Total additional pensions liabilities accrued in the year	<b>199</b>	606

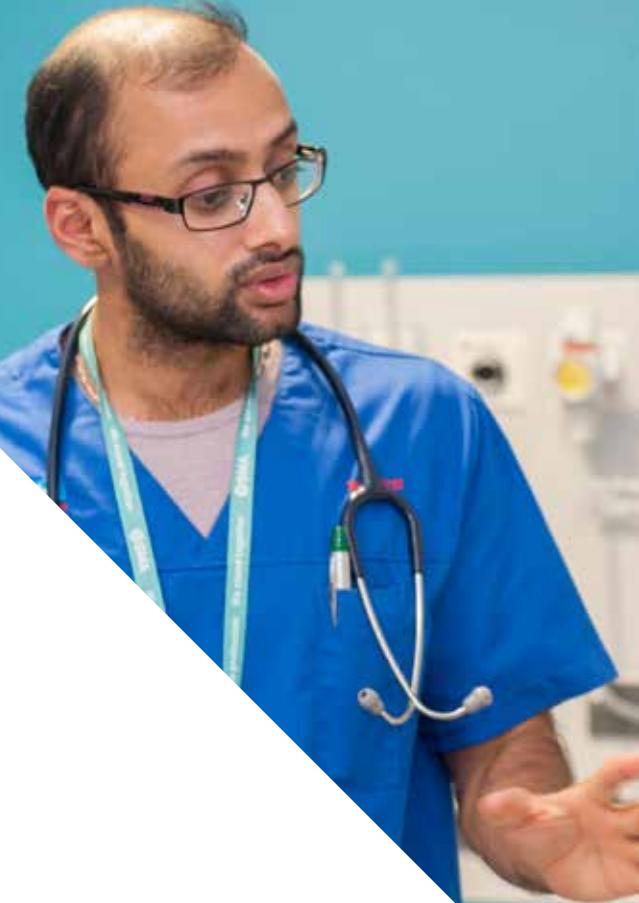
## 9.4

### Exit Packages agreed in 2015/16

Exit package cost band (including any special payment element)	2015/16		2014/15	
	Number	Cost of compulsory redundancies	Number	Cost of compulsory redundancies
Less than £10,000	14	73,125	25	108,920
£10,000-£25,000	3	63,161	13	188,290
£25,001-£50,000	4	167,808	13	497,455
£50,001-£100,000	0	0	9	628,095
£100,001 - £150,000	0	0	7	816,148
£150,001 - £200,000	1	170,234	2	339,815
>£200,000	1	425,747	1	215,372
	<b>23</b>	<b>900,075</b>	<b>70</b>	<b>2,794,095</b>

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.

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.



## 9.4

### 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](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

#### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as at 31 March 2015, updated to 31 March 2016 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

## 10 Better Payment Practice Code

### 10.1

#### Measure of compliance

	2015/16		2014/15	
	Number	£000s	Number	£000s
<b>Non-NHS Payables</b>				
Total non-NHS trade invoices paid in the year	<b>189,273</b>	<b>816,145</b>	146,575	623,787
Total non-NHS trade invoices paid within target	<b>141,013</b>	<b>692,024</b>	128,304	551,916
% of Non-NHS trade invoices paid within target	<b>74.50%</b>	<b>84.79%</b>	87.53%	88.48%
<b>NHS Payables</b>				
Total NHS trade invoices paid in the year	<b>3,169</b>	<b>113,208</b>	1,845	77,988
Total NHS trade invoices paid within target	<b>1,979</b>	<b>98,996</b>	1,658	73,557
% of NHS trade invoices paid within target	<b>62.45%</b>	<b>87.45%</b>	89.86%	94.32%

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.

### 10.2

#### The Late Payment of Commercial Debts (Interest) Act 1998

Amounts included in finance costs from claims made under this legislation was nil 2015/16 (nil in 2014/15).

## 11 Investment Revenue

	2015/16	2014/15
	£000s	£000s
Bank interest	<b>183</b>	134
	<b>183</b>	134

## 12 Other Gains and Losses

	2015/16	2014/15
	£000s	£000s
Gain on disposal of assets held for sale	<b>74</b>	105
Gain on disposal of property, plant and equipment	<b>30,042</b>	1,504
Change in fair value of investment property	<b>0</b>	37
	<b>30,116</b>	1,646

## 13 Finance Costs

	2015/16	2014/15
	£000s	£000s
<b>Interest</b>		
Interest on loans and overdrafts	<b>1,714</b>	138
Interest on obligations under finance leases	<b>828</b>	951
<b>Interest on obligations under PFI contracts:</b>		
- main finance cost	<b>36,550</b>	36,375
- contingent finance cost	<b>18,375</b>	17,610
<b>Total interest expense</b>	<b>57,467</b>	55,074
Provisions - unwinding of discount	<b>228</b>	304
	<b>57,695</b>	55,378

**14.1****Property, plant and equipment**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery equipment	Transport technology	Information technology	Furniture & fittings	Total
	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
<b>Cost or valuation:</b>									
<b>At 1 April 2015</b>	197,790	1,209,546	3,982	43,792	121,304	170	32,000	864	<b>1,609,448</b>
Additions of Assets Under Construction	0	6,255	0	0	6,426	0	3,205	0	<b>26,040</b>
Additions Purchased	0	50	0	1,501	929	0	0	0	<b>15,886</b>
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	286	0	0	0	0	<b>2,480</b>
Additions - Purchases from Government Grants	0	77,338	0	0	0	0	0	0	<b>286</b>
Additions Leased (including PFI/LIFT)	0	1,400	686	(70)	(38,312)	6,809	0	1,669	<b>0</b>
Transferred from investment property	0	29,904	(10,556)	(919)	0	0	0	0	<b>0</b>
Reclassifications	(8,050)	(218,506)	1,412	0	0	0	0	0	<b>(19,525)</b>
Disposals other than for sale	(40,805)	(67,927)	0	0	0	0	0	0	<b>(257,899)</b>
Upward revaluation/positive indexation	(18,318)	<b>1,026,790</b>	<b>4,405</b>	<b>33,307</b>	<b>135,468</b>	<b>170</b>	<b>36,874</b>	<b>864</b>	<b>1,369,895</b>
<b>At 31 March 2016</b>	<b>132,017</b>	<b>1,026,790</b>	<b>4,405</b>	<b>33,307</b>	<b>68,229</b>	<b>36</b>	<b>14,259</b>	<b>396</b>	<b>1,279,439</b>
<b>Depreciation</b>									
<b>At 1 April 2015</b>	0	181,172	600	0	49,602	107	16,868	425	<b>248,774</b>
Reclassifications	0	0	0	0	0	0	0	0	<b>0</b>
Disposals other than for sale	0	(191)	(18)	0	0	0	0	0	<b>(209)</b>
Reversal of depreciation from year-end revaluation	0	(210,019)	(757)	0	0	0	0	0	<b>(210,776)</b>
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	<b>0</b>
Charged During the Year	0	29,038	175	0	17,637	27	5,747	43	<b>52,667</b>
<b>At 31 March 2016</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>67,239</b>	<b>134</b>	<b>22,615</b>	<b>468</b>	<b>90,456</b>
<b>Net Book Value at 31 March 2016</b>	<b>132,017</b>	<b>1,026,790</b>	<b>4,405</b>	<b>33,307</b>	<b>68,229</b>	<b>36</b>	<b>14,259</b>	<b>396</b>	<b>1,279,439</b>
<b>Asset financing:</b>									
Owned - Purchased	132,017	289,464	3,137	31,520	50,552	0	14,230	396	<b>521,316</b>
Owned - Donated	0	25,931	328	1,501	16,493	36	29	0	<b>44,318</b>
Owned - Government Granted	0	410	0	286	0	0	0	0	<b>696</b>
Held on finance lease	0	10,372	940	0	1,184	0	0	0	<b>12,496</b>
On-SOFP PFI contracts	0	700,613	0	0	0	0	0	0	<b>700,613</b>
<b>Total at 31 March 2016</b>	<b>132,017</b>	<b>1,026,790</b>	<b>4,405</b>	<b>33,307</b>	<b>68,229</b>	<b>36</b>	<b>14,259</b>	<b>396</b>	<b>1,279,439</b>

## 14.2

### Property, plant and equipment

										Total
			Buildings	Dwellings		Assets under construction & payments on account	Plant & machinery equipment	Transport technology	Information & fittings	
			£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
<b>At 1 April 2015</b>			67,386	156,435	304	2,698	0	0	0	226,823
Movements			(44,521)	(8,030)	2,103	(2,698)	0	0	0	(53,146)
<b>At 31 March 2016</b>			<b>22,865</b>	<b>148,405</b>	<b>2,407</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>173,677</b>
<b>Additions to assets under construction in 2015/16</b>										
Buildings excl dwellings						25,127				
Plant & machinery						913				
<b>Balance as at YTD</b>			<b>0</b>	<b>0</b>	<b>0</b>	<b>26,040</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>



## 14.3

### Property, plant and equipment

	Buildings Land excluding dwelling dwelling		Assets under construction & payments on account		Plant & machinery equipment		Transport information technology & fittings		Furniture		Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
<b>Cost or valuation:</b>											
At 1 April 2014	181,466	1,004,623	3,979	35,472	108,384	104	26,451	864	1,361,343		23,411
Additions of assets under construction				23,411							
Additions purchased	0	157,096	0	0	9,718	0	3,238	0	170,052		
Additions - non cash donations (i.e. physical assets)	0	0	0	0	1,719	66	54	0	1,839		
Reclassifications	0	11,766	0	(15,763)	1,740	0	2,257	0	0	0	0
Disposals other than for sale	(2,965)	(5,211)	0	0	(257)	0	0	0	0	(8,433)	
Revaluation	19,974	42,375	72	672	0	0	0	0	0	63,093	
Impairments/negative indexation charged to reserves	(685)	(1,103)	(69)	0	0	0	0	0	0	(1,857)	
<b>At 31 March 2015</b>	<b>197,790</b>	<b>1,209,546</b>	<b>3,982</b>	<b>43,792</b>	<b>121,304</b>	<b>170</b>	<b>32,000</b>	<b>864</b>	<b>1,609,448</b>		
<b>Depreciation</b>											
At 1 April 2014	0	98,548	161	0	33,448	34	10,833	298	143,322		
Disposals other than for sale	0	(176)	0	(248)	0	0	0	0	0	(424)	
Impairments/negative indexation charged to operating expenses	0	44,847	177	0	0	0	0	0	0	45,024	
Charged during the year	0	37,953	262	16,402	73	6,035	127	60,852			
<b>At 31 March 2015</b>	<b>0</b>	<b>181,172</b>	<b>600</b>	<b>0</b>	<b>49,602</b>	<b>107</b>	<b>16,868</b>	<b>425</b>	<b>248,774</b>		
<b>Net Book Value at 31 March 2015</b>	<b>197,790</b>	<b>1,028,374</b>	<b>3,382</b>	<b>43,792</b>	<b>71,702</b>	<b>63</b>	<b>15,132</b>	<b>439</b>	<b>1,360,674</b>		
<b>Asset financing:</b>											
Owned - purchased	197,790	281,915	1,069	23,543	49,916	17	15,016	429	569,695		
Owned - donated	0	25,083	1,280	1	19,983	46	116	10	46,519		
Owned - government granted	0	541	0	0	0	0	0	0	541		
Held on finance lease	0	11,226	1,033	0	1,803	0	0	0	14,062		
On-SOFP PFI contracts	0	709,609	0	20,248	0	0	0	0	729,857		
<b>Total at 31 March 2015</b>	<b>197,790</b>	<b>1,028,374</b>	<b>3,382</b>	<b>43,792</b>	<b>71,702</b>	<b>63</b>	<b>15,132</b>	<b>439</b>	<b>1,360,674</b>		

**14.4****Property, plant and equipment - donated assets**

The donor of the donated assets in 2015/16 is the Barts and The London Charity. Income for the purchase of donated assets is shown in the statement of comprehensive income in the year of purchase. Previously the income was transferred to a donation reserve and released to the statement of comprehensive income as the donated asset was depreciated. The change to the treatment of donated assets was due to the accounting policy change outlined in the Treasury FREM for 2011/12.

**14.5****Property, plant and equipment - revaluation**

Land and Building assets were revalued at 31st March 2016. 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.

**15 Intangible non-current assets****15.1****Intangible non-current assets**

	<b>IT - in-house &amp; 3rd party software</b>	<b>Computer Licenses</b>	<b>Total</b>
	<b>£000's</b>	<b>£000's</b>	<b>£000's</b>
<b>At 1 April 2015</b>	<b>670</b>	<b>1,803</b>	<b>2,473</b>
Additions purchased	0	186	186
Additions - non cash donations (i.e. physical assets)	0	19	19
<b>At 31 March 2016</b>	<b>670</b>	<b>2,008</b>	<b>2,678</b>

**Amortisation**

<b>At 1 April 2015</b>	<b>613</b>	<b>488</b>	<b>1,101</b>
Charged during the year	28	321	349
<b>At 31 March 2016</b>	<b>641</b>	<b>809</b>	<b>1,450</b>
<b>Net Book Value at 31 March 2016</b>	<b>29</b>	<b>1,199</b>	<b>1,228</b>

**Asset Financing: Net book value at 31 March 2016 comprises:**

Purchased	29	1,182	1,211
Donated	0	17	17
<b>Total at 31 March 2016</b>	<b>29</b>	<b>1,199</b>	<b>1,228</b>

**15.2****Intangible non-current assets prior year**

	IT - in-house & 3rd party software	Computer Licenses	Total
	£000's	£000's	£000's
Cost or valuation:			
At 1 April 2014	670	1,724	2,394
Additions - purchased	0	79	79
<b>At 31 March 2015</b>	<b>670</b>	<b>1,803</b>	<b>2,473</b>
Amortisation			
At 1 April 2014	383	289	672
Charged during the year	230	199	429
<b>At 31 March 2015</b>	<b>613</b>	<b>488</b>	<b>1,101</b>
Net book value at 31 March 2015	57	1,315	1,372

**16 Analysis of impairments and reversals recognised**

	31 March 2016	31 March 2015
	£000's	£000's
Impairments and reversals taken to SoCI		
Other	<b>53,992</b>	38,660
Changes in market price	<b>32,253</b>	6,364
<b>Total charged to SOCI</b>	<b>86,245</b>	<b>45,024</b>
<b>Donated and gov. granted assets, included above</b>	<b>£000s</b>	<b>£000s</b>
Donated and government granted asset impairments charged to SOCI	<b>39</b>	<b>0</b>

**17 Investment property**

	31 March 2016	31 March 2015
	£000's	£000's
<b>At fair value</b>		
<b>Balance at 1 April 2015</b>	<b>2,086</b>	2,049
Gain from Fair Value Adjustments	0	37
Reclassification to "property, plant and equipment"	(2,086)	0
<b>Balance at 31 March 2016</b>	<b>0</b>	<b>2,086</b>

## 18 Commitments

### 18.1

#### Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000's	£000's
Property, plant and equipment	1,302	729
<b>Total</b>	<b>1,302</b>	<b>729</b>

## 19 Inventories

	Drugs	Consumables	Energy	Total
	£000s	£000s	£000s	£000s
<b>Balance at 1 April 2015</b>	<b>7,413</b>	<b>10,797</b>	<b>291</b>	<b>18,501</b>
Additions	155,535	64,751	147	220,433
Inventories recognised as an expense in the period	(155,259)	(61,776)	(29)	(217,064)
<b>Balance at 31 March 2016</b>	<b>7,689</b>	<b>13,772</b>	<b>409</b>	<b>21,870</b>

### 20.1

#### Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS receivables - revenue	61,370	116,185	0	0
NHS prepayments and accrued income	11,558	6,750	0	0
Non-NHS receivables - revenue	47,369	42,130	0	0
Non-NHS prepayments and accrued income	8,316	6,364	0	0
PDC Dividend prepaid to DH	5,009	1,105		
Provision for the impairment of receivables	(18,698)	(26,971)	0	0
VAT	16,465	10,378	0	0
PFI and PPP arrangements prepayments and accrued income	100	100	3,125	11,153
Other receivables	1,067	1,038	0	0
<b>Total</b>	<b>132,556</b>	<b>157,079</b>	<b>3,125</b>	<b>11,153</b>
<b>Total current and non current</b>	<b>135,681</b>	<b>168,232</b>		
<b>Included in NHS receivables are prepaid pension contributions:</b>		<b>0</b>		

**20.2****Receivables past their due date  
but not impaired**

	<b>31 March 2016</b>	31 March 2015
	£000's	£000's
By up to three months	<b>6,026</b>	3,122
By three to six months	<b>3,547</b>	1,681
By more than six months	<b>10,799</b>	3,186
<b>Total</b>	<b>20,372</b>	<b>7,989</b>

**20.3****Provision for impairment of receivables**

	<b>2015/16</b>	2014/15
	£000's	£000's
<b>Balance at 1 April 2015</b>	<b>(26,971)</b>	(24,788)
Amount written off during the year	<b>1,134</b>	390
Amount recovered during the year	<b>15,729</b>	11,698
Increase in receivables impaired	<b>(8,590)</b>	(14,271)
<b>Balance at 31 March 2016</b>	<b>(18,698)</b>	<b>(26,971)</b>

**21 Cash and cash equivalents**

	<b>31 March 2016</b>	31 March 2015
	£000's	£000's
<b>Opening balance</b>	<b>3,109</b>	30,478
Net change in year	<b>108</b>	(27,369)
<b>Closing balance</b>	<b>3,217</b>	<b>3,109</b>

**Made up of**

Cash with Government Banking Service	<b>3,099</b>	3,017
Commercial banks	<b>87</b>	64
Cash in hand	<b>31</b>	28
<b>Cash and cash equivalents as in statement of financial position</b>	<b>3,217</b>	<b>3,109</b>
Third party assets - bank balance (not included above)	<b>86</b>	85



## 22 Trade and other payables

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS payables - revenue	<b>8,813</b>	10,109	<b>0</b>	0
NHS accruals and deferred income	<b>19,775</b>	15,076	<b>0</b>	0
Non-NHS payables - revenue	<b>54,530</b>	41,648	<b>0</b>	0
Non-NHS payables - capital	<b>7,156</b>	19,363	<b>0</b>	0
Non-NHS accruals and deferred income	<b>88,281</b>	82,320	<b>0</b>	0
Social security costs	<b>216</b>	830		
Accrued Interest on DH Loans	<b>83</b>			
Tax	<b>170</b>	764		
Other	<b>6,310</b>	6,481	<b>0</b>	0
<b>Total</b>	<b>185,334</b>	176,591	<b>0</b>	0
<b>Total payables (current and non-current)</b>	<b>185,334</b>	<b>176,591</b>		

**Included above:**

Outstanding pension contributions at the year end	<b>172</b>	<b>0</b>
---	------------	----------

## 23 Borrowings

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
Loans from Department of Health	<b>2,806</b>	5,048	<b>134,629</b>	7,634
PFI liabilities: Main liability	<b>21,601</b>	19,153	<b>1,061,886</b>	1,021,659
Finance lease liabilities	<b>414</b>	393	<b>12,327</b>	12,741
<b>Total</b>	<b>24,821</b>	24,594	<b>1,208,842</b>	1,042,034
<b>Total borrowings (current and non-current)</b>	<b>1,233,663</b>	<b>1,066,628</b>		

### Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH	Other	Total
	£000s	£000s	£000s
0-1 Years	2,806	22,015	<b>24,821</b>
1 - 2 Years	2,806	24,962	<b>27,768</b>
2 - 5 Years	131,823	73,122	<b>204,945</b>
Over 5 Years	0	976,129	<b>976,129</b>
<b>TOTAL</b>	<b>137,435</b>	<b>1,096,228</b>	<b>1,233,663</b>

## 24 Deferred income

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
<b>Opening balance at 1 April 2015</b>	<b>16,955</b>	16,798	<b>0</b>	0
Deferred revenue addition	<b>13,772</b>	16,955	<b>0</b>	0
Transfer of deferred revenue	<b>(16,843)</b>	(16,798)	<b>0</b>	0
<b>Current deferred income at 31 March 2016</b>	<b>13,884</b>	16,955	<b>0</b>	0
 <b>Total deferred income (current and non-current)</b>	 <b>13,884</b>	 <b>16,955</b>		

The Trust receives income for Research and Development. As research projects can be for more than one financial year, the income that has been received for spend in future years is deferred.

In 2015/16, £5,995k of Research and Development income was deferred (£10,243k in 2014/15).

## 25 Finance lease obligations as lessee

### Amounts payable under finance leases (Buildings)

	Minimum lease payments		Present value of minimum lease payments	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
Within one year	<b>1,216</b>	1,216	<b>414</b>	389
Between 1 and 5 years	<b>4,866</b>	4,866	<b>1,933</b>	1,818
After 5 years	<b>16,097</b>	17,313	<b>10,394</b>	10,923
Less future finance charges	<b>(9,438)</b>	(10,265)		
Minimum lease payments / present value of minimum lease payments	<b>12,741</b>	13,130	<b>12,741</b>	13,130

Included in:

Current borrowings	<b>414</b>	389
Non-current borrowings	<b>12,327</b>	12,741
	<b>12,741</b>	13,130

## 26 Provisions

	Total £000s	Early Departure Costs £000s	Legal Claims £000s	Other £000s	Redundancy £000s
Balance at 1 April 2015	<b>23,888</b>	16,009	1,369	5,808	702
Arising during the year	<b>2,877</b>	1,027	1,074	450	326
Utilised during the year	<b>(4,826)</b>	(1,356)	(117)	(2,843)	(510)
Reversed unused	<b>(4,903)</b>	(429)	(1,121)	(2,985)	(368)
Unwinding of discount	<b>228</b>	208	0	20	0
Change in discount rate	<b>(85)</b>	(85)	0	0	0
<b>Balance at 31 March 2016</b>	<b>17,179</b>	<b>15,374</b>	<b>1,205</b>	<b>450</b>	<b>150</b>

Expected Timing of Cash Flows:

No later than 1 year	4,162	2,357	1,205	450	150
Later than 1 year, not later than 5 yrs	9,428	9,428	0	0	0
Later than 5 years	3,589	3,589	0	0	0

Amount Included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:

**As at 31 March 2016** 482,465  
**As at 31 March 2015** 266,657

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

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

## 27 Contingencies

	31 March 2016 £000s	31 March 2015 £000s
<b>Contingent liabilities</b>		
NHS Litigation Authority legal claims	<b>(154)</b>	(157)
<b>Net value of contingent liabilities</b>	<b>(154)</b>	(157)



## **28 PFI additional information**

### **28.1**

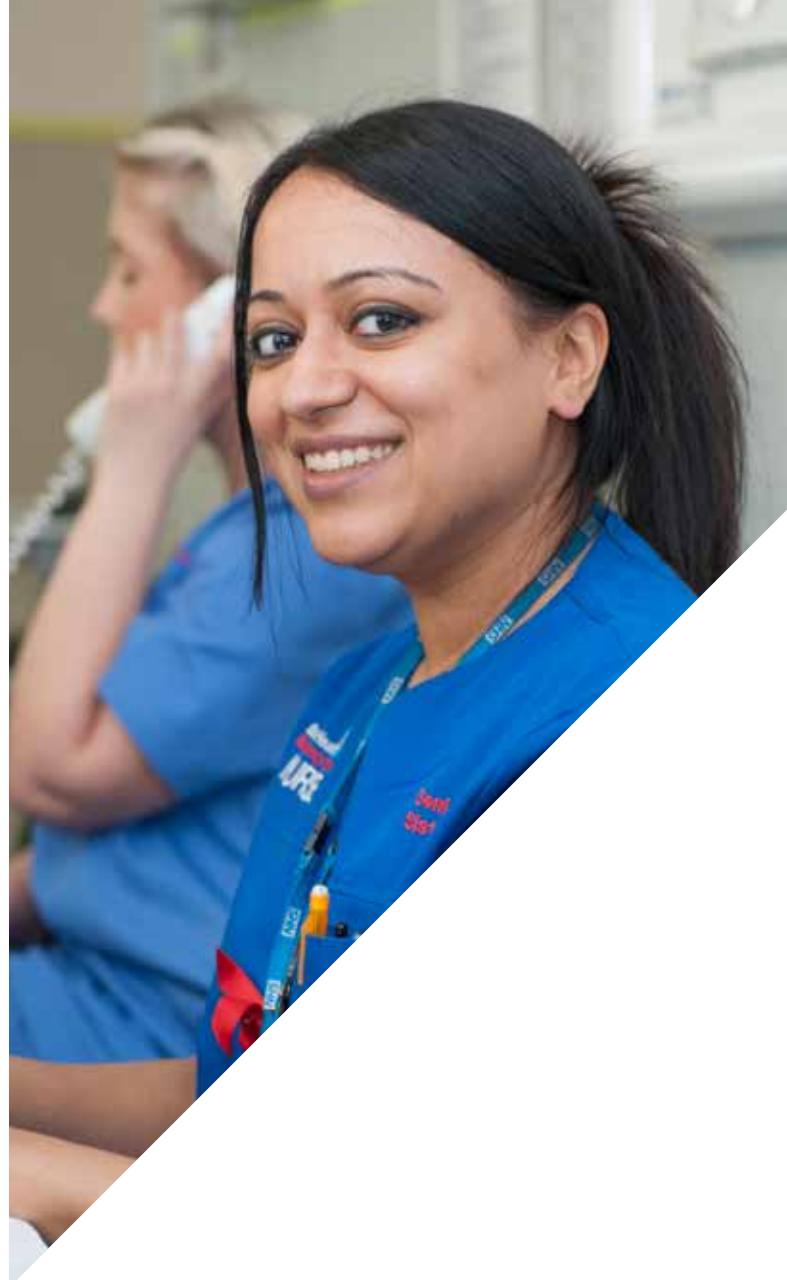
#### **Barts and The Royal London Hospitals**

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

Under the PFI contract, which ends on 25th April 2048, the Trust's PFI provider has constructed two new hospitals and 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 3.2755% (excluding contingent rent) or 7.5% (including estimated contingent rent in note 28.3).

The first phases of Barts (phase 1A & 1B) were commissioned in March 2010, and the second phases (phase 2A & 2B) were commissioned in September 2014. The remaining phase of Barts was commissioned in March 2016 (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.



### **28.2**

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

	Total £000s	Lifecycle Replacement £000s	Services Received £000s
Within 1 year	<b>53,198</b>	4,761	48,437
Between 1 and 5 years	<b>226,302</b>	24,382	201,920
Later than 5 years	<b>2,456,554</b>	420,016	2,036,538
<b>Total</b>	<b>2,736,054</b>	<b>449,159</b>	<b>2,286,895</b>

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

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

	Total £000s	Repayment of borrowings £000s	Interest £000s	Contingent rent £000s
Within 1 year	<b>74,591</b>	21,482	34,075	19,034
Between 1 and 5 years	<b>317,614</b>	93,532	128,807	95,275
Later than 5 years	<b>3,044,917</b>	938,552	481,383	1,624,982
<b>Total</b>	<b>3,437,122</b>	<b>1,053,566</b>	<b>644,265</b>	<b>1,739,291</b>

There are no future phases for the Barts and the Royal London PFI Scheme as it has been handed over to the Trust in full.

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

**28.4****Newham University Hospital**

The Newham University Hospital PFI scheme is managed through a contract with John Laing (Healthcare Support Newham Limited - HSNL) which ends on 31st March 2039. At the conclusion of the contract, ownership of the assets will revert to the Trust. Under IFRIC 12, the asset is treated as an asset of the Trust with an internal rate of return on the finance lease of 11.198% (excluding contingent rent) or 15% (including estimated contingent rent in note 28.6).

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

	Total £000s	Lifecycle Replacement £000s	Services Received £000s
Within 1 year	<b>12,150</b>	920	11,230
Between 1 and 5 years	<b>49,357</b>	1,830	47,527
Later than 5 years	<b>301,179</b>	21,253	279,926
<b>Total</b>	<b>362,686</b>	<b>24,003</b>	<b>338,683</b>

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

**28.6**
**Newham University Hospital PFI Scheme  
committed future charges: provision of buildings**

	Total	Repayment of borrowings	Interest	Contingent rent
	£000s	£000s	£000s	£000s
Within 1 year	<b>4,492</b>	119	3,259	1,114
Between 1 and 5 years	<b>21,476</b>	2,619	12,553	6,304
Later than 5 years	<b>115,700</b>	27,183	34,760	53,757
<b>Total</b>	<b>141,668</b>	<b>29,921</b>	<b>50,572</b>	<b>61,175</b>

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

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



## 29 PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

### Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2015/16 £000s	2014/15 £000s
Total charge to operating expenses in year - Off SoFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	<b>66,292</b>	69,872
<b>Total</b>	<b>66,292</b>	69,872

### Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

	2015/16 £000s	2014/15 £000s
No later than 1 year	<b>59,529</b>	61,074
Later than 1 year, not later than 5 yrs.	<b>252,067</b>	237,868
Later than 5 years	<b>2,328,216</b>	2,297,020
<b>Total</b>	<b>2,639,812</b>	2,595,962

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make materially different from those which the Trust is committed to make during the next year. The likely financial effect of this is:

### Imputed "finance lease" obligations for on SOFP PFI contracts due

	2015/16 £000s	2014/15 £000s
No later than 1 year	<b>58,935</b>	55,036
Later than 1 year, not later than 5 yrs.	<b>237,512</b>	225,196
Later than 5 years	<b>1,481,877</b>	1,453,505
<b>Subtotal</b>	<b>1,778,324</b>	1,733,737
Less: Interest element	<b>(694,837)</b>	(692,925)
<b>Total</b>	<b>1,083,487</b>	1,040,812

### Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due

	2015/16 £000s	2014/15 £000s
<b>Analysed by when PFI payments are due</b>		
No later than 1 year	<b>21,601</b>	53,538
Later than 1 year, not later than 5 yrs.	<b>96,151</b>	200,122
Later than 5 years	<b>965,735</b>	787,152
<b>Total</b>	<b>1,083,487</b>	1,040,812

### Number of on SOFP PFI Contracts

Total Number of on PFI contracts	2
Number of on PFI contracts which individually have a total commitments value in excess of £500m	2

### 30 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2015/16 Expenditure	2014/15 Expenditure
	£000s	£000s
<b>Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI)</b>		
Depreciation charges	16,315	15,912
Interest Expense	36,550	36,375
Impairment charge - AME	59,424	38,660
Other Expenditure	18,375	17,610
Impact on PDC dividend payable	(13,895)	(12,596)
<b>Total IFRS Expenditure (IFRIC12)</b>	<b>116,769</b>	<b>95,961</b>
Revenue consequences of PFI schemes under UK GAAP / ESA95	(72,445)	(69,668)
<b>Net IFRS change (IFRIC12)</b>	<b>44,324</b>	<b>26,293</b>
<b>Capital Consequences of IFRS : PFI and other items under IFRIC12</b>		
Capital expenditure 2015/16	77,338	148,872
UK GAAP capital expenditure 2015/16 (Reversionary Interest)	10,284	9,773

	2015/16	
	Income / Expenditure IFRIC 12	Income/ Expenditure ESA 10
	£000s	£000s
<b>Revenue costs of IFRS12 compared with ESA10</b>		
Depreciation charges	16,315	
Interest Expense	36,550	
Impairment charge - AME	59,424	
Impairment charge - DEL	0	
<b>Other Expenditure</b>		
Service charge	0	72,445
Contingent rent	18,375	
Lifecycle	0	
Impact on PDC dividend payable	(13,895)	
<b>Total revenue cost under IFRIC12 vs. ESA10</b>	<b>116,769</b>	<b>72,445</b>
Revenue receivable from subleasing	0	0
<b>Net revenue cost/(income) under IFRIC12 vs. ESA10</b>	<b>116,769</b>	<b>72,445</b>

## 31 Financial Instruments

### 31.1

#### Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the 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 the NHS Improvement Authority. 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.

#### 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 31 March 2016 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 clinical commissioning groups, 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.

### 31.2

#### Financial Assets

	2015/16	2014/15
	£000s	£000s
Receivables - NHS	72,928	122,935
Receivables - non-NHS	56,752	49,532
Cash at bank and in hand	3,217	3,109
<b>Total</b>	<b>132,897</b>	175,576

### 31.3

#### Financial Liabilities

	2015/16	2014/15
	£000s	£000s
NHS payables	28,588	25,185
Non-NHS payables	156,277	149,812
Other borrowings	137,435	12,682
PFI & finance lease obligations	1,096,228	1,053,946
<b>Total</b>	<b>1,418,528</b>	1,241,625

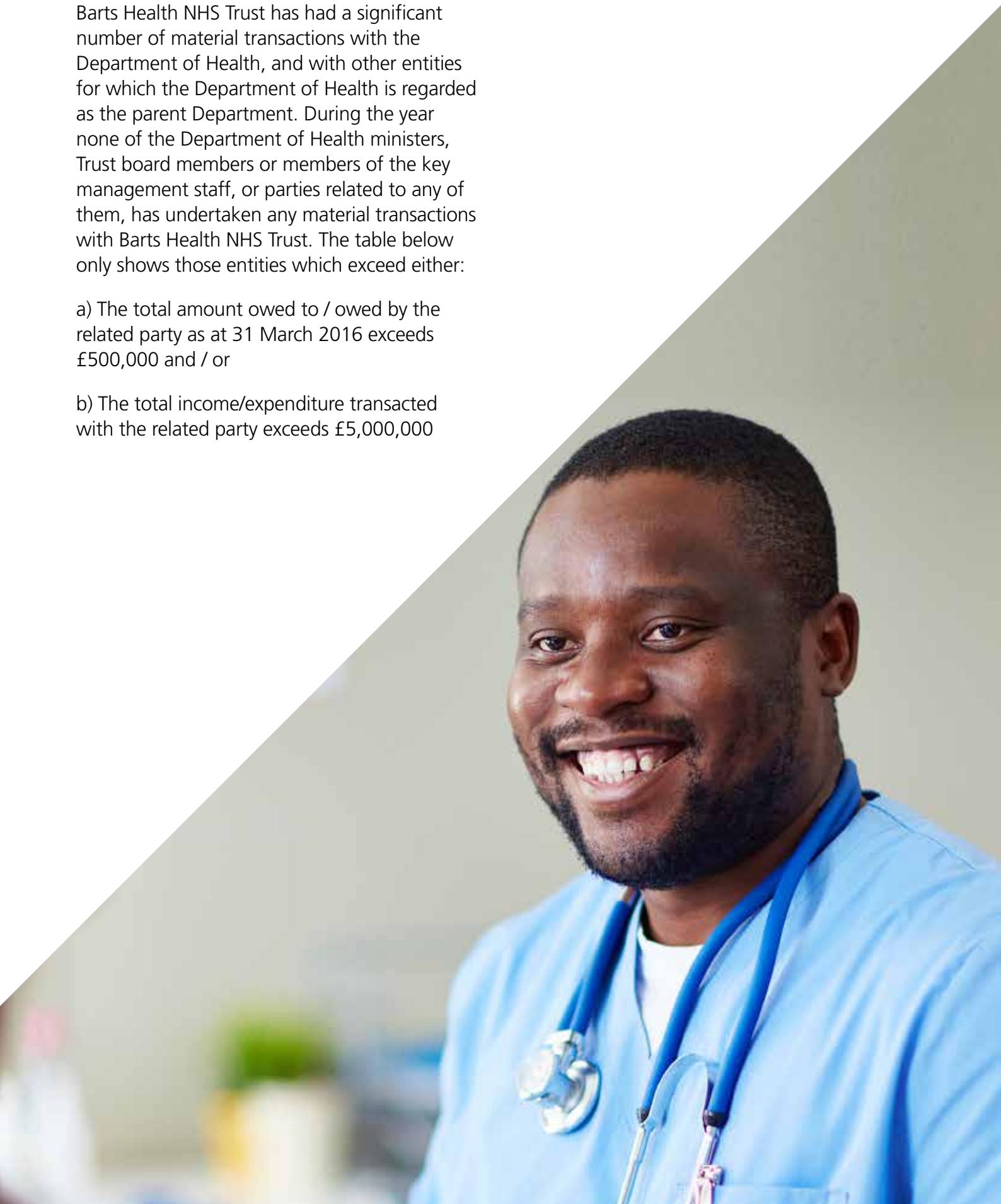
## 32 Events after the end of the reporting period

There are no events after the end of the reporting period that require disclosure.

### **33 Related party transactions**

Barts Health NHS Trust has had a significant number of material transactions with the Department of Health, and with other entities for which the Department of Health is regarded as the parent Department. During the year none of the Department of Health ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Barts Health NHS Trust. The table below only shows those entities which exceed either:

- a) The total amount owed to / owed by the related party as at 31 March 2016 exceeds £500,000 and / or
- b) The total income/expenditure transacted with the related party exceeds £5,000,000



**33.1****Amounts owed to / from related parties**

	Amounts owed to related party		Amounts due from related party	
	2015/16		2014/15	
	£000	£000	£000	£000
Barking and Dagenham CCG	434	435	224	364
Barking, Havering & Redbridge NHS Trust	2,184	561	940	562
Barnet CCG	1	28	632	0
Basildon and Brentwood CCG	0	0	4,405	1,861
Camden CCG	252	399	1,216	0
Castle Point and Rochford CCG	44	0	0	1,295
City and Hackney CCG	40	40	1,742	4,165
Common Council of the City of London	1,146	604	0	252
Community Health Partnerships	1,009	1,943	0	0
Department of Energy and Climate Change	587	631	0	0
Department of Health	140	0	444	519
East and North Hertfordshire CCG	0	0	636	496
East London NHS FT	1,986	1,523	3,908	3,049
Enfield CCG	4	4	1,509	135
Great Ormond Street Hospital for Children	592	401	614	180
Haringey CCG	8	244	1,541	0
Havering CCG	19	19	113	214
Health Education England	523	1,072	1,427	3,968
Herts Valleys CCG	0	0	1,469	799
HM Revenue and Customs Trust Statement	386	1,594	16,465	10,653
Homerton University Hospital NHS FT	1,619	1,105	1,760	1,623
Islington CCG	4	4	1,336	100
Kings College Hospital NHS Foundation Trust	78	25	362	506
Mid Essex CCG	0	0	1,560	1,401
Moorfields Eye Hospital NHS FT	357	264	692	144
National Health Service Pension Scheme	612	4,756	0	0
Newham CCG	2,292	2,222	3,000	12,356
Newham London Borough Council	676	1,340	412	1,626
NHS Blood and Transplant	1,509	833	0	105
NHS Business Services Authority	1,176	438	0	0
NHS England	26	362	14,919	50,305
NHS Litigation Authority	429	37	0	22
NHS Property Services	2,696	1,733	0	0
North East Essex CCG	0	0	90	614
Redbridge CCG	585	585	1,119	1,567
Royal Free London NHS FT	1,377	275	2,346	162
Southend CCG	0	0	816	1,122
Thurrock CCG	0	0	2,305	1,372
Tower Hamlets CCG	1,261	1,214	7,709	16,352
Tower Hamlets London Borough Council	3,438	1,135	1,687	1,645
University College London NHS FT	1,071	1,079	1,444	249
Waltham Forest CCG	961	911	3,134	6,702
Waltham Forest London Borough Council	623	255	230	518
West Essex CCG	0	2	1,280	2,986

**33.2****Income / expenditure with related parties**

	Income from related party		Expenditure with related party	
	2015/16		2014/15	
	£000	£000	£000	£000
Barking and Dagenham CCG	19,930	18,652	0	0
Barking, Havering & Redbridge NHS Trust	1,039	1,426	3,057	2,097
Barnet CCG	2,890	1,426	0	0
Basildon and Brentwood CCG	4,784	3,798	0	0
Camden CCG	2,419	1,116	68	184
Castle Point and Rochford CCG	2,095	2,018	0	0
City and Hackney CCG	23,378	28,438	0	0
Common Council of the City of London	1	98	431	2,152
Community Health Partnerships	0	0	2,424	2,767
Department of Energy and Climate Change	0	0	0	631
Department of Health	52,832	36,414	0	9
East and North Hertfordshire CCG	2,813	2,312	0	0
East London NHS FT	6,586	4,327	1,458	2,355
Enfield CCG	5,569	4,049	0	0
Great Ormond Street Hospital for Children	877	674	3,009	2,479
Haringey CCG	5,262	3,524	0	0
Havering CCG	11,224	10,759	0	0
Health Education England	83,045	85,374	230	37
Herts Valleys CCG	1,944	1,127	0	0
HM Revenue and Customs Trust Statement	0	0	52,707	49,344
Homerton University Hospital NHS FT	4,175	4,649	1,087	1,391
Islington CCG	6,050	4,835	0	0
Kings College Hospital NHS Foundation Trust	156	332	87	66
Mid Essex CCG	3,481	4,710	0	0
Moorfields Eye Hospital NHS FT	882	381	1,103	1,360
National Health Service Pension Scheme	0	0	64,369	58,692
Newham CCG	178,855	178,317	78	119
Newham London Borough Council	3,333	4,322	63	1,478
NHS Blood and Transplant	234	257	7,996	8,454
NHS Business Services Authority	0	0	1,503	1,340
NHS England	412,775	408,536	23	315
NHS Litigation Authority	1,677	50	34,725	22,692
NHS Property Services	0	0	2,166	2,001
NHS Trust Development Authority	1,719	0	41	0
North East Essex CCG	2,162	1,695	0	0
Redbridge CCG	60,375	56,664	0	0
Royal Free London NHS FT	8,190	7,757	3,372	1,902
Southend CCG	2,298	1,898	0	0
Thurrock CCG	3,148	2,594	0	0
Tower Hamlets CCG	179,103	190,919	0	0
Tower Hamlets London Borough Council	10,238	9,395	0	7,934
University College London NHS FT	1,757	364	9,024	7,126
Waltham Forest CCG	136,787	135,761	50	50
Waltham Forest London Borough Council	1,678	1,729	289	1,186
West Essex CCG	20,776	18,682	0	2

**33.3****Other related party transactions**

The Trust has incurred costs of up to £329.7k plus VAT, with Maxentius and Co. for some consultancy fees, and for the period that Ian Miller was Chief Financial Officer of the Trust (from 1st February 2015 to 14th June 2015). Ian Miller is a director of the Maxentius and Co..

**34 Losses and special payments**

The total number of losses cases in 2015/16 and their total value was as follows:

	Total value of cases £s	Total number of cases
Losses	1,582,886	473
Special payments	71,644	45
<b>Total losses and special payments</b>	<b>1,654,530</b>	<b>518</b>

The total number of losses cases in 2014/15 and their total value was as follows:

	Total value of cases £s	Total number of cases
Losses	320,609	128
Special payments	125,087	38
<b>Total losses and special payments</b>	<b>445,696</b>	<b>166</b>

**35 Financial performance targets**

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

**35.1****Breakeven performance**

	2015/16 £000s	2014/15 £000s	2013/14 £000s	2012/13 £000s
Turnover	<b>1,342,594</b>	1,319,964	1,288,172	1,324,338
Retained deficit for the year	<b>(223,606)</b>	(133,673)	(112,532)	(49,237)
Adjustment for:				
Adjustments for impairments	<b>86,245</b>	45,024	70,902	44,765
Adjustments for impact of policy change re donated/government grants assets	<b>2,480</b>	9,007	3,360	4,881
Break-even in-year position	<b>(134,881)</b>	<b>(79,642)</b>	<b>(38,270)</b>	<b>409</b>
Break-even cumulative position	<b>(252,384)</b>	<b>(117,503)</b>	<b>(37,861)</b>	<b>409</b>

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

**Materiality test (i.e. is it equal to or less than 0.5%):**

	2015/16 %	2014/15 %	2013/14 %	2012/13 %
Break-even in-year position as a percentage of turnover	<b>-10.05</b>	-6.03	-2.97	0.03
Break-even cumulative position as a percentage of turnover	<b>-18.80</b>	-8.90	-2.94	0.03

**35.2****Capital cost absorption rate**

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

**35.3****External financing**

The Trust is given an external financing limit which it is permitted to undershoot.

	2015/16 £000s	2014/15 £000s
Cash flow financing	93,830	107,265
Finance leases taken out in year	0	0
<b>Charge against external financing limit</b>	<b>93,830</b>	107,265
External financing limit (EFL)	<b>93,998</b>	107,724
<b>Underspend against EFL</b>	<b>168</b>	459

**35.4****Capital resource limit (CRL)**

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015/16 £000s	2014/15 £000s
Gross capital expenditure	122,235	195,655
Less: book value of assets disposed of	(19,316)	(8,008)
Less: capital grants	(286)	0
Less: donations towards the acquisition of non-current assets	(2,499)	(1,839)
<b>Charge against the capital resource limit</b>	<b>100,134</b>	185,808
Capital resource limit	<b>85,993</b>	186,315
<b>(Over)/underspend against the capital resource limit</b>	<b>(14,141)</b>	507

The CRL overspend in 2015/16 was as a result of reduced capital receipts available to fund capital expenditure following the disposal of the London Chest Hospital.

**36 Third party assets**

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

	31 March 2016 £000s	31 March 2015 £000s
Patients' monies	19	22
Consultant's funds	67	63
<b>Third party assets held by the Trust</b>	<b>86</b>	85





©Barts Health NHS Trust  
Switchboard: 020 3416 5000  
[www.bartshealth.nhs.uk](http://www.bartshealth.nhs.uk)

© Copyright Barts Health NHS Trust 2016



BH4616