A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

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Annual Report and Accounts 2019/20

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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1.1 Overview of Performance

As a public benefit corporation, Royal Brompton & Harefield NHS Foundation Trust has been an independent legal entity since 1 June 2009. The powers of the Trust are set out in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012. The Trust governance arrangements are set out in the Constitution of Royal Brompton & Harefield NHS Foundation Trust and include the Trust's membership, the Council of Governors and the Board of Directors.

Royal Brompton & Harefield NHS Foundation Trust is a partnership of two specialist heart and lung hospitals, Royal Brompton Hospital in Chelsea, London and Harefield Hospital near Uxbridge. We are a national centre, the largest specialist heart and lung centre in the country and among the largest in Europe, and as such our patients come from all over the UK (and beyond). The nature of the diseases and conditions we treat means many are with us for a lifetime of specialist care, and we are proud of the life-changing and life-saving treatments that our dedicated clinical teams provide.

Our integrated approach to caring for patients, adults and children, has been replicated around the world and has gained the Trust an international reputation as a leader in heart and lung diagnosis, treatment and research.

In common with other specialist trusts, we treat patients with rare and complex conditions and our clinical teams are skilled in the development and early adoption of new therapies and techniques. We are at the forefront of innovation in healthcare and are often responsible for breakthroughs in treatments, which are then adopted by the NHS and elsewhere.

The following pages constitute the Annual Report of Royal Brompton & Harefield NHS Foundation Trust for the period 1 April 2019 to 31 March 2020, its tenth full year as a Foundation Trust. The information contained in this Report is presented and prepared in accordance with the requirements set out by NHS Improvement in the *NHS Foundation Trust Annual Reporting Manual 2019/20*.

Summary of overall performance

The Trust is committed to the provision of high-quality services for patients of all ages. During 2019/20 the Trust cared for more than 216,000 patients at our outpatient clinics and nearly 40,000 patients of all ages on our wards.

NHS Improvement has continued to keep the Trust in Segment 2 under its NHS Oversight Framework. More information about performance against the NHS Oversight Framework indicators can be found in section 2.5 of this Annual Report.

The financial outcome for the year was a deficit of £1.05m (after a revaluation gain of £1.1m, absorbing an annual leave pressure associated with Covid-19 of £1.0m, and combined Provider Sustainability Funding (PSF) & Financial Recovery Funding (FRF) of £29.8m).

Joint Statement from the Chair and Chief Executive

The aim of our Trust has been to deliver the highest standards of care to patients with heart and lung diseases. We have always been proud of our work, in particular of the commitment and compassion of our staff; and we have not been complacent, continually seeking to improve the quality of our care by continuous improvement and innovation.

The importance of this mission has arguably never been demonstrated so clearly as during the Covid-19 pandemic during the last quarter of 2019-20. As part of an exceptional London-wide and national response, both our hospitals nearly tripled their critical care capacity to accommodate just under 100 ventilated patients. As one of 5 adult ECMO centres in England, at one stage in mid-April Royal Brompton supported 26 Covid-19 patients on ECMO, with our Trust's cumulative ECMO caseload being one of the highest in Europe. This required enormous flexibility and commitment on the part of all our teams, very many of whom took on new and challenging roles to enable us to meet the demand for expert critical care, re-skilling and re-familiarising themselves in a matter of days. For example, at the instruction of NHS England, we consolidated our specialist paediatric heart and lung patients at children's hospitals elsewhere in London, and our paediatric intensive care teams immediately stepped in to support the care of a further 12 ventilated and ECMO-supported Covid-19 adult patients.

The crisis also brought the best out of our clinical and supporting teams in terms of their ability to innovate: a system of webcams was implemented across all critical care areas within a week, with equipment crowdsourced via social media or through the Trust's charity, which both enabled frontline staff to access virtual support from intensivist consultants at any time and also allowed patients in ICU to see and talk to family members who were unable to visit due to infection risks. In addition, ours was one of the most active in Covid-19 research units in the UK, taking the lead nationally in identifying the linkage between blood clotting and Covid-19 related lung failure. We have treated over 200 critically ill Covid-19 patients, the very great majority transferred in from intensive care units across London and Southern England, with more than two-thirds of these patients now discharged back home.

In parallel to its efforts in caring for Covid-19 patients, Harefield was designated one of two centres in London to maintain an essential cardiac surgical and interventional caseload. Cardiac specialists from both our hospitals, and colleagues from GSTT (Guy's and St Thomas' NHS Foundation Trust) and ICHT (Imperial College Healthcare NHS Trust), have worked closely together with pooled waiting lists across all subspecialties. A daily cardiac clinical hub MDT has ensured not only that all patients have been appropriately triaged according to their clinical need but that our theatre, cath lab and recovery capacity has been utilised to a record high level of productivity. The fact that none of the c.150 (at the time of writing) surgical patients discharged home during the last 8 weeks were infected by the Covid-19 virus is testament to the rigorous planning and sheer hard work of all the clinical and supporting teams involved. Even with these demands on staff and capacity we still managed to carry out 21 cardiothoracic transplants during the first 5 months of 2020.

With the acute phase of the pandemic now behind us, the Trust is both in readiness for any further phases of it, while also looking forward to deploying many of the new ways of working developed in response to Covid-19, as part of a transformation of our specialist model of care. Information technology is a big part of this – whether it be the use by all our doctors and specialist nurses of video-conferencing for follow-up outpatient appointments, which increased significantly and successfully during the Covid-19 pandemic; or the launching of apps through which patients on cardiac surgical waiting lists and with long-term chronic diseases such as asthma and pulmonary hypertension can record and report symptoms, enabling better prioritisation of treatment according to clinical need; or the greater degree of self-management by cystic fibrosis patients of their own condition through an app linked to devices (e.g. pulse oximeter, blood pressure cuff, weighing scales) that they use at home. In addition, our clinical service leads across the Trust are also starting to define more clearly how they can deliver existing and emerging sub-specialty services (e.g. in the treatment of cardiogenic shock and

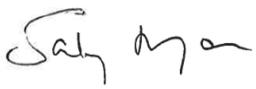
complex aorto-vascular conditions) more effectively across a wider geography in partnership with colleagues from GSTT (Guy's and St Thomas' NHS Foundation Trust) and KCH (King's College Hospital NHS Foundation Trust).

In March 2020 our Board resolved with the GSTT Board to pursue a merger of our two organisations through a joint letter of intent to create a new, expanded academic healthcare system. We believe that this goal is best pursued through a merger, since it will provide clearer governance and a simpler means of pooling resources and driving efficiencies across our combined, integrated services. We believe too that it is the most effective way to secure the longer-term future of our Trust's world-renowned services for the benefit of patients across the UK and beyond. Importantly, our proposed merger was endorsed by the Boards of NHS England and NHS Improvement (NHSE/I) in January 2020. Work is ongoing to prepare a business case for the merger.

Forging a new academic healthcare system presents exciting opportunities for better coordination of care; for developing new treatments; and for building new partnerships in research and multi-professional education. But we also recognise the importance of our history, and the heritage that is embodied in the names of both Harefield and Royal Brompton, which will live on in the merged organisation. So, too, will our commitment to life-long care for patients with heart and lung disease, which has been such a feature of both of our hospitals, and will be enhanced by ever closer collaboration with GSTT and the broader KHP Partnership.

Important though it will be to undertake the process of bringing our organisations together with care and diligence, merger is not an end in itself, but a means to deliver improved services, bespoke facilities and new developments and opportunities for patients and staff alike. Our past and future successes depend in particular upon our staff, and our ability to retain, recruit, invest in and develop the best clinicians, scientists and academics in the fields of heart and lung medicine. If the Covid-19 pandemic has taught us nothing else, it has shone a spotlight on the energy, fortitude, resilience and talent of those who work here, and we are tremendously proud of what all our teams achieved in scaling up to care for a huge surge of acutely ill patients, covid and non-covid. Our staff-members' dedication and resilience are little short of remarkable, especially in the context of their own particular domestic challenges caused by the pandemic. On behalf of our patients and their families, our Board and our Council of Governors, we would like to put on record our sincere and heartfelt gratitude to all our staff for everything they have done.

..... **Robert J Bell** **22 June 2020**
Chief Executive



..... **Baroness (Sally) Morgan of Huyton** **22 June 2020**
Chair

For queries regarding this Annual Report please contact the Trust Secretary, Royal Brompton & Harefield NHS Foundation Trust, Sydney Street, London SW3 6NP 0207 349 7713
www.rbht.nhs.uk

Our Vision and Values

Our vision is to be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world.

The Trust will achieve this vision by:

- improving patient safety and satisfaction
- providing world class specialist treatments that others cannot offer
- bringing innovation to clinical practice through our research partnerships
- attracting, developing and retaining world-class clinical leaders
- investing in services, technologies and facilities to support new service models at both sites.

We are supported in this by active patient and community groups who enthusiastically encourage and challenge us to deliver our goals. To further enhance our vision the Trust in entering into plans to merge with Guys and St Thomas' NHS Foundation Trust.

Our Values
At the heart of any organisation are its values; belief systems that are reflected in thought and behaviour. When values are successfully integrated throughout an organisation, the result is a shared outlook and consequent strength, from performance through the style of communications to the behaviour of employees.

Our three-core patient facing values are:

We care
We believe our patients deserve the best possible treatment for their heart and lung condition in a clean, safe place.

We respect
We believe that patients should be treated with respect, dignity and courtesy and that they should be well informed and involved in decisions about their care. We always have time to listen.

We are inclusive
We believe in making sure our specialist services can be used by everyone who needs them, and we will act on any comments and suggestions which can help us improve the care we offer.

And the following values support us in achieving them:

We believe in our staff
We believe our staff should feel valued and proud of their work and know that we will attract and keep the best people by understanding and supporting them.

We are responsible
We believe in being open about where our money goes, and in making our hospitals environmentally sustainable.

We discover
We believe it is our duty to find and develop new treatments for heart and lung disease, both for today's patients and for future generations.

We share our knowledge
We believe in sharing what we know through teaching so that what we learn can help patients everywhere.

Key issues and risks for the Trust

During 2019/20, the Trust continued to identify a number of issues and risks that could affect the safe and effective delivery of our services. The principal issues addressed in 2019/20 by the Risk & Safety Committee included the Learning from Deaths, 7-Day Services, Infection Prevention and Control and it also undertook various deep dives, including into Emergency Preparedness, Resilience and Response, and Cyber Security (which was also reviewed by the Audit Committee). More information can be found in the Committee's report on page 44. The principal issues addressed by the Audit Committee were the Trust as a 'going concern', reviews conducted by Internal Audit and Reports presented by Counter Fraud, estates risks and IT including cyber security risks, and work to complete the Data Security and Protection toolkit, which has been delayed due to Covid-19. More information can be found in the Committee's report on page 38.

Our Top Trust Risks are listed and covered in greater detail in the Annual Governance Statement (page 86). They include: Estate General Maintenance Backlog, Compliance with External Regulations, Cyber Risks, Project Implementation and Staff Retention and Recruitment. The Trust's Audit Committee and Risk and Safety Committee meet regularly to ensure these risks are monitored, mitigated and addressed; their reports are on page 38 onwards. An assessment of our significant risks is discussed annually by our Board.

The Board Assurance Framework is the framework for identification and management of the issues and programmes that are key to achieving the Trust's strategic objectives, and of the strategic risks that might compromise their achievement. The Board Assurance Framework is described in more detail on page 49 and page 86.

Our position in the healthcare market

A growing market
Heart and lung diseases are the world's biggest killers. Demand for treatment is high and increasing, a result of both increased need and national policy initiatives to meet that need. Long-term survival has improved for many diseases and more patients in later years are being seen by our experts. The adoption of new technologies, such as percutaneous valve programme, also makes possible the treatment of patients who may previously have been too unwell for major surgery.

Our international role
The Trust does not operate in a single, local health economy. Patients are referred by NHS colleagues in other parts of the United Kingdom and from other countries, either though government schemes, or as private patients. The size of the patient population served by the Trust creates the opportunity to undertake research projects on a scale that is attractive to global enterprises and academia. During the year, the Trust developed a service agreement and Memorandum of Understanding to provide consulting services and technical advice to Ain Shams University Hospital, Cairo.

A strong reputation
Our strong reputation, both in the UK and internationally, enables us to maintain and grow our market position, both by developing new interventions and by securing referral patterns through established networks of referring hospitals.

NHS Services
The majority (over 80%) of NHS services provided by the Trust are commissioned by NHS England. The bulk of the remainder is commissioned by Clinical Commissioning Groups (CCGs) which cover the whole population of England. The services commissioned by NHS

England, and those commissioned by CCGs, are commissioner-requested services covered by the Trust's NHS Provider Licence issued by NHS Improvement. Only a small proportion of our services are commissioned by NHS Trusts located close to our hospitals.

Private Patients Unit

The Trust's world class private patient business operates at both Royal Brompton and Harefield Hospitals and has an Outpatient and Diagnostic Centre in Wimpole Street, central London. It operates under the brand name 'Royal Brompton and Harefield Hospitals Specialist Care'. The income derived from private practice is used to support NHS services and infrastructure and is reported as part of the overall financial position.

Whilst 2019/20 continued to be a difficult year for the UK private patient 'market' Private Patients continued to deliver a revenue and activity performance above budget. Both the UK private medical insurance sector and the International markets, particularly the Gulf Cooperation Council (GCC) countries remained challenging with low growth in subscriptions and the decline in patients being referred abroad, respectively. However, both we and other NHS Private Patient Units continue to see higher levels of growth in both these areas compared to the UK's independent sector.

The Private Patient financial result for the last month of the year was impacted by Covid-19 and the ceasing of elective inpatient work at both sites. Whilst some of these factors put pressure on the Trust's private patient revenues, we still achieved good growth during the year from £41.6m the previous year to £45.5m, an increase of 10%. Whilst inpatient activity grew by 13% it was the continuing increase in the numbers of international patients and a more complex case-mix, including the use of implantable devices that drove the revenue growth.

The Wimpole Street Outpatient and Diagnostic centre had a very strong performance both in terms of consultant and diagnostic activity. Whilst the majority of the work continues to be from the Trust's own consultants, external consultants and third-party diagnostic referrals continue to play an important part of the Centre's business. This financial year we saw a revenue growth of 36% at Wimpole Street.

The new facilities and services at Harefield Hospital, opened in October 2017 continue to attract an increasing number of complex cardiac patients from the GCC and central London leading to a growth of 18% and 12% in cardiac surgery and cardiology revenues respectively.

Research and Development

Research is a fundamental component of the Trust's mission: "undertaking pioneering and world class research into heart and lung disease in order to develop new forms of treatment which can be applied to the NHS and beyond".

During 2019/20 our research teams recruited 2,320 patients into 114 research studies of which 1,916 (94 studies) were recruited into NIHR portfolio research. This is a slight reduction on 2018/19 recruitment numbers (2018/19 - 2,100). This reduction was a result of Royal Brompton and Harefield Foundation Trust (RB&HFT) suspending new recruitment into research studies in early March, in response to the Covid-19 pandemic. From March 2020 our research portfolio became focussed on the delivery of Covid-19 research and primarily the establishment urgent public health (UPH) research. Four UPH research studies were open to recruitment before the end of March to help support the national effort in understanding and treating Covid-19. During this period many research staff were redeployed to support the wider Trust response, whilst those who remained supporting research focussed on the establishment and delivery of this new research portfolio

In addition to specific research project many patients consented to donate their tissue for retention within the Trust's three ethically approved Biobanks, with many more participating in the full range of our research endeavours across our public engagement events.

Whilst income generated by research was in line with 2018/19 levels of £6.2m, a material reduction in monthly income was seen in March, following the suspension of new recruitment into research studies.

Other highlights include:

- Trust researchers and their collaborators were successful in securing over £14m of grant funding awarded by a variety of funding bodies including the NIHR, British Lung Foundation, British Heart Foundation, independent charities and the Health Foundation. Of the £14m awarded, £2.6m will be received by the Trust. These monies will be drawn down over several years as the individual grants progress;

- Commercial research income including collaborative research, contract research, consultancy and service agreements contributed around £2.1m to research income at the Trust, A slight increase of £0.1m over 2018/19 levels which is a marked improvement when considering the reduction in research activity from early March.

- The Trust launched its first call for applications to its non-medical fellowship programme funded by Royal Brompton and Harefield Hospitals charities. Following a highly competitive application process three fellowships were awarded to RB&HFT staff across a variety of Trust departments. These awards will allow the recipients to undertake their own research projects and take steps into developing a career in research

- Royal Brompton Cystic Fibrosis (CF) Clinical Trials team celebrated three well-deserved honours at the North West London Clinical Research Awards. The team, which has many years' experience running trials of new medicines and is supported by the Cystic Fibrosis Trust's Clinical Trials Accelerator Platform (CTAP). The Trials Accelerator has given Royal Brompton Hospital the capacity to scale up on clinical trials in partnership with a network of other London CF Centres, which include King's College, Great Ormond Street NHS Foundation Trust and Bart's Health NHS Trust.

- Professor Jane Davies was appointed as an NIHR Senior Investigator. Senior Investigators are among the most prominent researchers funded by the NIHR and the most outstanding leaders of patient-based research within the research community and beyond.

- Nine consultants at Royal Brompton & Harefield NHS Foundation Trust were recognised in the National Heart and Lung Institute's (NHLI's) 2019-20 academic promotions. That is

over half the total number of promotions during 2019/20.

- 2019/20 has seen an increase in collaboration opportunities between King's Health Partners and RB&HFT. Regular engagement events have been held throughout the year to promote engagement across clinical teams and a number of collaborative projects are in development

- During 2019/20, Trust researchers produced 866 peer-reviewed publications, including letters and abstracts, with its academic partners, making the Trust a leading centre for cardiovascular, critical care and respiratory research.

The Trust continues to be an active partner in Imperial College Academic Health Science Centre (AHSC) which has received a re-designation as an AHSC until 2025. Working in collaboration with its partners: Imperial College London; Imperial College Health Care Trust; The Royal Marsden NHS Foundation Trust and The Institute of Cancer Research the Trust actively participates and develops key research and education programmes.

Education

The Trust continues to recognise the value of delivering high-quality, targeted education and is committed to developing and supporting its workforce to provide the highest of standards of patient care.

Providing excellent education and educational support to the future medical workforce are measured nationally by the GMC survey by the numbers of green flags. Paediatrics (respiratory and cardiology) has received the highest numbers of green flags amongst all the specialities within the Trust with Paediatric Cardiology receiving the highest numbers of green flags nationally.

There has been a recent appointment of a new Director of Medical Education, namely Dr Beverly Tsai-Goodman, together with the recruitment of two permanent members of staff within the medical education team to support the delivery of high-level training to junior doctors. This has led to restructuring of the department and relocation of library services.

The Covid-19 outbreak has led to many unprecedented challenges not only clinically but also educationally. Innovative way of providing teaching under very difficult circumstances has successfully allowed the upskilling of the current workforce in a very short period. There were new training opportunities not previously recognised and novel ways of teaching and training.

To meet future challenges of a post Covid-19 era, our focus continues to be on quality improvement, service development and focused support. It acknowledges that an educational plan inspires a culture of continuing professional development which in turn supports the retention of a motivated, knowledgeable, and competent workforce.

We are planning to increase the development of income-generating opportunities and focusing on simulation training which is pivotal in upskilling and maintaining skills within the workforce.

The Trust received £5,761,480 from Heath Education England (HEE) under the annual learning and development agreement (LDA). This includes £148,787 for nursing placements, £344,096 for undergraduate training (short-term placements for 70-90 undergraduate medical students per year) and £3,945,941 for 113 postgraduate placements (a combination of salary support and placement fee, with additional support for trainees working less than full-time).

Going Concern

The Directors have carefully considered the financial position of the Trust and its expected future performance given the demanding financial context in which it is operating and forecast financial deficits.

Key factors have included:

- Anticipated levels of clinical activity and income;
- Anticipated levels of operational costs and planned savings;
- Anticipated additional costs due to Covid-19
- The level of planned capital expenditures, including the new imaging centre, the costs associated with the proposed merger with Guy's and St Thomas' NHS Foundation Trust and costs associated with the collaboration with King's Health Partners;
- The continuing availability of borrowing facilities, including a planned bridging facility to finance the imaging centre; and
- A level 4 incident being declared by NHS England, placing the Trust under the command, control and co-ordination of NHS England, the amended NHS financial regime for 2020/21 (and anticipated receipt of Covid19 related funding), including the guidance received from NHS Improvement on planning and forecasting after the current arrangements end (currently confirmed to the end of July).
- And in extreme circumstances, and subject to approval at the time, the possibility of financial support arrangements from the Department of Health & Social Care to support providers with demonstrable cash needs.

These factors have been the subject of sensitivity analysis against which the Trust's capacity to mitigate downside risks has been assessed.

Having made appropriate enquiries, the Directors have concluded that there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. Accordingly, they continue to adopt the going concern basis in preparing the accounts.

With regard to the Covid-19 pandemic, there is, and remains, significant uncertainty about the likely demand for hospital services and the impact Covid-19 will have on the costs incurred by NHS organisations. In response the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) have announced a series of measures to ensure the continuity of services, including the provision of additional funding to NHS Trusts and Foundation Trusts to cover additional costs/lost income relating to the Covid-19 pandemic. In terms of lost income, this includes addressing the adverse impact of the decrease in the treatment of private patients. Whilst the Trust has made reasonable estimates of the level of additional costs/lost income claimed, and to be claimed, there is no certainty that all of these will be recovered and this has been considered in the sensitivity analysis.

1.2 Performance Analysis

Our performance is regulated by two national bodies: Care Quality Commission and NHS Improvement (NHSI). Performance against Trust key performance indicators is monitored and tracked at Board and Division level.

Trust Financial Performance for 2019/20

The Trust reporting a deficit for the year of £1.05m (2018/19 – deficit of £31.7m) after paying a dividend on Public Dividend Capital of £8.4m (2018/19 - £7.7m).

This result reflects an upward revaluation of investment properties of £1.1m (2018/19 – downward revaluation of £7.6m) and total combined earnings from PSF and FRF of £29.8m (2018/19 - PSF of £10.8m). Furthermore, the Trust incurred a £4.65m revenue impact from Covid-19, of which £4.6m was recognised for financial support - £3.6m additional funding, £1.0m headroom against the control total.

The Trust's planned result for the year was a deficit of £9.85m (or a deficit of £8.2m on a control total basis excluding the financial impact of donated assets and prior year PSF). This equalled the financial target ('control total') set by its regulator NHS Improvement. The Trust has achieved its financial target for 2019/20, with headroom on the control total of up to £1.0m after adjusting for Covid-19 expenditure not covered by additional funding.

As a result of meeting its control total, the Trust earned a total of £29.8m PSF and FRF, comprising: £20.4m core PSF and FRF, £0.3m prior year PSF, and £9.1m incentive FRF. (Incentive FRF is an additional payment over and above core PSF and FRF for those Trusts achieving their financial targets, redistributing available cost PSF and FRF for those Trusts which failed to meet their financial targets in full.)

The financial impact of increased expenditure and reduced income due to Covid-19 during March 2020 was £4.65m, for which we received £3.6m additional funding and a concession of £1.0m for delivery against our control total target.

After stripping out the effects of the investment property revaluation, Covid-19 expenditure reflected in the control total (rather than funded), and all PSF and FRF payments the Trust's underlying deficit was £31.0m (2018/19 - £35.0m).

During 2019/20 the Trust continued with its transformation project (the 'Darwin' programme) designed to re-engineer and streamline many clinical and other processes to enhance and support patient care. Notwithstanding the cessation of external support to the transformation programme, the Trust delivered a Cost Improvement Programme (CIP) of £13.8m (2018/19 - £14.7m) against a plan of £13.7m. Quality impact assessments were undertaken on all changes to clinical pathways to ensure that patient care is not compromised.

The Trust invested a further £21.05m in fixed assets (both tangible and intangible) during the year (2018/19 - £11.85m). These investments reflect the continuing need to expand and improve facilities, equipment and IT systems. Of particular note is expenditure incurred on the Trust's new imaging centre, (£8.9m), which is expected to come on stream in mid-2021. The original intention was to fund the construction of the imaging centre from the proceeds of sale of Chelsea Farmers Market site. However, due to the continuing safeguarding of that property by Transport for London pending a decision on the route of Crossrail 2, the Trust has decided not to sell it at the present time and instead has arranged a £45m bridging loan facility with a financial institution in order to finance the construction of the imaging centre. The loan will be repaid in due course from the proceeds of the Chelsea Farmers Market sale.

The Trust had a positive cash balance of £7.3m at 31 March 2020 (2019 - £15.7m) (after drawing down £10m of the bridging loan facility to finance construction of the Imaging Centre).

It should be noted, in Quarter 1 2020/21 the Trust will receive £19.8m cash relating to 2019/20 performance: £16.2m PSF & FRF and £3.6m to fund Covid-19. A significant factor depressing cash is slow payment for the Trust's Private Patient services by a small number of Middle Eastern debtors.

In 2014 and 2015 the Trust secured loan facilities totalling £50m on favourable terms from the Independent Trust Financing Facility (ITFF). These were fully drawn down by April 2017. The Trust is making annual repayments totalling £4.9m (including interest) which will cease with full repayment of the ITFF loans in 2029. The total outstanding balance at 31 March 2020 was £38.7m (2019 - £42.6m).

The Trust also benefits from a £10m borrowing facility from a private sector banking institution which enabled the fit out in 2015/16 of private patient facilities at Wimpole Street. At 31 March 2020 the outstanding balance on this loan, which will be fully repaid in 2022, amounted to £5.2m (2019 - £7.0m).

Note: The Trust's annual accounts have been prepared under a direction issued by NHS Improvement pursuant to paragraph 24(1) of Schedule 7 to the National Health Service Act 2006.

Trust Performance Against Key Healthcare Targets 2019/20

The NHS England and NHS Improvement's NHS Oversight Framework details a number of performance targets to help oversee NHS Trusts and NHS Foundation Trusts in England, using one consistent approach. The framework is seen as a supportive mechanism to help NHS Improvement identify if trusts need any help or support.

The overarching purpose of the NHS Oversight Framework is for NHS Improvement to be able to help NHS providers achieve and maintain Care Quality Commission ratings of 'Good' or 'Outstanding', meet NHS constitution standards, manage their resources effectively and work alongside local partners.

Our performance against key clinical performance targets within the NHS Oversight Framework is shown in the table below.

NHS Oversight Framework

Indicator	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2019 /20	Target
Clostridium difficile	0	1	0	0	2	1	1	2	0	2	0	0	9	12
MRSA Bacteraemia	0	0	0	0	0	0	1	1	0	0	0	0	2	0
Maximum time of 18 weeks from point of referral to treatment (RTT)	92.3%	94.0%	93.7%	94.3%	93.4%	93.6%	92.8%	92.9%	92.3%	92.9%	93.2%	90.4%	93%	92%
Cancer - 62 day Urgent GP referral to first definitive treatment {09/05/2020 Snap shot from NHSD)	60%	66.7%	58.3%	60%	46.7%	75%	81.8%	66.7%	42.9%	62.5%	42.9%	33.3%	59%	85%

Percentage of wait- times for a diagnostic test > 6 wks	0	1%	0	0	0	0	0	0	0	2%	0	31%	2%	1%
Never Events	0	0	0	0	0	1	0	0	0	0	0	0	1	0

The NHS Oversight Framework was operated by NHS Improvement throughout 2019/20.

During this period:

- The Trust reported 9 cases of Clostridium difficile. 7 of these cases were confirmed as hospital onset – healthcare associated and no cases were identified as being due to lapses of care. Post Infection reviews were undertaken for each case and where learning was identified this was shared across the organisation. This is equivalent to 5.59 infections per 100,000 beddays with no lapses of care identified. (The calculation for *clostridium difficile per 100,000 bed days is as follows: (clostridium difficile cases due to lapses of care / Total bed days over night for 19-20) x 100,000. Therefore:(9 / 160978) x 100,000 = 5.59 infection rate with no lapses of care identified.*

- The Trust reported 2 cases of *Meticillin-resistant Staphylococcus aureus (*MRSA) (the same number as reported in 2018-19). Both cases underwent a Post-Infection Review in partnership with Public Health England. Both cases were identified as hospital onset and learning was shared across the Organisation.

- The Trust reported an average 18-week Referral to Treatment Time (RTT) of 93%, exceeding the national target of 92%.

- The 62-day Urgent GP referral to first definitive treatment national target is for more than 85% of patients to be treated within 62 days of an urgent referral from their GP. As the table above shows, 59% of our patients on this patient pathway were treated in 62-days of their urgent GP referral. It is important to note that the Trust shares this referral pathway with the local receiving hospital and that those patients referred to the Trust have complex clinical needs, treatment of which often lengthens the clinical pathway.

- The Trust did not meet the standard for 6-week diagnostic waits throughout the period. This was due to the impact of Covid-19 in Q4 when diagnostic tests needed to be rearranged and patients also chose to stay at home.

- Never Events are clinical incidents that should never occur. One Never Event was confirmed during the reporting period. This incident related to a piece of retained vascular sheath being located during a procedure.

Link Between KPIs, Risk and Uncertainty

The Trust's Board Assurance Framework forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. In turn, risks and uncertainty arising from performance, in pursuit of our strategy, are addressed as part of the Trust's risk management process.

Each area of service within the Trust is required to regularly update its risk register to ensure that performance issues are both identified and addressed, with corresponding actions and mitigations monitored in a timely manner.

The Trust's Risk and Safety Committee is the committee with umbrella oversight for the Board Assurance Framework. The Committee has regular oversight reviews at all levels, from service level meetings, directorate and divisional reviews and every meeting of the Board of Directors receives reports on risk, quality and performance. This approach ensures that key performance indicators are assessed together within the organisational assurance structure and set within the framework for managing risk and uncertainty ensuring accountability and transparency.

Operational and Financial Performance by Division

Royal Brompton Heart Division (including Children's services)

In 2019/20, Royal Brompton Heart division generated a contribution of £21.7m, (£7.7m) behind plan, based on total income of £149.4m, (£0.9m) behind plan. However, this is an increase on total income with an increase of £9.7m compared to last financial year (2018/19: £139.7m). This end of year position represents an improvement of £0.7m (2018/19: £21.0m).

Total NHS income was £127.9m in 2019/20 (2018/19: £120.5m), representing a 6% increase.

Adult ECMO activity has continued to grow and generated £9.3m of income, £1.2m greater than the previous year and representing growth of 15%, with critical care income only minimally reducing, (1%). Overall, adult services income was ahead of plan by £1.6m.

Children's services income increased by £3.8m to £52.4m (2018/19: £48.6m). However, £1.9m of this increase is from PbR excluded drugs and devices, offset by expenditure; the rest of the increase, £1.8m, is from inpatient activity including critical care. Overall, children's services income was behind plan by (£3.3m), largely from reduced activity in March due to Covid-19 and reduced Paediatric surgery capacity during Q2.

Private patients generated income of £19.7m which was ahead of plan by £0.5m with an improvement in case mix. Inpatient activity was (173) cases behind plan for the year. Despite this, there is an increase in income of £2.0m (2018/19 £17.7m); however, this income is still lower than it was in previous years: 2016/17 generated £21.1m and 2017/18 generated £19.8m.

Pay costs increased by 4% to £79.7m (2018/19: £76.6m), in line with the national pay award and inflation, and better substantive nursing recruitment. The division delivered £1.0m of pay efficiency savings. This was achieved from an improvement in consultant ad-hoc payments, skill-mix improvements in theatres and further agency spend reductions.

Divisional non-pay costs amounted to £48m (2018/19: £42.2m), an increase of £5.8m, with an overspend of (£7.4m). £3.0m of the increase is from PbR excluded drugs and devices, and is offset on NHS income, notably Homecare drug costs. £2.5m of the increase is from cath lab and theatre spend driven from additional consumables, notably EP (electrophysiology) products. The division delivered £1.3m of efficiencies in non-pay, predominantly due to changes in paediatric long-term ventilation including termination of their previous contract for the provision of an online hosted patient pathway.

Harefield Heart Division

In 2019/20, Harefield Heart division generated total income of £112.3m and a contribution of £18.2m, (£1.2m) behind plan. This compares to total income of £101.0m and a contribution of £9.6m in 2018/19.

Total NHS income was £102.4m in 2019/20, representing a 11.7% increase (2018/19: £91.7m). This increase in income was driven by the expansion to Harefield Hospital providing additional inpatient beds and imaging facilities. Notwithstanding this year on year growth, income was lower than plan by (£1.9m) due to the Transplant & Ventricular Assist Device (VAD) contract being behind plan by (£2.3m).

There were 7,461 inpatient and day-case spells in 2019/20 which was behind plan by (359). It was also behind levels achieved in 2018/19 by 119 spells (2018/19: 7,580 spells).

Transplant and VAD activity was lower than in 2018/19. Activity in 2019/20 stood at 23 heart transplants, 40 lung transplants and 15 VAD implants, compared with 36 heart transplants, 49 lung transplants, and 32 Ventricular Assist Device (VAD) implants in 2018/19

Private patients generated income of £9.0m which was £0.1m ahead of plan. Inpatient activity was (154) cases behind plan for the year. However, due to improvement in case mix, there was an increase in income of £0.6m from 2018/19.

Divisional pay costs were underspent by £0.3m due to vacancies seen in the first half of the year as a result of challenges in recruitment. Pay costs increased by 5.8% from £55.0m in 2018/19 to £58.2m, mainly driven by nursing.

Total non-pay costs stood at £35.9m, a decrease of £566k from 2018/19, with an overspend of £0.3m. There was an increase seen within PbR excluded drugs and devices, which is offset by NHS income, predominately in Homecare drug costs. Furthermore, overspends in non PBR clinical supplies of consumables within theatres and cath labs were offset by underspends in VAD implants.

Lung Division

The Lung division continues to experience income growth due to increased activity. The division generated total income of £103.9m and a contribution of £32.8m, £1.0m ahead of plan. This compares to total income of £95.6m and a contribution of £30.2m in 2018/19. Of total income, NHS services accounted for £98.2m (2018/19: £90.0m), and private practice £4.8m (2018/19: £4.5m); non-clinical income accounted for the remainder.

Increased activity was seen across almost all NHS services with the total increase of £8.2m being driven by inpatient activity £2.7m and high-cost contract-excluded drugs £4.5m. Driving the inpatient variance, the asthma service has seen an increase in activity driven by biologic drug treatment. Critical care matched 2018/19 at £5.9m and outpatient income decreased by £0.1m. The Adult Primary Ciliary Dyskinesia (PCD) service also started during the year generating £0.2m.

Private patient income increased by £0.3m compared to 2018/19 to £4.8m which was ahead of plan by £0.3m. The over-performance has been driven by respiratory medicine activity at Royal Brompton Hospital.

Pay costs increased by 4% from £33.9m in 2018/19 to £35.2m, mainly driven by junior doctors and nursing.

Compared to 2018/19, non-pay costs increased from £31.5m to £35.8m. The majority of this was due to increased numbers of patients requiring high cost drugs, offset by corresponding income received from commissioners as noted above.

Environmental Matters

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act 2012.

To fulfil our responsibilities for the role we play, the following Low Carbon Vision statement has been included in our Carbon Management Plan (CMP): "to minimise Royal Brompton and Harefield NHS Foundation Trust's environmental impact through effective carbon management. This will be achieved by adopting a long-term strategy, embedding good practice within the organisation, with all members of the organisation taking ownership and responsibility for reducing carbon emissions".

Sustainability plan

Currently the Trust's CMP is focused on core activities where it has the highest level of control and has prioritised energy usage in buildings as this accounts for the majority of the Trust's carbon footprint. The Trust reports its energy, water and waste annually to the NHS Sustainability Development Unit. Over time it plans to broaden the scope of its sustainability plan to include further aspects of travel and procurement. Longer term wider sustainability issues will be considered including community impact, adaption, green space and biodiversity.

The Trust has recently established a new Sustainability Management Group (SMG) under the leadership of the Director of Planning and Strategy. It works with departments throughout the Trust to implement the plan. Membership of the group includes representatives from Estates, Nursing, Transport, IT, Human Resources and front-line staff.

To support the ambitions of the CMP a Carbon Reduction Project Register has been created and this is updated regularly to capture energy saving opportunities and track progress through to implementation. There are currently 77 projects identified of which approximately 30% have been completed. The Trust was successful in its funding application from the NHS Energy Efficiency Fund (NEEF) in 2019 and was awarded £175,000 for LED lighting schemes across both the Royal Brompton and Harefield sites. This work will be completed by September 2020 and will save an estimated 375,000kWh/year (approximately 2% of the Trust's electricity consumption). A significant number of larger projects have been identified that are not currently viable as they require substantial capital investments and have extended payback periods.

Performance

As a part of the NHS, public health and social care system, it is our duty to contribute towards achieving the ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020.

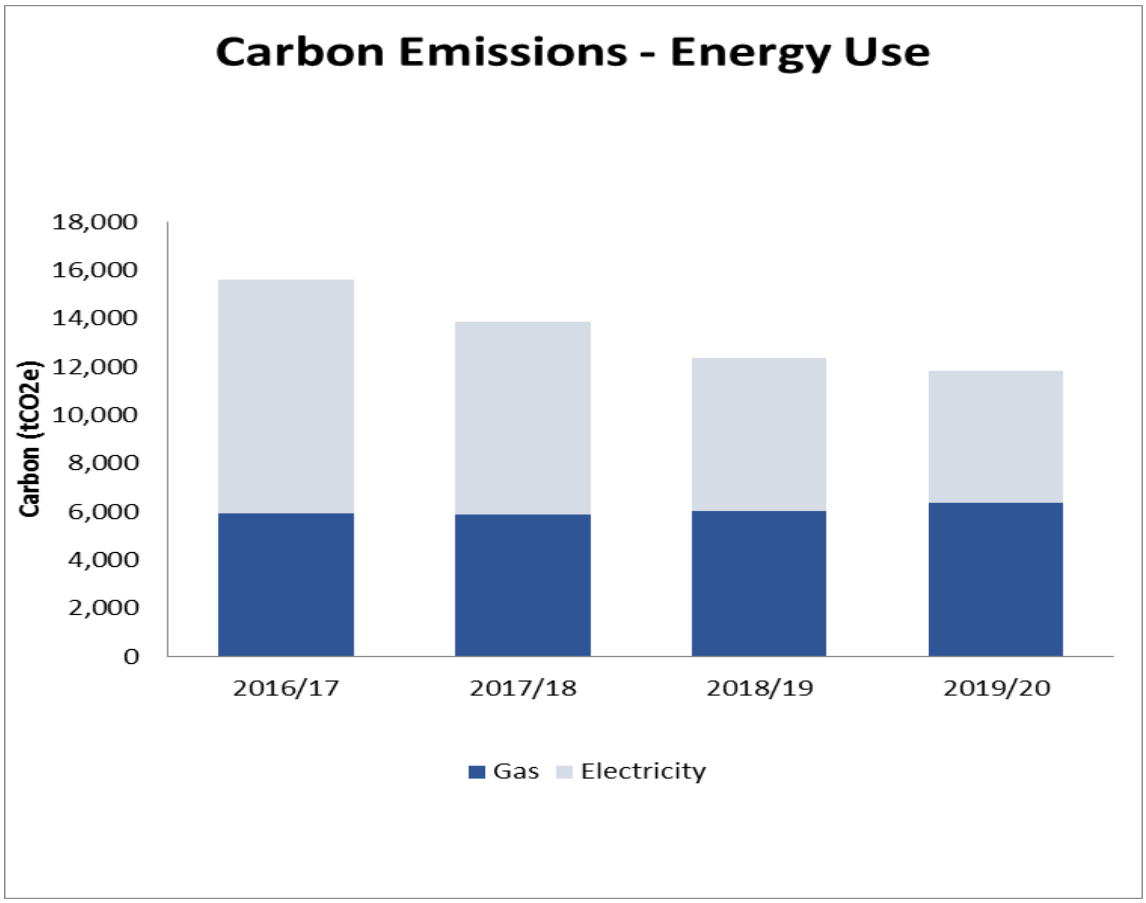
However, as a world-renowned heart and lung clinical and research centre, the Trust faces particular challenges as it balances the requirements to develop sustainably whilst providing continual advances in medical technology and patient care, together with increasing demand for our specialist services, which often requires new facilities and medical equipment. It is not possible to fully assess the impact of this continued expansion and consequently the Trust is unable to set an absolute target at this time. Therefore, to reflect this challenge in 2016/17 the Trust adopted an energy performance KPI of patients treated/tonnes CO_2e to demonstrate progress with the CMP and improving the sustainability of the organisation.

Energy Consumption, costs and carbon emissions

The energy consumption, cost and carbon emissions are detailed in the table below for the last four years. (Note due to a data breach with our Energy data supplier we have not been able to obtain consumption data for February and March 2020, consequently the energy data is for the 12-month period February 2019 to January 2020.

Resource		2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	28,499,496	27,733,341	28,460,070	30,580,213
	tCO_2e	5,956	5,880	6,045	6,353
Electricity	Use (kWh)	18,680,942	17,959,530	17,968,977	17,411,493
	tCO_2e	9,654	8,005	6,339	5,502
Total Energy CO_2e		15,610	13,885	12,384	11,855
Total Energy Spend		£2,590,590	£2,675,087	£3,093,594	£3,242,983

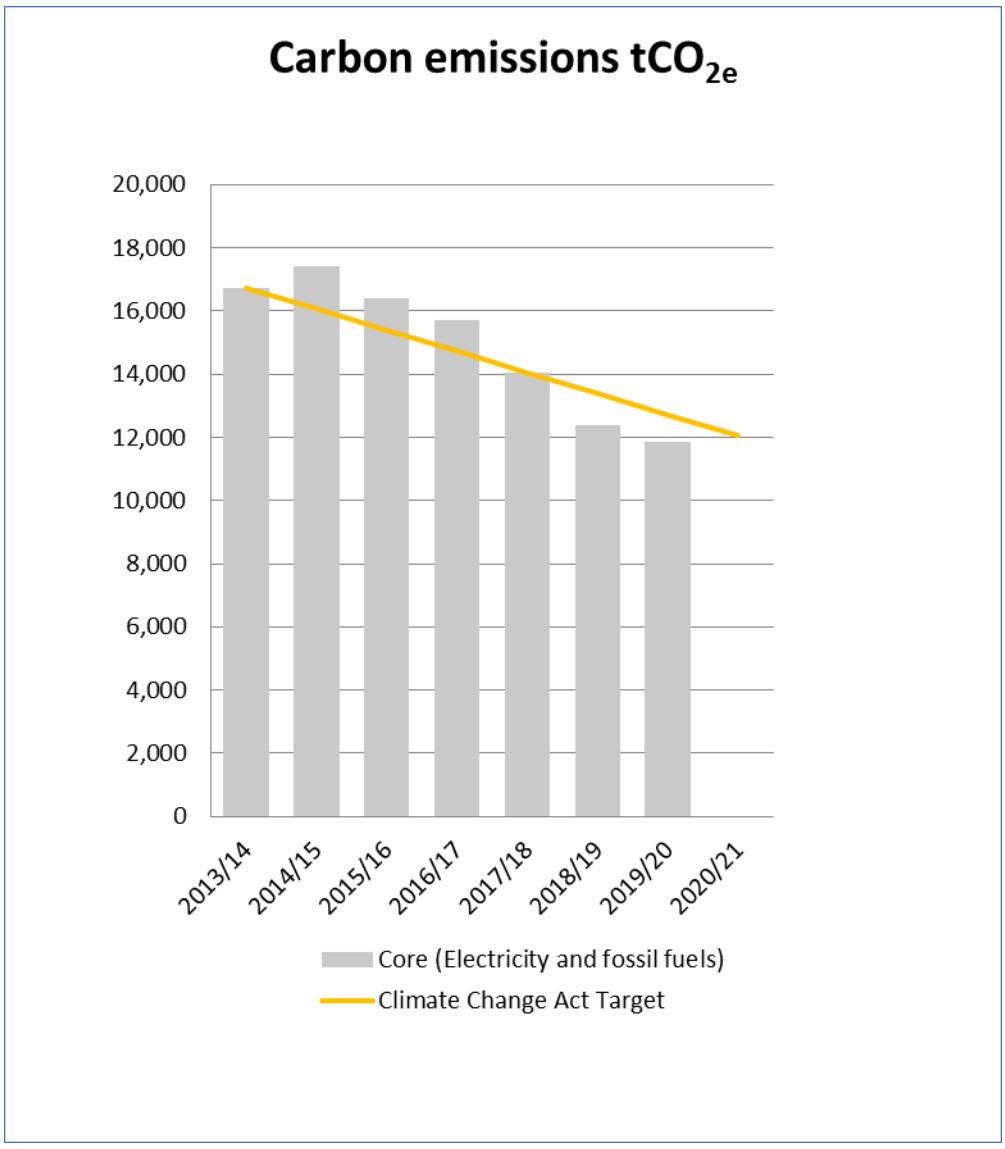
The Chart below illustrates that the declining carbon emissions over the period.



The Trust spent £3,242,983 on energy in 2019/20 which is a 4.8% increase in energy spend from the previous year reflecting the higher electricity charges together with an increase in gas consumption. However, when the gas consumption is normalised for weather (using degree days analysis) as there was a greater heating requirement for 2019/20 the energy usage is very similar to the previous year. Although there was a 3.1% reduction in electricity consumption, gas consumption rose by 7.4% resulting in an overall increase in energy consumption of 3.4%. Despite this increase, carbon emissions reduced by 4.3% which is partly the result of the reductions in electricity usage and also a result of the progressive decarbonisation of the national grid which has substantially reduced over recent years with the decommissioning of older coal-fired power stations and the increasing contribution of renewable energy.

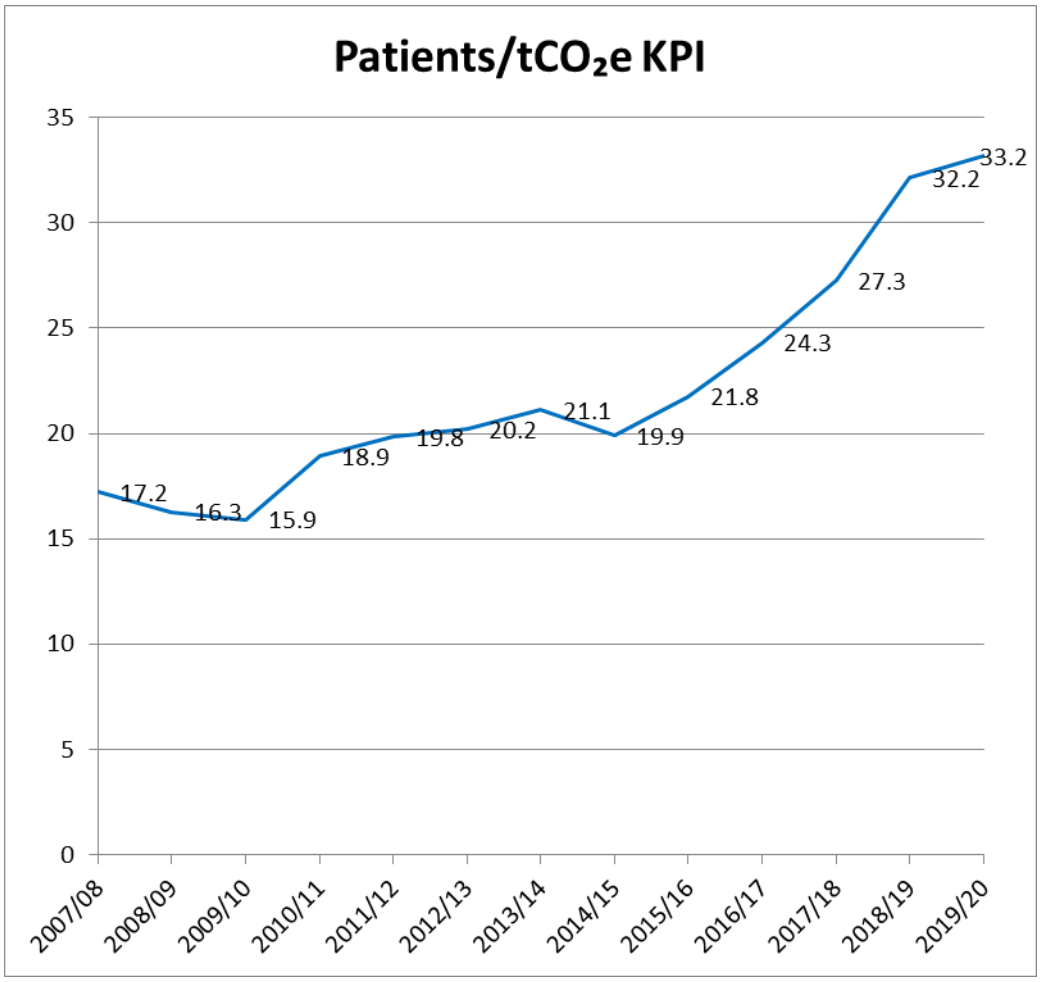
Performance against NHS Sustainability Development Strategy Target

The table below shows the Trust's carbon emissions due to core activities against the Sustainability Development Strategy target (in line with the Climate Change Act target). It can be seen that the emissions are significantly below the target, again this due to a combination of the reductions in electricity consumption for the year and also a result of the progressive decarbonisation of the national grid.



Performance against Patient Numbers KPI

The chart below shows that since 2007/08 the KPI performance has significantly improved with 33.2 patients/tCO_{2e} in 2019/20, a 92% increase. (Note the number of beddays reduced in March 2020 as a consequence of the Covid-19 pandemic, the assessment also includes an estimate of outpatient visits). It should be acknowledged however, that decarbonisation of the national grid has significantly contributed the carbon emission reduction and therefore the rising KPI values.



Waste

The Trust has a zero waste to landfill policy, both the clinical and non-clinical waste is disposed of in incinerators with energy recovery plant. Across the two main sites the Trust produced approximately 1,322 tonnes of waste over the year. Clinical waste accounts for around 60% of the total waste which is recovered in three streams; High Temperature Incineration (HTI) hazardous waste, alternative technology (AT) treated hazardous waste and non-hazardous clinical waste. Currently approximately 13% of residual waste is recycled. The emissions associated with waste are approximately 29tCO_2e, which is minimal when compared to energy emissions (0.2%).

Travel

Based on 2018/19 data contract patient transport accounts for around 2% of the Trust's carbon emissions around 270tCO_2e. As part of the planning for the New Imaging Centre the

Trust are working with Kensington and Chelsea Council to develop a Travel Plan; this will aim to reduce the environmental impact of travel for patients and staff and encourage travel by more sustainable means. The Trust have a cycle to work scheme to encourage staff to ride to work.

The Trust's patient transport contractor's fleet are now completely hybrid vehicles and they are also trialling electric vehicle.

Social, Community, Anti-Bribery and Human Rights Issues

At a strategic level social, community, anti-bribery and human rights issues are reflected within a range of strategic documents and enacted through Trustwide policies, and associated monitoring and reporting arrangements. Trustwide policies aim to ensure compliance with current legislation, regulation and national guidance. Associated risks are assessed and reflected within the Board Assurance Framework or risk registers.

The Trust recognises and works to ensure that it operates as a socially responsible organisation; is supportive of, and engages with, the diverse range of communities and interests in the delivery of its principal purpose as set out within the Constitution; and complies with and upholds the principles of human rights for all those who come into contact with the Trust.

The Trust has an Equality and Diversity Policy to ensure that there is equality of opportunity in the workplace, that dignity at work is safeguarded and that any issues relating to bullying and harassment are identified and addressed. The policy is linked to the core behaviours expected of employees. This has helped to ensure that core behaviours are championed, and that staff are made aware of good practice. The Equality and Diversity Steering Group monitors the effectiveness of the policy and ensures that it is kept up to date. This group is chaired by the Human Resources Director.

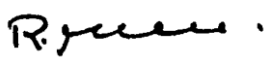
The Trust does not tolerate any form of fraud, bribery or corruption by, or of, its employees, associates, or any person or body acting on its behalf. The Trust employs an independent dedicated agency to provide local counter fraud services to support staff in dealing with counter fraud issues. The Trust's Audit Committee agrees the work plan for the counter fraud specialist and this is updated on a regular basis as progress is made. The Trust also works closely with NHS Counter Fraud Authority on any major investigations. Details of our approach to anti-bribery are disclosed in the report of the Audit Committee on page 38 and the Staff Report in section 2.3 of this document. Since 2018/19, the Trust has had in place a Freedom to Speak Up Guardian to offer support for staff who wanted to raise concerns without utilising the formal HR options.

Events Since 31 March 2020

There have been no important events since the end of the financial year affecting the Trust requiring disclosure.

Accounting Officer's Statement

This Performance Report has been prepared in accordance with the requirements of the *NHS Foundation Trust Annual Reporting Manual 2019/20*.



..... **22 June 2020**

Robert J Bell
Chief Executive

2. Accountability Report

2.1 Directors' Report

Introduction

The Trust's governance structure and arrangements are enshrined in the Trust's Constitution and include:

The Members:

Our Constitution makes provision for the Trust to be supported by a membership drawn from three constituencies: a public constituency; a staff constituency; and a patient constituency. We have around 10,500 Members. Our membership community is made up of the public, patients, carers and staff members. From these members, Governors are elected to our Council of Governors to represent their interests and influence the Trust's future plans. Members play an important role in ensuring that our services accurately reflect the needs and expectations of the communities that we serve.

The Council of Governors, with two committees:

(i) The Nominations & Remuneration Committee of the Council of Governors which is responsible for recommending the appointments of the Chair of the Trust Board and the Non-Executive Directors, and also for setting and reviewing their remuneration.

(ii) The Membership Steering Committee of the Council of Governors which is responsible for developing and reviewing the Trust's Membership Strategy.

The Trust Board of Directors to which operational management is devolved. The Board has established four Board Committees to facilitate its direction and monitoring role:

(i) Audit Committee

(ii) Risk & Safety Committee

(iii) Nominations & Remuneration Committee

(iv) Finance Committee

These Committees enable the Board to discharge its responsibilities regarding the management of the financial, risk and control environment within which the Trust operates and to oversee senior managers' pay and conditions.

Detailed disclosures regarding the Council of Governors, the Board of Directors and each of the committees are set out in the next section of the Annual Report.

There is a Redevelopment Advisory Steering Group which includes members drawn from both Executive and Non-Executive Directors. However, it has not been constituted as a formal committee of the Trust Board during 2019/20, although it meets every two months to review progress on major property development programmes, their related risks and plans.

Council of Governors, Trust Board and Committees

The Board of Directors and Council of Governors have distinct roles. The Board is responsible for all aspects of operation and performance, strategic direction, and for effective governance of the Trust, with the Council of Governors being responsible primarily for seeking assurance about the performance of the Board.

Council of Governors

The Constitution makes provision for a Council of Governors comprising both elected and appointed members. The elected Governors are drawn from the membership and the appointed Governors represent key stakeholders with whom the Trust is engaged.

The role of the Council of Governors is to challenge the Board and hold the Non-Executive Directors to account for the Board's performance. It appoints or removes the Chair of the Trust and other Non-Executive Directors of the Trust; approves the appointment of the Chief Executive; and decides the remuneration and other terms and conditions of the Non-Executive Directors. Non-Executive Directors are normally appointed for three years and may be re-appointed for a further three years. They may be removed by the Council of Governors following due process under the powers given by the NHS Act 2006. The process followed by the Council of Governors in relation to the appointments of the Chair and Non-Executive Directors is that the Nominations and Remuneration Committee makes recommendations to the Council of Governors for approval. The Council of Governors receives the Trust's annual accounts, any auditor's reports on those annual accounts, and the annual report from the Board of Directors.

The Council of Governors also:

(i) provides views to the Board of Directors in respect of forward plans

(ii) is consulted by the Board of Directors in relation to strategic matters affecting the Trust

(iii) approves and reviews the membership strategy

(iv) approves purchase or sale of Trust property assets

(v) approves the appointment of the Trust's external auditors.

The Council of Governors met four times during 2019/20. Details of attendance, including that of Board members, are given in the table on the following pages of this report.

Nominations and Remuneration Committee of the Council of Governors

Members of the Committee who served during 2019/20 were:

Name	**Attendance** Actual/Possible
John Hensley (Chair of the Committee)	4/4
Baroness (Sally) Morgan (Chair of the Trust)	4/4
Steve Caddick	4/4
George Doughty (Lead Governor until 11 February 2020)	4/4
Professor Claire Hogg	2/4
Paul Murray	3/4
Rt Hon Michael Mates (Lead Governor from 12 February 2020)	2/2
Dr Ejikeme Uzoalor (until 30 November 2019)	3/4

Please see the Remuneration Report (section 2.2) for further information about the work of this Committee during 2019/20.

The Council of Governors Attendance

Name	Date of Appointment/ Election	Term of Appointment	Term Expired	Appointing Body/ Constituency	Attendance Record Council of Governors Actual/Possible
Governors					
Tim Ahern	24.1.19	3 years		Royal Borough of Kensington & Chelsea	3/4
Julie Bartlett	23.1.20	3 years		Patient	1/1
Lady Victoria Borwick (previously an RBKC appointee)	26.1.19	3 years		Patient	4/4
Helena Bridgman	1.6.18	3 years		Patient	2/4
Steve Caddick	1.6.18 (2nd term)	3 years		Staff	4/4
Revd Patrick Davies	7.3.19	3 years		Public	2/4
George Doughty (Lead Governor until 11.02.20)	1.6.18 (2nd term)	Until 31.08.20		Public	4/4
Ryan Fletcher	23.1.20	3 years		Patient	0/1
Elizabeth Henderson	1.1.17 (2nd term)	Until 31.12.21		Staff	3/4
Cllr John Hensley	12.5.17	3 years		London Borough of Hillingdon	3/4
Caroline Karlsen	1.6.18 (2nd term)	3 years		Patient-Carer	3/4
Rt Hon Michael Mates (Lead Governor from 12.02.20)	7.3.19	3 years		Public	3/4
Paul Murray	1.6.18	3 years		Patient	4/4
Sean O'Reilly	1.1.18	3 years		Patient	2/4
Maxine Ovens	1.6.18	3 years		Staff	2/4
Stephen Palmer	1.6.18	3 years		Staff	3/4
Rishi Pabary	26.02.20	Until 31.05.21		Staff	-
Ajay Shah	11.4.19	3 years		King's College London	3/4
Pravin Shah	26.1.19	3 years		Public	1/4
Jeremy Stern	1.6.18	3 years		Patient	3/4
Prof Jadwiga Wedzicha	31.1.19	3 years		Imperial College	3/4
Leavers in the year					
Brenda Davies	1.12.16 (2nd term)	3 years	30.11.19	Patient	3/3
Prof Claire Hogg	1.6.18 (2nd term)	3 years	25.2.20	Staff	2/4
Dr Ejikeme Uzoalor	1.12.16 (2nd term)	3 years	30.11.19	Patient	3/3

Other attendees at the Council of Governors meetings including **Board Members:**				**Attendance** Actual/Possible
Chair				4/4
Chief Executive				4/4
Medical Director				2/2
Chief Financial Officer				1/1
Chief Operating Officer				3/4
Director of Nursing & Clinical Governance				2/4
Director of Development and Partnerships				3/4
Director of Commissioning and Service Development				3/4
NED: L Bardin				3/4
NED: M Batten				0/4
Non-Independent NED: Professor K Fox				0/1
NED: S Friend				3/4
NED: J Hogben				2/4
NED: Professor P Hutton				3/4
NED: R Jones				3/4
NED: B Keavney				1/3
NED: Dr J Khan				0/4
Trust Secretary				4/4

Governors' Interests at 31 March 2020

NAME	**CONSTITUENCY/APPOINTED BY**	**DECLARATION**
Tim Ahern	APPOINTED The Royal Borough of Kensington and Chelsea	Director: Louise Hewlett Property Consultants Ltd Member: Conservative Party
Julie Bartlett	PATIENT Bedfordshire, Hertfordshire and Essex	Unavailable
Lady Victoria Borwick	PATIENT North West London	Founder and Trustee: Edwin Borwick Charitable Trust Director: Poore Ltd, Second Poore Ltd Member: Conservative Party Husband is a Trustee of the Royal Brompton & Harefield Hospitals Charity
Helena Bridgman	PATIENT Rest of UK and Overseas	Freelance Nationally Accredited Advanced Communication Skills Trainer Trainer: Oakhaven Hospice Trust, Lymington, Hants and Oxford Centre for Education & Research in Palliative Care
Steve Caddick	STAFF	None

Revd Patrick Davies	PUBLIC Rest of England and Wales	Patient Representative at the Liverpool Heart & Chest Hospital
George Doughty Lead Governor	PUBLIC North West London	None
Ryan Fletcher	PATIENT South London & South-East England	None
Elizabeth Henderson	STAFF	Director: Friends of Royal Brompton (Charity) Director: 215NKR London Ltd Shadow Board of Trustees of SEACC
Cllr John Hensley	APPOINTED London Borough of Hillingdon	Councillor: London Borough of Hillingdon Member: Conservative Party
Caroline Karlsen	PATIENT Carers	Director: C-Squared Consulting Ltd Independent Member: National Information Board (NIB) Trustee: Knightsbridge School Educational Foundation.
Rt Hon Michael Mates	PUBLIC South London and South-East England	Honorary President Royal British Legion – Midhurst Branch Member: Conservative Party
Paul Murray	PATIENT South London and South-East England	Nominated as an Attendee by the Somerville Foundation: Patient-Public Reference Group of the RBHFT and King's Health Partners Partnership. Patient and Public Lay Member of the RBH-KHP Cardiovascular Oversight Group Non-Executive Director, Cincinnati Global Underwriting Agency Ltd.
Sean O'Reilly	PATIENT Bedfordshire, Hertfordshire and Essex	None
Maxine Ovens	STAFF	None
Dr Rishi Pabary	STAFF	None
Stephen Palmer	STAFF	None
Prof Ajay Shah	APPOINTED KING'S COLLEGE	British Heart Foundation Professor of Cardiology and Director, King's College London BHF Centre of Excellence Honorary Consultant Cardiologist at King's College Hospital NHS Foundation Trust Senior editing positions with the American Journal of Physiology, Cardiovascular Research, and the European Heart Journal.
Pravinchandra Shah	PUBLIC Bedfordshire, Hertfordshire and	Joint owner (with wife): Centra Pharmacy trading as Abalane Ltd

	Essex	
Jeremy Stern	PATIENT North West London	Chief Executive: Promo Veritas Ltd Director: PromoVeritas Ltd
Prof Jadwiga Wedzicha	APPOINTED Imperial College	Professor of Respiratory Medicine, National Heart and Lung Institute, Imperial College London Honorary Consultant, Royal Brompton Hospital
GOVERNORS WHOSE TENURE ENDED DURING 2019/20		
Brenda Davies	PATIENT Bedfordshire and Hertfordshire	None
Prof Claire Hogg	STAFF	Director: S. Padley Ltd Trustee: The Brompton Fountain Charity
Dr Ejikeme Uzoalor	PATIENT Elsewhere	Member: Labour Party

1 x Patient Governor Rest of UK and Overseas – Vacant.

Governors' Expenses

Name	£
Helena Bridgman	£119.10
Brenda Davies	£317.82
Revd Patrick Davies	£252.70
Michael Mates	£1,620.32
Dr Ejikeme Uzoalor	£86.50

These expense claims cover travel expenses for attendance at:

- Meetings of the Council of Governors, committees and working groups
- PLACE (Patient-Led Assessments of the Care Environment) meetings
- GovernWell courses (National Training Programme for NHS Foundation Trust Governors provided by the Foundation Trust Network)
- Interview panels for the appointment of Non-Executive Directors.

Trust Board of Directors and Committees

Led by an independent Chair, the Board of Directors is appointed to exercise the powers of the Trust on its behalf. It plays a key role in shaping the strategy, vision and purpose of the organisation and has a collective responsibility for the performance of the Trust.

Board members bring a wide range of experience and expertise to the stewardship of the Trust. The membership of the Board of Directors meets the requirements of the *NHS Foundation Trust Code of Governance* in respect of balance, completeness and appropriateness. The Board is composed of a Non-Executive Chair, eight independent Non-Executive Directors and seven Executive Directors.

Non-Executive Directors are appointed to provide an independent perspective on, and challenge to, the discharge of the responsibilities of our Chief Executive as the Accounting Officer, who has delegated certain of his powers and functions to his colleague Executive Directors.

Board members are responsible for seeking assurance that risks to the Trust and the public are managed and mitigated effectively.

The arrangements for the appointment and removal of Non-Executive Directors by the Council of Governors are set out in the Trust's Constitution, which is available on the Trust's website. Non-Executive Directors are appointed for a period of three years in the first instance. All of our Board members meet the standards of Code Provision B.2.2 and the Fit and Proper Person Test in Regulation 5 of *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.*

Between 1 April 2019 and 31 March 2020, the Trust Board convened on six occasions.

Board Composition, Committee Duties and Attendance

Name	**Role/Committee**	**Attendance Record** (Actual/Possible)				
		Trust Board	**Audit Committee**	**Risk & Safety Committee**	**Nominations & Remuneration Committee**	**Finance Committee**
Chair Baroness (Sally) Morgan of Huyton	Trust Board Chair Nominations and Remuneration Committee Finance Committee	6/6	-	-	1/1	6/11
Executive Directors						
Robert Bell	Chief Executive Finance Committee	6/6	-	-	-	9/11
Robert Craig	Director of Development and Partnerships	5/6	-	-	-	-
Joy Godden	Director of Nursing and Clinical Governance	5/6	-	-	-	-
Dr Richard Grocott-Mason	Medical Director (to 15/07/19) Finance Committee	0/1	-	-	-	0/4
Dr Mark Mason	Medical Director (appointed 15/07/19) Finance Committee	5/5				4/8
Nicholas Hunt	Director of Commissioning and Service Development	6/6	-	-	-	-
Jan McGuinness	Chief Operating Officer Finance Committee	6/6	-	-	-	9/11
Richard Guest	Chief Financial Officer (appointed 1/02/20) Finance Committee	2/2	-	-	-	2/2
Richard Paterson	Associate Chief Executive – Finance (contract ended 31/1/20) Finance Committee	4/4	-	-	-	9/9

Name	Role	Attendance Record (Actual/Possible)				
		Trust Board	Audit Committee	Risk & Safety Committee	Nominations & Remuneration Committee of the Trust Board	Finance Committee
Non-Executive Directors						
Luc Bardin	Audit Committee Risk and Safety Committee Finance Committee Education, Training and Research NED	5/6	3/4	4/5	-	7/11
Mark Batten	Finance Committee (Chair)	5/6	-	-	-	9/11
Prof Kim Fox (term ended 31/5/19)	-	1/1	-	-	-	-
Simon Friend	Trust Board Deputy Chair Audit Committee (Chair) Risk & Safety Committee Finance Committee Nominations and Remuneration Committee EPRR (Emergency Preparedness Resilience and Response) NED	5/6	4/4	5/5	1/1	9/11
Janet Hogben	Audit Committee Nominations and Remuneration Committee (Chair) Patient and Public Engagement Group (PPEG) NED Freedom to Speak Up Guardian NED	5/6	3/4	-	1/1	-
Prof Peter Hutton	Audit Committee Risk and Safety Committee (Chair)	5/6	2/4	5/5	-	-
Richard Jones	Nominations and Remuneration Committee Finance Committee	5/6	-	-	1/1	10/11
Prof Bernard Keavney (appointed 2/06/19)	Risk & Safety Committee Safeguarding (Adults and Children) NED Children and Young People Service NED	4/5	-	1/2	-	-
Dr Javed Khan	Risk and Safety Committee	3/6	-	1/5	-	-
Other Attendees						
Neil Netto (left 17.7.19)	Trust Secretary	1/1	2/2	1/2	-	-
Noreen Adams (appointed 21/8/19	Interim Trust Secretary	2/2	1/1	2/2	-	-
Samuel Armstrong (appointed 9/12/19)	Trust Secretary	2/2	1/1			

Note - The Chief Executive and Executive Directors, although attendees at Board Committee meetings, are not formally members of those Committees other than the Finance Committee.

The table in the Governors section of this report demonstrates that Executive and Non-Executive Directors shown above have also been in attendance at meetings of the Council of Governors in order to understand the views of Governors. Non-Executive Directors also attended the Annual Members' Meeting at which the views of members were expressed. It

should be noted that some Governors are also regular attendees, as observers, at meetings of the Trust Board.

Directors' Interests

The Trust has an obligation as a Foundation Trust to compile and maintain a register of Directors' interests, which might influence their role. The register is available to the public via the Trust website. The Trust is also required to publish in its annual report the directorships of any member of the Board in companies that are likely to, or seek to, conduct business with the NHS. In this context, declarations of the Directors of Royal Brompton & Harefield NHS Foundation Trust are as follows:

Chair

Baroness (Sally) Morgan of Huyton
Board Advisor – Absolute Return for Kids (ARK) Charity
Non-Executive Director - Countryside Properties plc
Trustee – Education Policy Institute
Master - Fitzwilliam College, University of Cambridge
Trustee – National Heart & Lung Institute Foundation

Deputy Chair

Simon Friend
Member - General Council, Royal Academy of Arts
Chair - Audit Committee, Royal Academy of Arts
Member - Finance Committee, Royal Academy of Arts
Non-Executive Director - Bevan Brittan LLP
Chair - Audit & Risk Committee, Bevan Brittan LLP
Member - Remuneration Committee. Bevan Brittan LLP
Trustee and Chair - Community Services Committee, Jewish Care
Board Advisor - Otsuka Pharmaceutical Europe Limited

SID Non-Executive Director

Luc Bardin
Director - Strategic Partnering Ltd
Director - The Strategic Brand Ltd
Adjunct Professor - Imperial College Business School
Advisory Board Member - MSc Strategic Marketing, Imperial College Business School
Senior Advisor on Strategic Partnering - UK Government Cabinet Office
Crown Representative – UK Government Cabinet Office
Non-Executive Director – UK Atomic Energy Authority
Advisory Board Member – Managing Partner's Forum

Non-Executive Directors

Mark Batten
Non-Executive Director, and Chair, Audit & Risk Committee - Picton Property Income Ltd
Non-Executive Director and Chair - Audit and Risk Committee – Armour Holdings' UK Regulated Entities
Non-Executive Director and Chair - Audit Committee – Assured Guaranty Europe plc Non-Non-Executive Director – Catalyst Business Finance Limited
Non-Executive Director - Floreat Overseas Holdings Limited
Senior Advisor - UK Government Investments (UKGI)
Governor - Westminster School
Director – Debate Mate Schools Limited (until April 2020)

Professor Kim Fox (until 31 May 2019)
Board Member - Institute of Cardiovascular Medicine & Science (ICMS)
Director - Versalius Trials Ltd
Trustee - Magdi Yacoub Institute

Trustee - National Heart & Lung Institute Foundation
Advisor – Celixir plc
Advisor - Servier Pharmaceuticals Ltd
Advisor - European Society of Cardiology (Past President)
Data & Safety Monitoring Board Member - TauRx Pharmaceuticals

Janet Hogben
Board Trustee – Canal & River Trust (Charity)
Board Member – Ice Wharf Company Ltd (Residential Flats)

Professor Peter Hutton
Hon. Professor – Birmingham University: Undergraduate and postgraduate mentor
Patron – Birmingham Museums
Mature Student – Oxford University

Richard Jones
Director - RJ Real Estate Consulting Ltd
Non-Executive Director - Commercial Development Advisory Group, Transport for London
Independent Investment Committee Member - Henley Secure Income Property Unit Trust

Professor Bernard Keavney
Professor of Cardiology - The University of Manchester
Honorary Consultant Cardiologist - Manchester University NHS Foundation Trust
Member - Medical Research Council (MRC) Population and Systems Medicine Board

Dr Javed Khan
Chief Executive – Barnardo's
Director – JayKay Associates Ltd
Non-Executive Advisor **-** Birmingham City Council:

Executive Directors

Robert J Bell
Chair - University Hospitals Association (UK)
Board Member - Imperial College Health Partners
Board Member - Institute of Cardiovascular Medicine and Science
Visiting Professor - Imperial College

Robert Craig
Nothing to declare

Joy Godden
Nothing to declare

Richard Guest
Trustee – The London Pathway

Dr Richard Grocott-Mason (until July 2019)
Director - RM Grocott-Mason Ltd

Dr Mark Mason (July 2019)
Founder and Director - Ayres International Limited

Nicholas Hunt
Chair - Governing Body of Manor Farm Community Junior School
Chair - Governing Body of Jordan's School

Jan McGuinness
Nothing to declare

Richard Paterson (until January 2020)
Chair - Hurlingham Court Ltd

Directors' Profiles

Chair

Baroness (Sally) Morgan was appointed by the Council of Governors' as the Trust's Chair on 1 January 2017 for a term of three years, and again for a second three-year term.

Baroness Morgan was made a life peer in 2001. She has served as minister of state in the Cabinet Office, political secretary to the prime minister and director of government relations at 10 Downing Street. Since leaving government in 2005 she has been a board member in the private, public and charity sectors. She was Chair of OFSTED and board member of the Olympic Delivery Authority, chaired the House of Lord's Select Committee on Digital Skills and was a member of the Science and Technology Select Committee.

Baroness Morgan is currently Master at Fitzwilliam college, University of Cambridge and serves as a Trustee of both the NHLI and Education Policy Institute. She is board adviser to ARK, an education charity and is a non-executive director of Countryside Properties PLC.

Deputy Chair

Simon Friend joined the Board in August 2017. He is a chartered accountant and was a partner at PricewaterhouseCoopers LLP (PwC), where his career spanned more than 30 years. He has extensive experience of finance, governance and audit in healthcare, pharmaceutical and life sciences settings, leading PwC's Global Pharmaceutical and Life Sciences Industry Group, and was a member of PwC's UK and Global Board.

He has a depth of expertise in finance and audit, as well as a thorough understanding of governance across a range of sectors, technical rigour and board experience at the highest level. Simon is also a trustee and chair, Community Services at Jewish Care, a charity providing residential and day care facilities and is a member of the General Council at the Royal Academy of Arts and on the Board of Bevan Brittan LLP, a UK top 100 commercial law firm.

Non-Executive Directors

Luc Bardin was appointed to the Board in June 2015 and brings a wealth of experience in leadership and strategic transformation to the Trust. He spent many years in executive roles with BP plc, including group chief sales and marketing officer, CEO of multiple businesses, and CEO and founder of the "Strategic Accounts" business. He was a group vice president for 12 years and a member of the BP Downstream ExCo. His career in global business leadership spans 30 years and, alongside BP, he has worked for Burmah Castrol, Hoechst and Pechiney groups.

Since January 2014, he has been executive chairman of Strategic Partnering Ltd and THE Strategic Brand Ltd. He is the author of *Strategic Partnering - remove chance and deliver consistent success*, published in 2013 and THE Strategic Brand, published in 2017. Luc is an adjunct professor at Imperial College Business School, and has a PHD from UCL, an MBA from INSEAD and qualifications in engineering, political science and finance.

Mark Batten Mark Batten was appointed to the Board in November 2017. Mark was formerly a partner for over 25 years at PricewaterhouseCoopers LLP (PwC) and is a Chartered Accountant. He has broad experience of corporate finance, restructuring, financial services and real estate. Mark currently has a portfolio of Non-Executive roles in the areas of Insurance, Finance and Real Estate and is a senior advisor to UK Government Investments,

part of HM Treasury. He is also the Executive Deputy Chairman of the Westminster School Governing Body.

Janet Hogben started her career with BP where she spent 21 years, before moving to North American conglomerate Seagram as organisational capability director for Europe, Middle East and Africa.

After Seagram was taken over by Diageo and Pernod Ricard in 2002, Janet was invited to join Diageo's management team as HR director for global corporate functions. She later became the company's global talent and organisation strategy director. Janet spent 10 years with the business, before leaving to become HR director for EDF Energy in the UK. She became responsible for a range of HR issues including health, safety and well-being.

Janet retired in 2017 and has since become a trustee of the Canal & River Trust. She joined Royal Brompton & Harefield NHS Foundation Trust in December 2018.

Professor Peter Hutton until 2018 was a consultant anaesthetist at University Hospital Birmingham and Honorary Professor at the University of Birmingham. He also undertook medical examiner duties. In the past, he has served on hospital boards in both executive and non-executive roles, and has a major interest in medical ethics and medical safety.

During his career he has served on a number of national bodies, such as the GMC and the Bar Standards Board, and between 2007 and 2009 as joint clinical lead for unscheduled care for NHS London.

Peter was also president of the Royal College of Anaesthetists (2002-2003) and chair of the Academy of Medical Royal Colleges (2002-2004). He established and chaired a Home Office ethics group to manage the ethical aspects of forensic DNA analysis (2008-2010), and more recently was the independent hospital consultant advisor to the two Mid-Staffs inquiries.

In 2014, he was appointed by the Home Office to lead an enquiry into forensic pathology services in England and Wales, and has recently led a review of 'age and the anaesthetist' for the Association of Anaesthetists of Great Britain and Ireland. Peter joined the Trust in February 2019.

Richard Jones joined the Trust Board as a Non-Executive Director in February 2014. He is an experienced real estate executive director. He brings to the Board extensive expertise in investment and asset performance and management gained from a long career with Aviva Investors as Head of European Life Funds, Managing Director UK Real Estate and, most recently, Managing Director of Aviva Clients and Global Asset Management. While in this role he was a member of the Aviva Investors Global Real Estate Board, chair of the Real Estate Operational Management Group and chair of the Real Estate Sustainability Group. Richard is the Chair of the Trust's Redevelopment Advisory Steering Group, a member of the Finance Committee and the Nominations and Remuneration Committee.

He is currently a Non-Executive Director of the Transport for London Commercial Development Advisory Group and an Independent Investment Committee member of Henley Secure Income Property Unit Trust.

Professor Bernard Keavney comes to the Trust with twenty years' experience as a consultant cardiologist, specialising in the diagnosis and treatment of coronary artery disease, inherited cardiovascular conditions, and heart disease in pregnancy.

Currently British Heart Foundation Professor of Cardiovascular Medicine and a consultant cardiologist at Manchester University NHS Foundation Trust, Bernard's research career at the Universities of Oxford, Newcastle, and Manchester has seen him contribute widely to studies involving genetic cardiovascular diseases, including the first genome-wide association studies of congenital heart disease.

Bernard has served in several advisory roles in organisations such as the UK Biobank, the UK Government's 100,000 Genomes Project, and the Medical Research Council.

Dr Javed Khan is Chief Executive of the Charity Barnardo's, leading a staff of over 8,000 and more than 20,000 volunteers. He is a leading figure in the UK public and voluntary sectors, regularly advising government ministers, and is a high-profile contributor in the media and at national and international conferences.

Javed began his teaching career in the West Midlands, and made rapid progress, becoming head of department, assistant principal and then director of development in a further education college, before moving to assistant director of education at Birmingham City Council. He has been awarded honorary doctorates from Birmingham City University (2015) and The University of Salford (2018).

His previous roles include Chief Executive at Victim Support, Executive Director - London Serious Youth Violence Board and Director of Education, Harrow Council. He has also been a member of the advisory board for the Children's Commissioner for England and o the governing body of Hounslow Clinical Commissioning Group and served on the Government's Grenfell Recovery Taskforce. He is currently a Non-Executive Advisor to Birmingham City Council. He joined Royal Brompton & Harefield NHS Foundation Trust in February 2019.

Non-Independent Non-Executive Director

Professor Kim Fox has been a consultant cardiologist at the Trust as well as Professor of clinical cardiology and former head of the National Heart and Lung Institute, Imperial College, London. Kim is a Board Member of the Institute for Cardiovascular Medicine and Science (in partnership with Liverpool Heart and Chest Hospital). He is a Trustee of both the Magdi Yacoub Institute and National Heart and Lung Institute. He was appointed as Non-Executive Director (non-independent) to the Trust Board in June 2013. His tenure of office ended on 31st May 2019.

Executive Directors

Robert J Bell joined the Trust as Chief Executive in 2005, from the William Osler Health Centre, Ontario, Canada, where he was president and chief executive officer. He has over 40 years' international experience in hospital and health services management. He is a member of the Board of Directors of Imperial College Health Partners and the Institute of Cardiovascular Medicine and Science. He has previously held positions as vice president Health Care and Life Sciences Market Sectors, Cap Gemini, Ernst & Young Canada Inc; partner at Ernst & Young and KPMG (Peat Marwick), Toronto; vice president, Hilton Universal Hospitals UK Ltd, London; vice president, International Services, Extendicare Inc (London and Toronto); executive director of District Health Councils in the Ministry of Health, Ontario; Treasury Board officer, Management Board of Cabinet, Government of Ontario; and systems engineer, Hospital for Sick Children, Toronto. He is a Bachelor of Applied Science in Industrial Engineering and a Master of Public Administration. In 2014 he was appointed a visiting Professor of Global Health Innovations by Imperial College and is also Chairman of University Hospitals Association (UK).

Richard Paterson served the Trust as interim Director of Finance in January 2011 for a six-month term. He subsequently joined the Trust as Associate Chief Executive – Finance, and was appointed to the Board in October 2011. He worked at KPMG, accountants and business advisors, for 40 years, appointed to the partnership in 1986 and retiring in 2010. In addition to client responsibilities for listed companies and public interest entities, his management roles included six years in charge of KPMG UK's infrastructure, government and healthcare division; head of markets for KPMG's Europe, Middle East and Africa region; and executive chair of the global professional indemnity insurance committee of the international board of KPMG. Richard retired from the Trust at the end of January 2020.

Richard Guest joined the Trust as Chief Financial Officer in January 2020 from the professional services firm EY (Ernst & Young). At EY, he was the UK public health sector leader, where advised numerous NHS Trusts on financial improvement, integration and collaboration and capital schemes. Prior to joining EY in 2012, he was a Director at the health regulator, Monitor.

Richard is a trustee of Pathway, a charity focused on supporting homeless people in hospitals.

Robert Craig is the Director of Development and Partnerships. He joined Harefield Hospital in 1995, having previously worked in community and general hospital services. Following the Trust merger in 1998, he became site director at Harefield and, in 2001, Deputy Director of Operations for the Trust. Robert has also fulfilled the roles of Director of Governance & Quality (2003-2006) and Director of Planning & Strategy (2006-2009) – in the latter post, he was responsible for the Trust's successful application for Foundation Trust. He was appointed to the Board in the role of Chief Operating Officer in 2008 and as Director of Development and Partnerships in July 2018.

Joy Godden, Director of Nursing and Clinical Governance, joined the Trust in 1996 as a Senior Nurse, and worked as the general manager of the lung division between 2004 and 2015. Joy has a broad portfolio that has included a number of corporate projects.

Dr Richard Grocott-Mason, consultant interventional cardiologist, has worked at Harefield Hospital regularly since 1999 and was appointed divisional director of the heart division in October 2014. He has also held roles at The Hillingdon Hospitals NHS Foundation Trust, including clinical director for medicine, and joint medical director and responsible officer. He was appointed Medical Director of the Trust in 2016 until his secondment to the post of Managing Director, RBH-KHP Partnerships in mid July 2019.

Dr Mark Mason is a consultant cardiologist at Harefield Hospital, where he played a key role in developing the nationally acclaimed primary angioplasty programme. He was seconded to the role of medical director at the Trust in July 2019.

He now specialises in pacemaker and implantable defibrillator implantation and removal, and has developed one of the busiest pacing services in the UK. He has been nationally recognised as a specialist in pacing lead extraction and has been a specialist advisor to the National Institute for Health and Care Excellence (NICE) on the use of laser sheaths to remove pacing leads.

He is actively involved in developing innovative pathways to make smoother transitions between primary care and secondary/tertiary care, to improve the patient journey at both a local and regional level.

He is a member of the Pan-London Arrhythmia Group looking to improve both elective and emergency care of patients with arrhythmias.

Nicholas Hunt is Director of Commissioning and Service Development and also site director for Harefield Hospital, a role he took on in 2006. He has worked at Royal Brompton & Harefield NHS Foundation Trust since its inception. Nicholas began his career at Regional HQ, the forerunner of strategic health authorities. His subsequent career in NHS management has included both operational and strategic roles at a number of London hospitals.

Jan McGuinness was appointed Chief Operating Officer in 2018. Prior to this, she was director of patient experience and transformation, taking up the newly created post in April 2015 after having worked in healthcare over a number of years, and in three international settings, most recently in Canada. She has held numerous senior roles, both clinical and non-clinical. These include director of operations for The Alberta Heart Institute, regional director of cardiac services for Vancouver and Fraser health authorities and at Bupa Cromwell Hospital in London where she improved the patient experience. Her areas of expertise include quality improvement, patient safety and project management related to design and transformation.

Audit Committee Report

Role and responsibilities

The Committee's terms of reference state that it will provide the Trust Board with an independent and objective evaluation of the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that support the achievement of the organisation's objectives. Within this overarching framework the Committee:

- monitors the integrity of the Trust's financial reporting, compliance with auditing standards and the appropriateness of going concern assumptions;
- challenges, where necessary, the consistency of, and any changes to, accounting and accounting policies;
- reviews the Trust's strategy for the management of key financial risks, ensures the Trust has followed appropriate accounting policies and has made appropriate estimates and judgements;
- ensures that regular reviews are undertaken of governance, risk management and internal controls;
- maintains oversight of the Trust's financial systems, financial information and financial reporting in compliance with relevant law, guidance and regulation;
- reviews and monitors the effectiveness of the Trust's internal audit and counter-fraud functions;
- reviews and monitors the effectiveness of the external audit process, the maintenance of the external auditor's independence and objectivity, and agrees the policy in relation to the external auditor's provision of non-audit services; and
- assesses the disclosures in the narrative sections of the Annual Report to ensure that they are fair, balanced and understandable.

In carrying out its activities the Committee fully recognises the interests of the Trust's Governors and Members.

The Committee's responsibilities and activities dovetail with those of the Finance and Risk & Safety Committees and procedures are in place to avoid both omission and duplication. It is an integral part of the Trust's Board Assurance Framework.

Composition of the Committee

The members of the Committee who served during the period under review are disclosed on pages 27 and 28 of this Annual Report. Committee meetings are also regularly attended by the Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Medical Director, Trust Secretary and other senior members of the finance team.

During 2019/20 Prof Peter Hutton chaired the Risk & Safety Committee, whose agenda links closely to that of the Audit Committee, particularly as regards risk identification and management. Simon Friend, who has chaired the Audit Committee since 1 August 2017, is also a member of the Risk & Safety, Finance and Nominations and Remuneration Committees.

Summary of Committee meetings

Since the approval of the 2018/19 Annual Report and Accounts the Committee has met on three occasions with an additional meeting cancelled due to Covid-19. These sessions considered the following subjects:

- November 2019
    - Progress reports from internal audit and counter-fraud services
    - Internal audit reports covering Data Security and Protection (DSP) toolkit benchmarking and also financial management
    - A DSP toolkit and Voice over Internet telephony update
    - An assurance report on emergency preparedness, resilience and response
    - Report on the management of property infrastructure including utilities risk surrounding the Estate
    - Report addressing Fire evacuation for Extra Corporeal Membrane Oxygenation (ECMO) patients
    - A bank mandate fraud review report
    - The external audit plan for 2019/20

- February 2020
    - Progress reports from internal audit and counter-fraud services
    - Internal audit reports on Mandatory training, DSP benchmarking and emergency preparedness
    - Report of the Trust's Library Strategy
    - Update on the Voice over Internet telephony
    - Report on managing electricity risks across the Estate

- April 2020
    - No meeting held due to the Covid-19 pandemic

- June 2020
    - Review of the final draft 2019/20 Annual Report and Accounts, including the governance statements
    - External auditor report on financial statements
    - Trust going-concern assessment
    - Internal Audit 2019/20 Annual Report including Head of Internal Audit Opinion
    - Internal Audit 2020/21 Plan
    - Report on progress with complying with GDPR
    - Counter Fraud 2019/20 Annual Report
    - Counter Fraud Workplan for 2020/21

Significant issues relating to the 2019/20 Annual Report and Accounts

The principal issues addressed have been:

- The Trust's ability to continue as a 'going concern'. The Committee considered cash flow projections for both 2020/21 and 2021/22 (the latter in summary form) including sensitised versions; evaluated the key assumptions underpinning the cash flows; considered the impact of Covid-19; and assessed the reliability of historical forecasts, following which it recommended that the Trust Board make the statement set out on page 11 of this Annual Report.

- The impact on the Trust's financial statements of the independent revaluation of the Trust's operational and investment property portfolios as at 31 December 2019 (updated to consider the position at 31 March 2020). This included a slight increase in the valuation of investment properties resulting from increases in some rental yields and a stabilisation in market sentiment, despite uncertainty relating to the United Kingdom's exit from the EU and the impact of Covid-19.

- The adequacy of provisions, for example in relation to debtors and contractual disputes, which are by their nature judgmental.

- An assessment of internal control environment and its impact on statements made in the Annual Report and Accounts.

- The findings by the external auditor regarding the Annual Accounts, and in particular its qualification of scope.

All matters in relation to the 2019/20 Annual Accounts were resolved to the satisfaction of both the Committee and the Trust's external auditors without requiring accounting adjustments. Where such adjustments are proposed by the auditors, the Committee considers both their nature and materiality in deciding whether the Trust should record them. No significant adjustments were proposed for the year under review.

Risk management and internal control

In tandem with the Risk & Safety Committee, which principally focuses on clinical and related risks, the Audit Committee keeps under review the overall risk profile and the financial and certain operational risks to which the Trust is exposed. Throughout the financial year the Board, through the Committee and assisted by the Internal Audit function, reviews the effectiveness of internal control and the management of risk. The Internal Audit function reports into the Committee and has authority to review any relevant part of the Trust and has a planned schedule of reviews that coincide with the Trust's risks. It also considers the output of the Trust's counter-fraud provider. From all these sources of data the Committee seeks to assess the quality and adequacy of the internal financial controls in place at the Trust. No new major financial risks were identified during the year.

During the year under review, the Trust's internal auditors (KPMG) issued an overall Head of Internal Audit Opinion of 'significant assurance with minor improvements required'. They found there 'is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in all key areas reviewed'. The overall opinion is based on the completion of five internal audit reviews. Three reviews found 'significant assurance with minor improvements required (Financial Controls, Mandatory Training and GDPR follow up) and two reviews found 'partial assurance with improvements required' (Data Security & Protection Toolkit and Emergency Preparedness). In all, there were three high priority recommendations, twelve medium and six low priority

Across the reviews and reports, 'medium' and 'low' priority recommendations were also made by the Trust's external and internal auditors aimed at improvements in systems and processes. The Committee monitors the implementation by executive management of all auditor recommendations. All recommendations have been accepted by management, or are under consideration, and the necessary actions have been agreed and are underway. There were no overdue responses to recommendations at the end of the year under review.

The Trust's counter-fraud service did not identify any matters of significant financial concern during the year under review emerging either from its own work programme or from reports by members of staff or the public.

External audit
The Committee engaged regularly with the external auditor over the course of the financial year. A summary of the meetings of the Committee and the significant issues relating to the Annual Report and Accounts is given above: they include consideration of the external audit plan, matters arising from the audit of the Trust's financial statements including any going concern considerations, and any recommendations on control and accounting matters proposed by the external auditor. There is also a private session held with the external auditor at which executive management is not present. The Committee has formally reviewed the independence of the External Auditor, who has provided a letter confirming that it believes it remained independent throughout the year, within the meaning of the regulations on this matter and in accordance with its professional standards. The Audit Committee regularly carries out an evaluation of the effectiveness of the external audit process. This is achieved through assessment by individual Committee members and attendees of performance against a set of pre-determined criteria. The Committee also undertakes a regular self-evaluation process with input from members and other Trust attendees. During 2019/20 no additional fees were earned by the external auditors for other assurance work. A formal tender process was conducted in 2019 for the provision of the external audit service. Deloitte LLP was re-appointed to that role for a period of three years after a competitive tender involving five other firms.

Internal audit
Each year the Committee reviews and approves the internal audit plan, and reviews internal audit reports and the internal auditor's annual report and head of internal audit opinion. These items are discussed with the internal auditors at Committee meetings, as are the outstanding recommendations from both internal and external auditors and how these are responded to by management.

Counter-fraud service
Each year the Committee reviews and, where appropriate, approves the counter-fraud annual risk assessment and work plan, progress reports and annual report. Details of individual referrals are considered and actions by executive management are noted.

Finance Committee Report

Role and responsibilities

Since September 2017 the Finance Committee has been a formally constituted committee established by the Trust Board to which it is directly accountable. Prior to that date the Committee had been an ad hoc Board committee which carried out a similar role. This change in status followed a recommendation resulting from a 'Well-Led' governance review of the Trust carried out in 2016/17 by PricewaterhouseCoopers LLP.

The Committee's objectives are:

- To monitor and oversee on a regular basis: the financial performance of the Trust, budgets and planning including capital expenditure plans, revenue and cash forecasts, liquidity and borrowings, and the effectiveness of the Trust's accounting systems.

- To consider and, where appropriate, make recommendations to the Board with respect to: operating practices which may impact on financial performance; aspects of financial performance which could be detrimental to achieving the Trust's financial objectives; the Trust's financial policies, financial reporting processes and formats; financial aspects of the Trust's strategic planning. Committee recommendations are considered carefully to ensure they are commensurate with the safety and well-being of Trust patients.

The Committee reports to the Trust Board at each Board meeting and at such other times as the Chair of the Trust may request. In carrying out its responsibilities the Committee reviews monthly finance reports and annual budgets and receives reports, principally from the finance team, on other significant financial matters.

Composition of the Committee

The members of the Committee who served during the year under review are disclosed on pages 27 and 28 of this Annual Report. Its membership comprises both executive and non-executive Board members. The Chair of the Audit Committee is also a member of the Committee. Other senior members of the finance team attend regularly; other Trust employees do so by invitation in accordance with the Committee's meeting agenda.

Summary of Committee meetings

Since the approval of the 2018/19 accounts there have been ten meetings of the Committee. At each meeting there was a review and discussion of the latest monthly finance report which includes details of variances against budget.

Other matters considered and discussed were:

- June 2019
    - Capital and Borrowing Controls
    - Write-offs of uncollectible NHS Overseas debtors

- July 2019
    - Darwin Programme
    - Financial position of Kier Construction, the main contractor of the Imaging Centre
    - A £10m Revolving Credit Facility (RCF) with HSBC
    - A £45m Bridging Loan facility with HSBC

- Write-off of uncollectible NHS Overseas debtors

- September 2019
  - Write-off of uncollectible NHS Overseas debtors
  - Interim Trust Long-term (5 Year) Plan
  - North West London STP/ICS

- October 2019
  - NHS Overseas Debtor Policy
  - Trust Long-term (5 Year) Plan status report
  - Approval of Delegated Authority for Compensation Events

- November 2019
  - Self-Evaluation Questionnaire
  - Trust Long-term (5 Year) Plan status report

- December 2019
  - Wimpole Street Performance
  - Embassy Debtors
  - Private Patient Options
  - Trust long-term plan status
  - Bridging Loan Facility

- January 2020
  - Internal Rate of Return (IRR) on and overall performance of Harefield Redevelopment
  - Critical Care (CC) Audit Update
  - Revised Standing Financial Instructions (SFI) Authority Levels
  - Processing of e-Fin Stock Requisitions
  - Self-Evaluation of Finance Committee

- February 2020
  - Darwin Progress
  - Research Income & Expenditure
  - Embassy Debtors/provisioning policy
  - 2020/21 Plan
  - Covid-19 contingency planning/financial implications

- March 2020
  - 2020/21 Plan and status of contract with NHS Commissioning bodies
  - Covid-19 Update

- April 2020
  - No meeting held due to the Covid-19 pandemic

- May 2020
  - Draft Annual Accounts 2019-20 - consideration of the Trust's going concern status
  - Covid-19 funding flows update
  - Capital Plan
  - Imaging Centre financing

The Risk & Safety Committee Report

Role and responsibilities

The Committee provides the Trust Board with independent and objective evaluation of whether the systems and processes in place in the Trust to manage risks, especially patient safety risks, are complete, appropriate, and working as intended and, through its work, will encourage continuous quality improvement.

In respect of risk management, the Committee reviews the trust's overall risk management systems, including clinical, infrastructure and risks to compliance with the terms of its NHS Provider Licence and, in particular, the Quality Governance Framework. Financial and corporate risks are overseen by the Audit Committee.

The Committee seeks assurance that the organisation has appropriate risk management processes in place to ensure delivery of the annual plan, and to ensure compliance with the registration requirements of the quality regulator.

In respect of financial and other risks covered by the Audit Committee, it draws on the work of that committee.

In respect of risks relating to patient safety and health & safety, the Committee reviews all sources of assurance on patient safety, clinical effectiveness, and patient and staff experience.

These include:

- Performance reports;
- Internal assessments - including, but not limited to, any reviews by internal audit and clinical audit; and
- External assessments - including, but not limited to, any reviews by Department of Health arm's length bodies or regulators / inspectors and professional bodies with responsibility for the performance of staff or functions.
- 'Deep dives' into specific areas of risk to review performance and to proactively anticipate future issues

In carrying out its activities the Committee is mindful of the interest of the Trust's Governors and Members.

Composition of the Committee

The members of the Committee who served during the period under review are disclosed on pages 27 and 28 of this Annual Report. Committee meetings are also regularly attended by the Chief Executive Officer, Chief Operating Officer, Medical Director, Director of Nursing & Clinical Governance and Trust Secretary.

Prof Peter Hutton chaired the Committee during 2019/20. The Committee's agenda links closely to that of the Audit Committee, particularly as regards risk identification and management. The chair of the Audit Committee is also a member of the Risk & Safety Committee and vice versa.

Summary of Committee meetings

Since the approval of the 2018/19 Annual Report and Accounts the Committee has met on four occasions. These sessions considered the following subjects:

- July 2019
  - Cancer Service
  - Risk Register – Review of Top Trust risks
  - Learning from Deaths
  - Serious Incidents
  - Quality Priorities
  - 7 Day Services
  - NHS Patient Survey 2018
  - Infection, Prevention & Control
  - Complaints
  - Safeguarding
  - Health & Safety
  - Controlled Drugs
  - Safer Working
  - Governance & Quality Committee minutes
  - Terms of Reference

- September 2019
  - Quality presentation: Raising the issue of end of life care for patients in ILD
  - Risk Register – Review of Top Trust risks and deep dive – risk with medication
  - Serious Incidents
  - Trust Insurance Arrangements
  - CQC Action Plan
  - Freedom to Speak Up update
  - Learning from Deaths
  - Pharmacy and Medicines Optimisation
  - Older people
  - End of Life Care
  - Controlled Drugs
  - Governance & Quality Committee minutes

- November 2019
  - Quality presentation: nutrition strategies 2019
  - CQC update
  - Top Trust risks – deep dive: Cyber security 3811
  - Leaning from deaths Medical Examiner update
  - Freedom to Speak Up Update
  - Tissue Governance
  - Mortuary Update
  - Serious Incidents
  - Controlled drugs
  - Safer Working

- February 2020
    - Quality presentation: Improving post-operative Nutrition provision to cardiac patients on PICU
    - CQC update
    - Top Trust risks – schedule of deep dives and deep dive risk 3845: staffing
    - Quality Priorities
    - Pathology Quality Assurance Dashboard
    - Serious Incidents
    - Learning from Deaths
    - Sustainability: Quality Improvement project presentation and Trust current position update
    - Governance & Quality Committee minutes

- April 2020

    The formal meeting of the committee was cancelled due to Covid-19, but the Chair and Executive Officers met to ensure that work in progress was on-going and to agree the processes that had been put in place to manage the Covid-19 epidemic.

The Committee's responsibilities and activities dovetail with those of the Audit Committee and procedures are in place to avoid both omission and duplication.

Significant issues addressed in 2019/20

The principal issues addressed included:

- **Care Quality Commission inspection report (Feb 19).** The related action plan was a focus for the Committee. There were two requirements identified in the report – firstly relating to strengthening the documentation of the Board Assurance Framework, and secondly providing assurance that historic gaps in records relating to Fit and Proper Persons processes have been closed. The associated action plan was reviewed and agreed. The Committee also recognised the areas of good practice that were identified during the inspection.

- **Learning from Deaths**. This process continued to evolve across the year, and changes discussed at the Committee included the introduction of the Structured Judgment Review to the current mortality review sessions on the RBH site, with a view to extending this to Harefield. A new Datix module has been purchased, improving the documentation from the mortality review process, and allowing for cross-reference with incidents, complaints and claims to identify themes and lessons learned by the Trust.

- **Learning Disability Strategy**. This was developed and presented in early 2020.
  Key priorities were identified as:
- Identification of total RBHT population
- Developing the skills of staff to respond to the needs of patients with learning disabilities
- Working in partnership with patients, family and carers to provide personalised and adjusted care.
- Promotion of the hospital passport system
- Partnering with health, social care and third sector to ensure seamless and safe care
- Development of an annual audit plan to track progress against the priorities.

- **The structure and membership** of the Committee had been static for many years. Both these aspects were reviewed in the light of the best practice of the Committee to meet current needs. This resulted in updated terms of reference, and revised membership for the Committee which was approved by the Trust Board on 24th July 2019.

Risk management and internal control

In tandem with the Audit Committee, the Risk & Safety Committee keeps under review the overall risk profile of the Trust and has a particular focus on the clinical risks to which the Trust is exposed. In this work it is informed not only by management but also by staff working at the frontline, and in some cases also by reports from internal and external auditors or other review mechanisms. From all these sources of data the Committee seeks to assess the quality and adequacy of the internal controls in place at the Trust.

Across the year, and following changes to how the risk register is presented to the Committee, a number of deep dives were presented by the overall risk owner to the Committee for discussion.

- Emergency preparedness, resilience and response - presented by the Trust EPRR officer.

  Overall, the Trust is strong in this area, with a mature programme established over the last few years. This includes a well-established programme of continuous exercise and training; including a 3 yearly multi-agency exercise at one of the Trust sites. This was most recently undertaken in partnership with LFB, and involved a full evacuation exercise at one of the Chelsea site buildings. The Trust EPRR officer also contributes to a number of workstreams at a national level.

  The Trust has been assessed in this area both by NHSE, and by our internal auditors (KPMG). Both assessments were positive, and actions from the assessments were focussed on strengthening the structure surrounding business continuity and clarifying the links between this programme and the governance structures of the Trust.

- Risks associated with medication - presented by Chief Pharmacist.

  There are currently detailed programmes of audit and review via our governance structures, identifying that the majority of risk remains the administration or medicines. Controls predominantly rest with the current pharmacy processes, which include working closely with the clinical teams at the bedside, education and advice, and monitoring of pharmacy incidents. Investment in technology to support medicines management includes the roll out of Medchart, and more recently, a software programme connecting syringe pumps with this system.

  Future priorities include working with Medchart to align and improve the system, extending the automated drug cabinet program outside of critical care areas, reducing the risk of picking errors, and extending the scope of weekend pharmacy services to reduce risk associated with pharmacy errors.

- Cyber security – presented by the Chief Innovation and Technology Officer

  Risk associated with aging IT estate were noted, and mitigations included the roll out of Window's 10 across the Organisation. It was also noted that because of the pace of change of digital technology and the increasing sophistication of attackers, it may be better to move towards a rolling programme of replacement and improvement without intermittent large-scale capital spends.

The need to balance clinician and patient ease of use against cyber-security levels that hampered care was underlined. The importance of good information governance training for all staff, whatever the grade, so that attacks could be recognised at their inception was recognised.

Key changes to summary risks.

- Risk associated with Brexit – removed Jan 2020
- Risk associated with Covid-19 – added Feb 20. Subset of risks documented covering issues associated with patient safety, staff safety, estates and procurement issues, as well as the potential broader impact on the organisation.

The Risk and Safety Committee has a key role in monitoring the Quality Report's content, the determination of Quality Priorities, their ongoing monitoring and for providing assurance to the Board of Directors that robust quality governance arrangements are in place throughout the Trust and working effectively. The Risk and Safety Committee and the Governance and Quality Committee were instrumental is agreeing the quality priorities for 2020/21.

The completed Quality Report is usually subject to review by the Trust's external auditors however, due to the exceptional circumstances experienced as a result of Covid-19, NHS England waived the external assurance requirements of the 2019/20 Annual Quality Report. The revised deadline for completion of the 2019/20 Annual Quality Report has also been delayed, and is now the 15 December 2020.

Board Assurance Framework

The Trust has a Board Assurance Framework (BAF), within which the key risks are identified that may prevent the Trust from achieving its stated objectives outlined in the Trust's strategy. The BAF consists of inter-related components: risk management structure (including roles and responsibilities), risk identification and assessment, action planning, monitoring, risk control review and assurance measures. In response to the CQC report published in February 2019, the Board has reviewed and expanded its Board Assurance Framework to include an enhanced focus on strategic risks and the monitoring of progress in delivery of the Trust's strategic objectives, and a refreshed version was presented to the Board in November 2019, with a risk and assurance cycle. The Trust continues to review and develop the Board Assurance Framework and a Board facilitated risk workshop was planned for 2020, however it is currently delayed with Covid-19 and NHSI guidance to streamline Board meetings.

Our Board Assurance Framework is the framework for identification and management of strategic risks that might compromise the achievement of our strategic objectives. The purpose of the BAF is to:

- Provide timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues

- Facilitate escalation of risk and control issues requiring visibility and attention by senior management, by providing a cohesive and comprehensive view of assurance across the risk environment

- Provide an opportunity to identify gaps in assurance needs that are vital to the organisation, and to address them

- Provide critical supporting evidence for the production of the Annual Governance Statement.

During 2019/20 the Audit, Risk and Safety and Finance Committees continued to adopt a robust approach to reviewing and monitoring risks associated with their respective remits. Each Committee considers any gaps in risks, the effectiveness of controls and the extent to which they are assured by the evidence presented for each risk.

In turn, these capabilities combine as a strategy to deliver our mission to be a leading centre in the delivery of care for patients with heart and lung diseases, and to help differentiate the Trust from our competitors and guide how we optimise our use of resources. Some programmes/issues are sufficiently wide-ranging to be linked to several of these capabilities – e.g. the Trust's collaboration with King's Health Partners.

As with the Risk Register, each of these programmes and issues is owned by, or linked to, a (Board or non-Board) Executive Director.

Our assurance framework provides the reliable evidence that underpins the assessment of the risk and control environment for the Annual Governance Statement (from page 86) supported by independent appraisal from our internal auditor.

Performance Evaluation of the Board of Directors

The Board of Directors recognises the importance of ensuring ongoing assessment of its own performance, that of its committees and of its directors, including the Chair, to ensure all aspects remain fit for purpose and support the sustainability of the Trust and the delivery of its strategic vision.

Monitor published guidance on the Well-Led Framework for governance reviews in April 2015 and NHS Improvement maintained the requirement to carry out these reviews since its inception on 1 April 2016.

Foundation Trusts are required to undertake a Well-Led Governance Review every three years. During 2016/17, the Trust commissioned PricewaterhouseCoopers LLP (PwC) to facilitate an evaluation of the Board of Directors. PwC was appointed following a competitive tendering process. PwC does not have any other connection to the Trust; Non-Executive Directors Simon Friend and Mark Batten are both former partners of PwC, but the appointment of PwC predates their involvement with the Trust.

The review was carried out between September and December 2016 and the findings were reported to the Trust Board at a Board Seminar held on 25 January 2017.

No material governance concerns were identified, and this finding was communicated to NHS Improvement in early February 2017 as required.

The *NHS Foundation Trust Code of Governance* requires an external review of Board performance every three years and therefore the next one was expected to be undertaken during 2019/20. A process to procure an external reviewer was underway, however this was paused due to the effects of Covid-19.

The Chair evaluates through appraisal all Non-Executive Directors. Similarly, the Chief Executive evaluates the Executive Directors; and the Senior Independent Director evaluates the Chair. The Chair reported her appraisals of the non-executive directors to the Nominations and Remuneration Committee (Governors) at its October 2019 meeting. The Senior Independent Director provided an appraisal of the Chair to the same meeting, and the Committee agreed to commend a proposal to reappoint the Chair for a second term, which

was ratified by the Council of Governors in October 2019. The Nominations and Remuneration Committee (Board) received appraisals of the Executive Directors at its meeting in March 2020, where they also considered their conditions.

Board of Directors

The Board of Directors brings a wide range of experience and expertise to the Trust and during 2019/20 has continued to deliver effective governance of the organisation. The Directors have been responsible for preparing this Annual Report and the associated Accounts and consider that, taken as a whole, they are fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

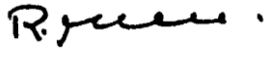
During 2019/20 the Board of Directors comprised:

Non-Executive Directors	Executive Directors
Chair Baroness (Sally) Morgan of Huyton	Chief Executive and Accountable Officer Robert J Bell
Deputy Chair Simon Friend	Associate Chief Executive – Finance Richard Paterson – Left 31 January 2020
Luc Bardin	Director of Development and Partnerships Robert Craig
Mark Batten	Director of Nursing & Clinical Governance Joy Godden
Professor Kim Fox (term ended 31 May 2019)	Medical Director and Responsible Officer Dr Richard Grocott-Mason (stepped down 15 July 2019)
Professor Peter Hutton	Director of Service Development Nick Hunt
Janet Hogben	Chief Operating Officer Jan McGuinness
Richard Jones (term ended 24 April 2020)	Chief Financial Officer Richard Guest (from 1 February 2020)
Dr Javed Khan	Medical Director and Responsible Officer Dr Mark Mason (from 15 July 2019)
Prof Bernard Keavney (from 2 June 2019)	

Further details of Board members, and their periods of office, are provided in Section 2.2 of this Annual Report.

Accounting Officer's Statement

This Accountability Report has been prepared in accordance with the requirements of the *NHS Foundation Trust Annual Reporting Manual 2019/20*.



..... **22 June 2020**

Robert J Bell
Chief Executive
On behalf of the Board of Directors

Disclosures in the Public Interest

NHS Improvement guidance indicates that a set of key disclosures should be incorporated within the Annual Report.

Income Disclosures required by Section 43 (2A) and Section 43 (3A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England, during the financial year 2019/20, was greater than the income received from the provision of goods and services for any other purposes.

Goods and services for the purposes of the health service in England continued to be delivered throughout 2019/20 and there was no detrimental impact on these services as a result of the other income received during this period.

Better Payment Practice Code

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 the later. The Trust's performance against the code in 2019/20 has been calculated as follows:

Measure of Compliance	Number	£000s
Non-NHS		
Total non-NHS bills paid in the year	89,143	220,453
Total non-NHS bills paid within target	87,681	207,932
Percentage of non-NHS bills paid within target	**98%**	**94%**
NHS		
Total NHS bills paid in the year	2,033	52,608
Total NHS bills paid within target	1,927	51,934
Percentage of NHS bills paid within target	**95%**	**99%**
Total		
Total bills paid in the year	91,176	273,061
Total bills paid within target	89,608	259,866
Percentage of bills paid within target	**98%**	**95%**

Countering Fraud and Corruption

The Trust contracts with TIAA Ltd to provide counter-fraud services. TIAA Ltd is an accredited counter-fraud specialist. Investigations are carried out as required and outcomes reported to the Audit Committee.

Remuneration - salary and pension entitlements of directors

Details of the salary and pension entitlements of directors are set out in the Annual Remuneration Report, at section 2.2 of this document.

Accounting Policies for Pensions and Retirement Benefits

Accounting policies for pensions and retirement benefits are set out in note 9 of the Accounts, Annex 1 of this document.

Staff Consultations

During 2019/20 The Trust has concluded the following formal consultations / organisational changes:

- Procurement team changes, new roles, future proofing skill set, and capability change of organisational structure.
- Pharmacy on call changes – circa 80+ people regarding on call provision and availability of pharmacy service across trust hospitals.
- Medical Secretaries – Organisational changes to a new way of working via "hubs" & providing service to internal consultants & medical staff as appropriate
- Physio team changes - Weekend Working Consultation on changes for therapy assistant staff
- Hospital2Home - restructure of department & roles with reduction in number of roles. Two staff at risk, all other staff redeployed within new structure.
- Clinical Records – close of dept at RBH, minimal impact on staff.

Public Consultations
None

Ill-health Retirements
Details of ill-health retirements during the period are disclosed in note 8 of the Accounts.

Other Operating Revenues
Details of Other Operating Revenues are disclosed in note 4 of the Accounts.

Data Loss/Confidentiality Breach
During 2019/20 there were no incidents which required reporting to the Information Commissioner's Office.

Cost Allocation and Charging Requirements
The Trust has complied with HM Treasury and Office of Public Sector Information guidance with regard to cost allocation and charging.

Value of Fixed Assets
As noted in the section of this report dealing with Trust Financial Performance for 2019/20, the Trust's operational and investment portfolios were revalued as at 31 December 2019 by independent valuers (see Notes 15-17 to the Financial Statements).

Donations
The Trust has made no charitable or political donations during the period.

Events since 31 March 2020
There have been no post-balance sheet events requiring disclosure.

Financial Instruments
The extent to which the Trust employs financial instruments is set out in note 26 to the Accounts.

Related Party Transactions
During the year the Trust had numerous material transactions with the Department of Health and Social Care and with other entities for which the Department is regarded as the parent. In addition, the Trust had a number of material transactions with Imperial College of Science, Technology and Medicine (relating to research projects). Related party transactions are set out in note 28 to the Accounts.

2.2 Remuneration Report

Annual Statement of Remuneration

The Chief Executive has confirmed, in line with the *NHS Foundation Trust Annual Reporting Manual 2019/20* (s2.49), that the definition of senior managers to be used for this Remuneration Report covers the Chair, and the Executive and Non-Executive members of the Trust Board.

The Nominations and Remuneration Committee of the Trust Board (composed of Non-Executive Directors) met on 31 March 2020 in order to agree remuneration for the Executive Directors during 2020/21.

The remuneration of Executive Directors increased as shown in the table on page 59 of this report.

…… **22 June 2020**

Janet Hogben
Chair of the Nominations and Remuneration Committee of the Trust Board

Annual Statement of Remuneration Continued

During 2019/20, the Nominations and Remuneration Committee of the Council of Governors (composed of Governors and the Chair of the Trust) met in April, June, October and November of 2019.

Remuneration of the Non-Executive Directors did not change between 2018/19 and 2019/20.

…… **22 June 2020**

John Hensley
Chair of the Nominations and Remuneration Committee of the Council of Governors

Senior Managers' Remuneration Policy

The Trust policy is for all Executive Directors to be on permanent Trust contracts with six months' notice. Salaries are awarded on an individual basis, taking into account the skills and experience of the post holder, and comparable salaries for similar posts elsewhere. Salary data, taken where appropriate from other NHS organisations and other public-sector bodies, is benchmarked. Pay is also compared with that of other staff on nationally agreed Agenda for Change Terms and Conditions, and Medical and Dental Terms and Conditions. Remuneration consists mainly of salaries (which are subject to satisfactory performance) and pension benefits in the form of contributions to the NHS Pension Fund.

The policy for Non-Executive Directors is to appoint on fixed term contracts of three years. Non-Executive Directors are not generally members of the Pension Scheme, and receive their emoluments based on benchmarking data for similar posts elsewhere in the NHS.

Future Policy Table

Item	Salary / Fees	Taxable Benefits	Annual Performance Related Bonus	Long-Term Related Bonus	Pension Related Benefits
Support for the short and long-term strategic objectives of the Foundation Trust	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives	None	Ensures recruitment / retention of a high calibre Medical Director	None	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid in even twelfths	None	Clinical Excellence Award; only available to medical staff	None	Contributions paid by both employee and employer
Maximum payment	As set out on page 58 of this Annual Report	None	As set out on page 58 of this Annual Report	None	Lifetime allowance for taxation purposes; £1,030,000 from April 2018
Framework used to assess performance	Trust appraisal system	None	Clinical Excellence Awards	None	N/A
Performance Measures	Tailored to the post concerned	None	Tailored to the post concerned	None	N/A
Performance period	Concurrent with the financial year	None	Concurrent with the financial year	None	N/A
Amount paid for minimum level of performance and any further levels of performance*	Salaries / Fees are agreed on appointment and set down in the contract of employment	None	There are a number of different levels of clinical excellence awards and the amount awarded depends upon an external assessment of the individual undertaken by their peers.	None	N/A
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any overpayments may be recovered	None	Any overpayments may be recovered	None	N/A

*In the case of the Medical Director, the Clinical Excellence Award is based upon his standing within the specialty of Cardiology. This is assessed by his peers, not by the Trust, although the payment is made by the Trust.

Annual Report on Remuneration

Nominations & Remuneration Committee of the Trust Board

The Nominations and Remuneration Committee of the Trust Board (composed of Non-Executive Directors) met in March 2020.

In discharging its responsibilities to oversee the remuneration of the Executive Directors, the Committee has taken into account information concerning the performance of the Executive Directors supplied by the Chief Executive. The Committee has been advised by the Hay Group in respect of benchmarking rates of pay for senior managers across London. The Hay Group is not connected to anyone at the Trust in any respect, and does not provide any other services to the organisation.

The policy on the pay of Executive Directors during 2019/20 was based upon comparison with salaries paid to directors of comparable healthcare organisations. The Chief Executive undertakes an objective-setting exercise with each senior manager and performance against these objectives is kept under review by the Chief Executive. The Chief Executive is in turn appraised by the Chair of the Trust. The Trust did not consult employees when preparing the senior managers remuneration policy.

Our Remuneration Committee work with respected and regarded agencies to secure appropriate candidates for consideration to executive roles at the Trust. In the past two years all agencies have been directed as part of their work to seek candidates that reflect the diverse and inclusive nature of our organisation and that drive the inclusivity agenda. Further to this, we recruit at all levels ensuring all candidates have an equal chance of appointment based solely on their merits.

The contracts of senior managers are normally awarded on the basis of a substantive contract.

During 2019/20 Mr. Richard Guest was appointed as Chief Financial Officer and is also a Board Executive Director.

Members of the Committee, and their attendance are shown on pages 27 and 28 of the Annual Report, and expenses are shown on page 26 for the Governors and 59 for the Board.

Nominations & Remuneration Committee of the Council of Governors

The Nominations and Remuneration Committee of the Council of Governors (composed of Governors and the Chair of the Trust) met four times during 2019/20: April, June, October and November 2019.

In discharging its responsibilities to oversee the remuneration of the Chair and the Non-Executive directors, the Committee has taken into account information concerning the performance of the Chair and the Non-Executive Directors.

During 2019/20, following the expiry of the terms of office of Professor Kim Fox and Mr. Richard Jones, the Nominations and Remuneration Committee of the Council of Governors recommended the Non-Executive Director appointments of Professor Bernard Keavney and Ian Playford. All of these recommendations were subsequently ratified by the full Council of Governors.

When dealing with the appointment of a Chair or Non-Executive Director, the Committee considers the appropriateness of obtaining external advice and support. The views of the Chair and the Board of Directors are taken into account as appropriate on the qualifications, skills and experience required for each position in order to identify suitable candidates. Following an open and transparent selection process the Committee makes recommendations

to the Council of Governors for appointment. The appointment and renewal of a Chair and Non-Executive Director is decided by the Council of Governors.

The remuneration of the Non-Executive Directors did not change between 2018/19 and 2019/20.

Members of the Committee, and their attendance are shown on page 22 of the Annual Report. The terms of reference of the Committee are available on request from the Trust Secretary.

The following Table shows the date of appointment of directors, together with the type of contract issued and the unexpired term of appointment where applicable:

Name	Role	Date Appointed	Contract / Unexpired Period at 31 March 2020
Baroness (Sally) Morgan	Chair	1 January 2017 Renewed 1 Jan 2020	33 months
Robert J Bell	Chief Executive	28 March 2005	Substantive contract, no end date specified
Luc Bardin	Non-Executive Director	1 June 2015 Renewed 1 June 2018	14 months
Mark Batten	Non-Executive Director	1 November 2017	7 months
Prof Kim Fox	Non-Executive Director	1 June 2013 Renewed 11 May 2016	Left 31 May 2019
Simon Friend	Non-Executive Director Deputy Chair	1 August 2017	4 months
Janet Hogben	Non-Executive Director	1 December 2018	20 months
Prof Peter Hutton	Non-Executive Director	26 February 2019	23 months
Dr Javed Khan	Non-Executive Director	26 February 2019	23 months
Richard Jones	Non-Executive Director	25 February 2014 Renewed 25 Feb 2017 Renewed 25 Feb 2020	1 month
Prof Bernard Keavney	Non-Executive Director	2 June 2019	27 months
Robert Craig	Director of Development & Partnerships	25 July 2018 (COO from Oct 2008 until July 2018)	Substantive contract, no end date specified
Joy Godden	Director of Nursing and Clinical Governance	29 July 2015	Substantive contract, no end date specified
Dr Richard Grocott-Mason	Medical Director (undertook new role from July 2019)	27 July 2016 to 15 July 2019	Substantive contract, no end date specified
Richard Guest	Chief Financial Officer	7th January 2020	Substantive contract no end date specified
Nicholas Hunt	Director of Service Development	23 July 2014	Substantive contract, no end date specified
Richard Paterson	Associate Chief Executive - Finance	26 October 2011	Left 31 January 2020
Dr Mark Mason	Medical Director	24 July 2019	Substantive contract, no end date specified
Jan McGuinness	Chief Operating Officer	25 July 2018	Substantive contract, no end date specified

Note: renewal of Non-Executive Director appointments is dated from the meeting of the Council of Governors at which the appointment was ratified. The term of the appointment itself is contiguous with the preceding term and this is reflected in the calculation of the unexpired period.

The standard notice period for an Executive Director is six months. No termination payments have been made to Executive Directors during the reporting period.

Salary and Pension Entitlements of Directors (Audited Information)

£000 unless otherwise stated	1 April 2019-31 March 2020								1 April 2018-31 March 2019							
	Salary	Other Remuneration	Taxable Benefits	Annual Performance Related Bonuses	Long-Term Performance Related Bonuses	Pension Related Benefits	TOTAL	Expenses	Salary	Other Remuneration	Taxable Benefits	Annual Performance Related Bonuses	Long-Term Performance Related Bonuses	Pension Related Benefits	TOTAL	Expenses
	(bands of £5000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)	Rounded to the nearest £100
Baroness Morgan Chairman	60-65						60-65	800	60 - 65						60 - 65	100
Robert J. Bell Chief Executive	290-295						290-295	900	285 - 290						285 - 290	1,000
Dr R Grocott-Mason Medical Director (until 14/7/19); Managing Director RBH-KHP Partnership (from 15/7/19)	80-85	150-155		35-40*		77.5-80.0	350-355		70 - 75	140 - 145		35 - 40*		0 - 2.5	250 - 255	
Dr M Mason Medical Director (from 15/7/19)	45-50	90-95		10-15*		32.5 - 35.0	185-190									
Robert Craig Director of Development & Partnerships	170-175					10-12.5	185-190		170 - 175					55 - 57.5	225 - 230	
Jan McGuinness Chief Operating Officer	160-165					40-42.5	205-210		150 - 155					37.5 - 40.0	190 - 195	
J. Godden Director of Nursing	140-145					65-67.5	210-215		130 - 135					70 - 72.5	200 - 205	
Richard Paterson Associate Chief Executive - Finance (until 31/1/20)	175-180						175-180		200 - 205						200 - 205	600
Richard Guest Chief Financial Officer (from 07/01/20)	45-50					10-12.5	55-60									
Nick Hunt Director of Service Development	130-135						130-135		130 - 135					nil	130 - 135	
Kate Owen Non-Executive Director (until 31/11/18)									10 - 15						10 - 15	
Dr Andrew Vallance-Owen Non-Executive Director (until 25/02/19)									20 -25						20 - 25	
Lesley-Anne Alexander Non-Executive Director (until 25/02/19)									10 - 15						10 - 15	
Kim Fox Non-Executive Director	0-5	30-35					30-35		0 - 5	30 - 35					30 - 35	
Richard Jones Non-Executive Director	15-20						15-20	800	15 - 20						15 -20	700
Simon Friend Non-Executive Director	20-25						20-25		20 - 25						20 -25	
Mark Batten Non-Executive Director	15-20						15-20		20 - 25						20 - 25	
Janet Hogben Non-Executive Director (from 2/01/19)	15-20						15-20		0 - 5						0 - 5	
Javed Khan Non-Executive Director (from 26/02/19)	15-20						15-20		0 - 5						0 - 5	
Peter Hutton Non-Executive Director (from 26/02/19)	25-30						25-30	3,900	0 - 5						0 - 5	
Bernard Keavney Non-Executive Director (from 02/06/19)	10 - 15						10 - 15	600								
Luc Bardin Non-Executive Director	15-20						15-20		15 - 20						15 - 20	

* Clinical Excellence Award

Dr R Grocott-Mason is no longer an executive director but is still considered to be a senior manager.

The reported figure for pension related benefits is calculated under the HMRC method for valuing pension benefits, and reflects the real increase in value of the individual's pension entitlement In the year, less employee contributions. The value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

Cabinet Office Senior Pay Transparency Threshold

£150,000 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. The threshold is £150,000 to align with the Cabinet Office senior pay transparency threshold. The Cabinet Office approvals process does not apply to NHS Foundation Trusts but is considered a suitable benchmark above which NHS Foundation Trusts should make this disclosure.

It can be seen from the table on page 59 of this report that four members of the Trust Board receive a salary greater than £150,000, disclosed pro rata as required. The Nominations and Remuneration Committee of the Trust Board has taken steps to satisfy itself that this level of remuneration is reasonable through benchmarking comparisons with Trusts of a similar size and complexity.

Fair Pay Multiple Requirements (Audited Information)

Median salary for Trust employee	**2019/20**	**2018/19**
	£39,030	£39,030

The highest paid officer of the Trust (total remuneration £290k-£295k, 2018/19 £285k-£290k) represented a multiple of 7.5 times that of the median employee (2018/19: 7.4).

Pension Entitlements of Directors
(Audited Information)

Name and title	Real increase/ (decrease) in pension at retirement age at 31 March 2020 (bands of £2,500) £000	Real increase/ (decrease) in lump sum at retirement age at 31 March 2020 (bands of £2,500) £000	Total accrued pension at retirement age at 31 March 2020 (bands of £5,000) £000	Lump sum at retirement age to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real increase/ (decrease) in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000
Robert J. Bell Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Richard Grocott-Mason Medical Director (until 14/7/19)	2.5 - 5.0	12.5 - 15.0	60.0 - 65.0	185.0 - 190.0	1,480	115	1,311
Dr Mark Mason Medical Director (from 15/7/19)	0.0 - 2.5	0.0 - 2.5	50.0 - 55.0	120.0-125.0	1,053	24	971
Richard Guest Chief Financial Officer (from 7/1/20)	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0	11	0	0
Robert Craig Director of Development & Partnerships	0.0 - 2.5	(2.5) - (5.0)	70.0 - 75.0	170.0 - 175.0	1,467	23	1,385
Joy Godden Director of Nursing	2.5 - 5.0	10.0 - 12.5	60.0 - 65.0	185.0 - 190.0	1,510	106	1,351
Jan Mc Guinness Chief Operating Officer	2.5 - 5.0	0.0 - 2.5	10.0 - 15.0	0	216	32	157
Nick Hunt Director of Service Development	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Pension calculations are provided by NHS Pensions Agency (NHSPA)

Dr.M Mason and Mr R Guest are new additions to this table in 2019/20

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement to secure pension benefits when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

There is no CETV for employees who have reached retirement age as defined by the scheme of which they are a member. Officers who were over the retirement age for 'the 1995 section', and who have now changed to 'the 2008 section' with its higher retirement age, will have acquired a CETV during the year.

Real increase (decrease) in CETV - this reflects the change in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement. During the year, the Government announced that public sector pension schemes will be required to provide indexation on the Guaranteed Minimum Pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

Off-Payroll Arrangements

In May 2012, HM Treasury published 'Review of the tax arrangements of public sector employees' the focus of which was the minority of individuals who are engaged to provide services within the public sector and who do not have PAYE and NICs deducted at source, and are therefore 'off-payroll'. The review recommended that for all new engagements and contract renewals:

- Board members and/ or senior officials with significant financial responsibility should be on the organisation's payroll, unless there are exceptional circumstances, in which case the Accounting Officer should approve the arrangements, and such exceptions should exist for no longer than six months; and

- engagements of more than six months in duration, for more than a daily rate of £245 (deemed 'highly paid'), should include contractual provisions that allow the Trust to seek assurance regarding the PAYE and NICs obligations of the individual, and to terminate the contract if that assurance is not provided.

The Trust engages 'highly paid' individuals off-payroll in circumstances where the engagement is of a project and/or specialist nature and as such does not fit the requirements of a permanent role and has put in place the contractual provisions as recommended in the review. The tables below, which follow reporting requirements as defined in the *NHS Foundation Trust Annual Reporting Manual*, disclose the position at the Trust at 31 March 2020.

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

Number of existing arrangements as of 31 March 2020	14
of which:	
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	8
Number that have existed for between two and three years at time of reporting	3
Number that have existed for between three and four years at time of reporting	1
Number that have existed for four or more years at time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	7
of which:	
Number assessed as within the scope of IR35	7
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to the Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll board member/senior official engagements

For any off-payroll engagements of Board Members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

No. of off-payroll engagements of Board Members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "Board Members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both off-payroll and on-payroll engagements.	19

Exit packages

Reporting of compensation schemes - exit packages 2019/20	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
<£10,000	1	10	**11**
£10,000 - £25,000	1	5	**6**
£25,001 - £50,000	-	3	**3**
£50,001 - £100,000	2	1	**3**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**4**	**19**	**23**
Total resource cost (£)	£137,364	£301,203	**£438,567**

Reporting of compensation schemes - exit packages 2018/19	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
<£10,000	-	1	**1**
£10,000 - £25,000	-	1	**1**
£25,001 - £50,000	-	1	**1**
£50,001 - £100,000	-	3	**3**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	1	**1**
Total number of exit packages by type	**-**	**7**	**7**
Total resource cost (£)	£0	£653,235	**£653,235**

Exit packages: other (non-compulsory) departure payments	2019/20		2018/19	
	Payments agreed Number	**Total value of agreements £000**	**Payments agreed Number**	**Total value of agreements £000**
Voluntary redundancies including early retirement contractual costs	-	-	3	543
Mutually agreed resignations (MARS) contractual costs	6	143	-	-
Early retirements in the efficiency of the service contractual costs	1	27	-	-
Contractual payments in lieu of notice	8	95	3	92
Exit payments following Employment Tribunals or court orders	4	36	1	18
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**19**	**301**	**7**	**653**
Of which:				
Non-contractual payments requiring HMT approval are made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Average numbers of employees (WTE basis)

Average number of employees (WTE basis)	Permanent Number		Other Number		2019/20 Total Number		2018/19 Total Number
Medical and dental	533		4		**537**		523
Ambulance staff	-		-		**-**		-
Administration and estates	935		49		**984**		984
Healthcare assistants and other support staff	219		6		**225**		209
Nursing, midwifery and health visiting staff	1,437		41		**1,478**		1,445
Nursing, midwifery and health visiting learners	-		-		**-**		-
Scientific, therapeutic and technical staff	661		24		**685**		658
Healthcare science staff	-		-		**-**		-
Social care staff	-		-		**-**		-
Other	-		-		**-**		-
Total average numbers	**3,785**		**124**		**3,909**		**3,819**
Of which:							
Number of employees (WTE) engaged on capital projects	-		-		**-**		-

The comparative headcount figure for 2018/19 has been adjusted compared to that reported in the prior year for comparability with the current year report, with a net increase in the headcount of 82 WTE.

This Remuneration Report has been prepared having regard to the requirements of the *NHS Foundation Trust Annual Reporting Manual 2019/20*.

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Robert J Bell **22 June 2020**
Chief Executive
On behalf of the Board of Directors

2.3 Staff Report

Introduction

Our Employees are our Trust, we are proud of them. Proud of the contribution they make to our organisation and the significant and positive difference they make to the lives of their patients. As an academic organisation, we champion their professional and personal development. We recognise that organisational health and good staff engagement are key to employee satisfaction, productivity and the quality of service we deliver to our patients. To drive strong organisational health and resilience, we have established people programmes in health and well-being, organisational development and our culture. We continue to develop comprehensive people initiatives that promote organisational health and the values-driven work environment to which we aspire.

The results of the national 2019 Staff Survey is one of the key measures on staff engagement, organisational health and benchmarks us nationally, were published by the NHS Survey Coordination Centre in March 2020. These results drive our people strategy. Our results and the year on year trend are mostly positive, notable improvements in staff engagement, staff morale and the quality of appraisals experience. We have seen a reduction in reported bullying although there is still more to do.

People Programmes

In 2019 we have continued and expanded a range of programmes in support of our staff. These programmes are grouped into four key areas. Culture, Leadership Development, Safe Working Environment and Organisational Development.

The launch of our learning and development platform ‘Learn Now’ in 2019 has been a key enabler for the advancement of organisational development across the Trust. With over 3,750 users. It is a world class learning platform, designed and built for staff, rich with content and access for all including our Non-Executive Directors and Governors. Our Trust

wide mandatory training levels have significantly improved, the ‘Learn Now’ platform acts as an information portal for Health and Wellbeing, Leadership and Culture. We have begun a different and transformational approach to performance and appraisals, by moving to one more closely linked to coaching and ongoing conversations on a quarterly or monthly basis. Our new appraisal process and system will be developed further over the coming 12 months to include team appraisal and a behavioural competency model.

A key area of focus in support of staff continues to be Staff Wellbeing. In 2018 we began with the introduction of yoga, Tai Chi, pranic healing, mindfulness, walking and running groups, wellness forums, fitness challenges and resilience training. These initiatives are aimed at improving general staff health and reducing the incidence of work-related stress; they have been very popular. As a result of feedback from Staff Survey 2018 we developed this further and began the introduction of our Care for the Carers Programme. It is a framework that provides different levels of care and support for teams, and spaces for people to share their experiences. It supplements our other Mental Wellbeing inititives such as our Employee Assistance Programme and Strength and Resilience Training.

The Trust promotes Schwartz Rounds. These are confidential multidisciplinary forums open to all caregivers to discuss challenging social and emotional issues that arise when caring for patients. The aim of these forums is to help reduce staff stress whilst supporting them to provide compassionate healthcare.

This year we continued our inspiring organisational development programmes with a number of specific interventions. Seven of our senior leaders both clinical and non clinical graduated from the six month AHSC Leadership Programme, we launched a Positive Leadership Coaching Programme for 26 Clinical Care Group Leads and we continued with our leadership programme for Women returning to work from Maternity leave. Manager coaching support has continued in both Clinical and Non Clinical teams to enable better conversations around performance and the delivery of Trust goals in a value driven way.

The Trust continues to encourage staff recognition both locally within teams and Trust wide with the popular pan-Trust ‘Champions’ Awards’ run twice yearly. Nominations are made for individuals or teams from colleagues or customers who feel individuals have made an outstanding contribution to their team, service improvement, or delivering efficiencies. A ceremony is held where stories are shared, awards given, and successes celebrated. The results are published, and these often inspire others. Last year we reviewed the Award Categories and evolved them to include award for Unsung Heroes, Investing in People, Living the Trust Values and Sustainability and Environment. In 2019, two hundred and eight nominations were made by staff and twenty-one awards made.

Photograph shows York ward Staff accepting an award for Exceptional Team – Clinical on behalf of their colleagues from The Trust Chair, Baroness Morgan and Chief Executive Officer Robert Bell.

Communications with Staff

The Trust's Chief Executive and the Leadership Team hold Staff Forums and many informal meetings with employees across the organisation. Our Chief Executive updates staff on recent news and developments from a strategic perspective, he also listens to questions and comments from staff. Questions can be submitted in advance of any forum by anyone uncomfortable asking a question in public. We continue to encourage staff to be confident to speak up. The content of the forums is published on the intranet to inform anyone unable to attend.

The Trust has a staff magazine 'In Touch', which is complemented by the monthly 'What's New?' news bulletin, both of which are distributed throughout the Trust. The 'Trust News' and 'Trust Matters' pages on the intranet are also widely used by Trust staff.

Staff Consultations

The staff consultations undertaken during the year are listed in full on page 53.

Summary of Performance - NHS Staff Survey

The Trust participates in the annual NHS Staff Survey and the results of the 2019 survey are summarised below.

Response rate

We invited 3,493 staff at the Trust to complete the survey. This year, being mindful of feedback from the 2018 survey and the environmental impact of issuing paper surveys, 92% of all surveys were provided for completion online. The survey itself consists of 90 questions correlating to 11 themes which are in turn reflective of the NHS National Workforce plan. The themes are as follows; Equality Diversity and Inclusion, Health and wellbeing, Immediate Managers, Morale, Quality of Appraisals, Quality of Care, Safe Environment (Bullying and Harassment) Safe Environment (Violence), Safety Culture, Staff Engagement, Team Working.

The survey was open for 8 weeks and 70% of our staff returned a response. This is an increase of 11% on last year's response rate, of 16% against the 2017 response rate and of 36% which was achieved in 2016.

This response rate was achieved by a campaign led strongly by Divisional Leadership in partnership with HR and the Communications Team. Staff were reminded of the changes that have been delivered in response to their feedback last year. A healthy level of competition was encouraged between teams to achieve a bigger response rate. A 70% response rate is a significant indicator of employee engagement.

Response Rate				
Trust 2017	**Trust 2018**	**Trust 2019**	**Benchmarking Group Average 2018**	**Trust Improvement/ Deterioration**
53.9%	59.2%	70%	58.1%	+11.9%

How we are improving

77% of staff said that they often or always felt enthusiastic about their job. This is the most positive result at RBHT for the previous 2 years. 70% of our employees informed us that they were satisfied with the support that they receive from their immediate manager. This is the most positive result for the last 5 years.

There has been much work within teams and with groups of employees when problems have arisen, over 200 mediations for example have taken place at the Trust in the last two years. It is therefore encouraging to see staff reporting a 4% increase in believing that working relationships in the Trust are unstrained. This brings RBHT to 47% which is on par with the national average for Specialist Acute Trusts. When discussing appraisals, 44% of staff confirmed that they felt that clear work objectives were definitely agreed but there is clearly still more to do here.

Areas for further focus

The number of our staff reporting experiencing musculoskeletal (MSK) problems as a result of work activities has been on an increase for the last 5 years at 32%. The national average for Specialist Acute Trusts is 28%.

Furthermore, of the staff responding to the survey this year, 40% reported feeling unwell due to work related stress compared to an average 36% for Specialist Acute Trusts nationally. Figures for the last 4 years indicate that this is an increasing issue year on year. 79% of our staff reported having had an appraisal in the last 12 months, a drop of 10% since 2018, this not surprising as we are currently beginning a transition with our appraisal methodology.

Top 5 Ranking Scores	**Trust 2019**
Staff are given feedback about changes made in response to reported errors/near misses/incidents	77%
My organisation treats staff involved in errors/near misses/incidents fairly	73%
I would recommend my organisation as a place to work	78%
There are enough staff in the organisation to do my job properly	46%
I am definitely supported by my manager to receive training, learning or development identified in my appraisal	63%

Bottom 5 Ranking Scores	Trust 2019
I have had an appraisal in the last 12 months	79%
In the last month I have not seen errors/near misses/incidents that could have hurt service users?	67%
In the last month I have not seen errors/near misses/incidents that could have hurt staff?	79%
In the last 12 months I have not experienced musculoskeletal problems as a result of work?	68%
In the last 12 months I have not felt unwell due to work related stress	60%

We are above average, or close to average, on six of the main staff themes and particularly proud of our results in Safety Culture and Quality of Care which are close to the best results in the UK and which rightly reflect the culture of our organisation. However, we have more to do on Health and Well-being, Immediate Manager Capability and Bullying and Harassment although on all three measures we have made a slight improvement.

Theme	2019/20		2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	8.9	9.2	8.9	9.3	8.9	9.3
Health and well-being	6.1	6.3	6.0	6.3	6.1	6.3
Immediate managers	7.0	7.1	6.9	7.0	6.8	6.9
Morale	6.3	6.4	6.1	6.3		
Quality of appraisals	6.1	5.8	5.8	5.7	5.8	5.5
Quality of care	7.9	8.1	7.9	7.8	7.9	7.7
Safe environment – bullying and harassment	8.1	8.3	8.0	8.2	8.0	8.4
Safe environment – violence	9.7	9.8	9.7	9.7	9.7	9.7
Safety culture	7.2	7.0	7.3	6.9	7.1	6.9

Staff engagement	7.5	7.5	7.4	7.4	7.4	7.4
Team Working	6.7	6.9				

Recommendations for addressing areas requiring improvement

The feedback from staff continues to be largely positive and in line with the other feedback from staff throughout the year. Our staff are highly engaged, patient focused and motivated; reporting excellent teamwork and communication throughout the Trust. They tell us they are proud to work for the Trust.

In 2017 we embarked on a programme to understand and tackle bullying and harassment amongst staff in the Trust. We are making progress and now match the national average for stated bullying involving a manager and are only 3% variance below the national average for bullying from a colleague. This downward trend is a notable improvement given that nationally within the NHS bullying is reported to be on the increase. Large numbers of sessions have been held with staff where they have been encouraged to share their views and experiences on bullying and all forms of harassment. We will continue the values-led interventions which are improving areas where we have invested in education and awareness. Some data on bullying suggests an issue with manager capability. We are working with managers on an ongoing capability training programme.

Last year we began a mediation programme for workplace grievances and disputes. We invested in establishing a successful Trustwide mediation service which has been extremely popular as the route to tackle workplace issues in a professional and positive way.

Listening groups continue where there have been higher reports of bullying or harassment. The Freedom to Speak Up Guardians ar active across the Trust.

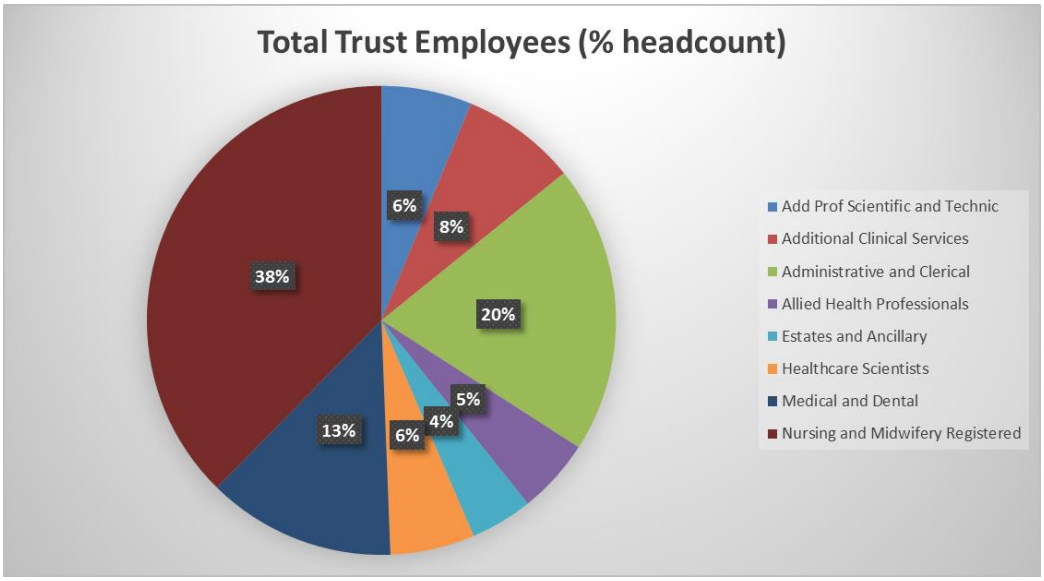
The Trust's Employees

As at **31 March 2020**, the Electronic Staff Record showed that the Trust employed **3944** people either on permanent or fixed term contracts (expressed as headcount)[1].

Of these, **1484** were registered as nurses and **512** were doctors. There were **204** allied health professionals and **314** people employed to provide additional clinical services (including healthcare assistants). Scientific and professional staff totalled **246** and there were **230** healthcare scientists.
There were **163** estates and ancillary staff and the administrative and clerical staff numbered **785**; this group includes ward clerks, medical secretaries, clinic receptionists as well as corporate teams such as Finance, Human Resources, Information Technology and members of the operational management team.

[1] Please note:
Workforce information is held in the Electronic Staff Record (ESR) which is the source of data used for external reporting of workforce matters, such as staff sickness. For the purposes of describing the Trust's employees the figures have been expressed as headcount. Elsewhere in this Annual Report, the reader will find reference to staff numbers derived from financial systems which may be expressed as whole-time equivalents (WTE) or full-time equivalents (FTE) which result in a lower figure when compared to headcount.

Composition of Workforce by Staff Group



Breakdown of the number of female and male members of staff in each of the specified groups at **31 March 2020**,

Role	Female	Male
Directors	**8**	**5**
Senior Managers (Grade 8c or above)	**37**	**26**
Employees	**2754**	**1114**

Staff Sickness

The following information has been taken from our Electronic Staff Record and covers the period **1 April 2019 to 31 March 2020**:

Available Days FTE	Days Lost FTE	Absence Rate %
1,315,817	**44,334**	**3.37%**

Occupational Health Service

We provide New Joiner health screening for staff at the moment of joining, which includes providing workplace immunisations and screening staff for immunity to infectious diseases in line with Department of Health recommendations.

Staff members are referred to our occupational health service in line with the Trust's Sickness Absence Management policy, or as self-referral.

The main causes of sickness absence are attributed to stress/anxiety and musculoskeletal conditions. To help address these issues, and reduce time lost from work, physiotherapy and counselling services are available to staff on a self-referral basis. Telephone counselling can also be obtained from our Employee Assistance Programme (EAP).

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The Seasonal Flu Campaign for 2019/20

The seasonal flu vaccination campaign for staff started in September 2019. The flu vaccinations were provided in the form of planned flu clinics in clinical areas, walk around flu clinics for staff unable to attend the planned clinics, booked and walk in appointments in occupational health.

We were again required by NHSE to record the numbers of staff declining the flu vaccination. We collected forms from 131 members of staff who declined the flu vaccination, there were additional staff who declined the vaccination and refused to complete the form.

56.7% of frontline healthcare workers were recorded as being vaccinated against flu this season; a decrease of 3.4% compared to the previous flu season. Over the last 2 years there has been a decline in the uptake of flu vaccination by 3.4-3.5%. In comparison the overall uptake in London was 69% which is an increase of 5% the previous year.

Our plan to deploy peer to peer vaccinations began slowly last year with only two members of staff completing the training. We hope to recruit and train peer vaccinators ahead of the flu campaign in September 2020.

The CQUIN target for 2020/21 is 90%.

The reasons given for not having the flu vaccination were:

Don't like needles	14
Don't think I will get the flu	8
Not beneficial, I don't think the vaccine is effective	22
Side effects	13
Times not convenient	2
Multiple reasons	26
Other	46
Total declined forms completed	131

Health and Safety

Health and Safety training is provided to all staff when they join the organisation. This is supported with ongoing training throughout their employment to ensure safety awareness and good practice is maintained. Additional specialist training relevant to the nature of individual roles is also provided. Site-based committees have been established to ensure that safety concerns can be raised through local safety representatives. The Trust also supports staff well-being at work through a comprehensive occupational health service to ensure that they, members of the public and patients enjoy a safe environment where occupational and safety risks are minimised. Health and Safety is supported and reported at

Board level.

Policies in Relation to Disabled Employees and Equal Opportunities

The Trust has an Equality and Diversity Policy which is due to be reviewed in the latter part of 2020.

The Trust is committed to ensuring equality of opportunity for all patients and staff, by maintaining a culture in which any form of discrimination is unacceptable. Patients, their families and carers, and the staff who care for them deserve to feel respected, valued and empowered. The Trust is committed to eliminating all forms of discrimination on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, in line with current legislation.

The Trust ensures that for people with a disability, full and fair consideration of their applications is given during the recruitment process, having regard to their aptitudes and abilities. Reasonable adjustments are made as required for people with a disability, and for those who become disabled during their employment. The Trust completed its first Workforce Disability Equality Standard (WDES) submission in 2019 along with its action plan identifying measures to support the outcomes.

The Trust's Equality and Diversity Policy will in conjunction with the soon to be launched Equality, Diversity and Inclusion Strategy provide a roadmap which contains clear guidance for managers in respect of training, career development and promotion of people with protected characteristics

During 2019/20 the Trust continued to meet its obligations, under the public-sector equality duty, to publish annual equality information in the form required.

Workforce Race Equality Standard (WRES)

The Trust completed its 2018/19 WRES submission in August 2019 and this was published on the Trust's website in autumn 2019 with an accompanying action plan.

For 2020, a greater focus has been placed on the WRES and on developing an action plan to support key targets arising out of it. The data itself showed continued improvement against some of the indicators when compared at a regional and national level, however compared to the 2017/18 WRES submission, only 1 indicator had deteriorated, with all the others showing an improvement.

To this end, an action plan was delivered to focus specifically on that area where we saw a deterioration but also to consolidate the continued trend of improvement in other indicators. This includes:

- Continued training for managers
- Simplified policies – recruitment focus
- The continuation and expansion of listening groups for all staff across the Trust.
- Staff sessions focussed on Speaking Up and Wellbeing.

Our action plan is being continually reviewed and it is expected that the 2020 submission will be particularly representative given the increased return rate (70%) on the 2019/20 Staff Survey. Separate to the Trust's 2019 WRES plan, the Trust has set up its first staff network , our LGBT network and will be using this as a template for our forthcoming BAME Network whom we hope will input to, support and review the Trust's WRES action plan.

In response to the recent incidents in the USA and subsequent to global protests about Black Lives Matter, including here in the UK, the Chief Executive wrote to all staff assuring them of the Trust's commitment to promoting fairness and equality in all forms, to all our staff, and the work the Trust undertook through its equality, diversity and inclusion strategy. The Board also discussed the matter in June 2020.

Information on Policies and Procedures with Respect to Countering Fraud and Corruption

Staff are provided with information on policies and procedures with respect to countering fraud and corruption through the Trust's Conflict of Interest Policy. The Trust's provider of counter fraud services, TIAA, carries out awareness raising activities and provides counter fraud training on a regular basis.

Analysis of Staff Costs

This table provides an analysis of staff costs which follows the format in the FTC template. It is the format specified within the Staff report section of the NHS FT Annual Reporting Manual 2019/20.

Staff costs	**Permanent**		**Other**		**2019/20 Total**		**2018/19 Total**
	£000		**£000**		**£000**		**£000**
Salaries and wages	188,951		2,817		**191,768**		179,595
Social security costs	20,510		-		**20,510**		19,341
Apprenticeship levy	901		-		**901**		849
Employer's contributions to NHS pensions	20,149		-		**20,149**		18,787
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	8,777		-		**8,777**		-
Termination benefits	137		-		**137**		653
Temporary staff – agency/contract staff	-		8,327		**8,327**		10,059
Total gross staff costs	**239,425**		**11,144**		**250,569**		**229,284**
Recoveries in respect of seconded staff	-		-		**-**		-
Total staff costs	**239,425**		**11,144**		**250,569**		**229,284**
of which							
costs capitalised as part of assets	-		-		**-**		-

In 2019/20 the Trust paid £1.0m in consultancy fees.

Off-payroll arrangements are shown from page 63.

Staff exit packages are shown on page 65.

The Trust's Gender Pay Gap (GPG) reports are published annually in line with Government requirements on the Trust's website, linked here: https://www.rbht.nhs.uk/about-us/trust-policies under Equality and Diversity and on the Government's GPG Service website linked here: https://gender-pay-gap.service.gov.uk/employer/M4IQmLsc. The Trust continues to make progress in reducing its Gender Pay Gap with specific targeted actions such as development of professional networks for female members of staff and greater emphasis on raising awareness of the Trust's Flexible Working options for all staff.

Trade Union Disclosures

These disclosures are made in order to ensure compliance with the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
15	15

Note: in preparing this table, the assumption was made that all trade union officials are members of the Joint Staff Committee.

Percentage of time spent on facility time

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

Percentage of time	*Number of employees*
0%	
1-50%	15
51%-99%	
100%	

Note: An assumption was made that 10% of trade union officials' working hours are spent on facility time.

Percentage of pay bill spent on facility time

Provide the figures requested in the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	£
Total cost of facility time	64,142
Total pay bill	224,536,934
The percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.029%

Note: This calculation is dependent upon the assumptions made above.

Paid trade union activities

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

100%

2.4 Disclosures NHS Foundation Trust Code of Governance

Compliance with the *NHS Foundation Trust Code of Governance*

Royal Brompton & Harefield NHS Foundation Trust has applied the principles of the *NHS Foundation Trust Code of Governance* on a 'comply or explain' basis. *The NHS Foundation Trust Code of Governance*, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is required to provide a specific set of disclosures in our Annual Report to meet the requirements of the *NHS Foundation Trust Code of Governance.* All provisions which require a supporting explanation in the Annual Report, even where we are compliant with the provision, are described in the appropriate section. A reference to the location of these disclosures is contained in the table below to avoid unnecessary duplication.

Code Provision	Page Number	Code Provision	Page Number	Code Provision	Page Number
A.1.1	22	B.5.6	-	C.3.9	38
A.1.2	27 - 28	B.6.1	49	D.1.3	N/A
A.5.3	23	B.6.2	49	E.1.5	20
B.1.1	30-37	C.1.1	83-84	E.1.6	80 - 82
B.1.4	27 & 30-37	C.2.1	87	E.1.4	82
B.2.10	54 - 56	C.2.2	95		
B.3.1	30	C.3.5	N/A		

The Trust is compliant with the requirements of the *NHS Foundation Trust Code of Governance* apart from the following provision where explanation is required:

B.2.4. The chairperson or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.

At a meeting of the Nominations and Remuneration Committee of the Council of Governors, held on 12 January 2017, Governors were of the firm view that this Committee must be chaired by a Governor and terms of reference to this effect were ratified by the Council of Governors when it met on 23 February 2017. The Trust Chair is a member of the Committee.

B.5.6

Due to Covid-19 pandemic, the production of the forward plan was delayed, and the Trust was unable to engage its governors on its development, thus far.

Membership

Members of the Trust come from assigned constituencies based on geographical areas and relationship to the Trust, in line with the criteria for membership set out in our Constitution. There are three constituencies: patient; public; and staff. The patients constituency has a subcategory for a carer. The patient and public constituencies consist of: North London; Bedfordshire, Hertfordshire and Essex; South London and South East London; Rest of United Kingdom and Overseas (for patient members); and Rest of England & Wales (for public members). The eligibility requirements for the membership constituencies are as follows:

Patients Constituency – an individual who has attended the Trust's hospitals for diagnosis and / or treatment, in the three years immediately preceding the date of an application to become a member, as either a patient or as the carer of a patient. Public constituency – an individual who resides in one of the four designated geographical areas.

Staff constituency - staff who are eligible for membership are those who are employed by the Trust under a contract, which has no fixed term or has a fixed term of at least 12 months or has been continuously employed by the Trust under a contract of employment for at least 12 months. All eligible staff are automatically given membership. Individuals who exercise functions for the Trust but do not hold a contract of employment - e.g. those employed by a university who hold an honorary contract, those who are a contractor or those employed by contractors - may also become members of the staff constituency. Volunteers to the Trust do not qualify for membership under the staff constituency but are invited to become public members.

Members of the staff constituency may opt out of staff membership by notifying the Membership Manager. When members of staff leave the Trust, they are invited to become public members.

Membership Strategy and Engagement

The Membership Steering Committee was established in June 2011 and reports to the Council of Governors. During 2019/20 it has been chaired by a patient governor and includes representation from patient, public and staff governors. Its remit includes development of the membership strategy which details the Trust's plan for recruitment, engagement and communication with its members.

The Membership Strategy was reviewed by the Membership Steering Committee and a refreshed strategy was presented to the Council of Governors in July 2019. The Committee also reviewed the constituency boundaries and proposed changes, which were agreed by the Council of Governors on 17th of July 2019, and ratified by Board.

The Trust is mindful of its duties to ensure a representative membership, in both patient and public constituencies. These are enshrined in the Health and Social Care Act 2012. The Membership database, hosted by Membership Engagement Services (MES), has functionality which enables comparisons to be made between the general population of the UK and the membership of the Trust.

Engaging Members

The Trust held its tenth Annual Members' Meeting on 17th of July 2019 and approximately 60 members attended, where the annual report and accounts were received.

The Trust had limited engaged with its members during 2019/20. Members have been invited to patient open days organised by clinical teams and research departments. Others have been engaged via volunteering, participating in national and local patient surveys, voting for governors in elections and standing for election. In August 2019 the Membership

Manager post was vacated. The Trust appointed a successor in January 2020, who commenced in post in April 2020. Due to other staff issues during the period, membership engagement diminished, however plans are in place to refresh the Trust's engagement with its members in 2020/21.

Analysis of Membership at 31 March 2020: Membership Size and Movements

		2018/19	2019/20
Public	At year start (April 1)	2,783	2,764
	New members	16	20
	Members leaving	(35)	(28)
	At year end (31 March)	2,764	2,756
Staff	At year start (April 1)	3,541	3,608
	New members	454	468
	Members leaving	(387)	(458)
	At year end (31 March)	3,608	3,618
Patient	At year start (April 1)	4,676	4,564
	New members	33	19
	Members leaving	(164)	(203)
	At year end (31 March)	4,545	4,380
TOTAL		10,917	10,754

Growing the Membership
The membership profile of the Trust is different to most other Trusts because, as a specialist Trust, there is no `local community'. Without a local community defined by geography, the main strategy for recruitment of new members is to attract in-patients before they are discharged. Patient members are also encouraged to recruit public members such as family members and friends. Work to recruit inpatients and day-case patients is mainly undertaken by hospital volunteers and the Membership Manager.

Ensuring a Representative Membership
Analysis of the membership database by age, gender and ethnicity is undertaken to ensure that positive action can be taken to address any areas of under-representation so that the Trust membership is representative of the population that it serves. The demographics of the population of England are taken as the benchmark for the purposes of comparison.

Communication with Members
For new patient and public members, a welcome letter is sent by the Membership Manager.

The Trust maintains contact with its members through a newsletter, 'Patient Focus'. The newsletter is sent by post or email to members, whichever is preferred. It is also available on the Trust's website. Members' events are advertised on the Trust website and intranet as well as in the Members' newsletters.

Since Covid-19, all membership activity has been suspended with the exception of communications pertaining to it. This is in keeping with NHSI guidelines.

Contact details for people who wish to become Members, or Members who would like to communicate with Governors and the Membership Manager:

There is also an email address for members who wish to contact the Membership Manager: members@rbht.nhs.uk

There is a generic email address available for members to communicate with governors: governors@rbht.nhs.uk

2.5 NHS Oversight Framework

NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care;
- Finance and use of resources;
- Operational performance;
- Strategic change; and
- Leadership and improvement capability (Well-Led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The NHS Oversight Framework has applied throughout 2019/20.

Segmentation

NHS Improvement has continued to keep the Trust in Segment 2 under its NHS Oversight Framework. The financial outcome for the year was a deficit of £1.0m after a revaluation gain of £1.1m and combined Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF) of £29.8m (2018/19 - deficit of £31.7m after a revaluation loss of £7.6m and PSF of £10.8m). The Trust's underlying financial performance, excluding exceptional items, was on plan for both years. This segmentation information is the Trust's position as at 26th May 2020. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

		2019/20 scores				2018/19 scores			
Area	Metric	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial Sustainability	Capital Service Capacity	2	4	4	4	4	4	4	4
	Liquidity	1	1	1	1	1	1	1	1
Financial Efficiency	I&E margin	2	4	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	1	1	1	4	1	1	1
	Agency Spend	2	2	2	2	3	3	2	2
Overall scoring		**2**	**3**	**3**	**3**	**3**	**3**	**3**	**3**

2.6 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Royal Brompton & Harefield NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Royal Brompton & Harefield NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal Brompton & Harefield NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

.....
Robert J Bell
Chief Executive and Accounting Officer **22 June 2020**

2.7 Annual Governance Statement 2019/20

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve polices, aims, objectives; it can therefore only provide a reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risk to the achievement of the policies, aims and objectives of Royal Brompton & Harefield NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The current system of internal control has been in place in Royal Brompton & Harefield NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
The Trust ensures its risk management system receives the appropriate depth and regularity of focus from all levels of clinical and non-clinical staff. The Trust has a risk management strategy in place, which is ratified by the Risk and Safety Committee, and which sets out the details of how risks are managed throughout the organisation.

The Trust has a Board Assurance Framework, within which the key risks are identified that may prevent the Trust from achieving its stated objectives outlined in the Trust's strategy. The BAF consists of inter-related components: risk management structure (including roles and responsibilities), risk identification and assessment, action planning, monitoring, risk control review and assurance measures. In response to the CQC report published in February 2019, the Board has reviewed and expanded its Board Assurance Framework to include an enhanced focus on strategic risks and the monitoring of progress in delivery of the Trust's strategic objectives, and a refreshed version was presented to the Board in November 2019, with a risk and assurance cycle. The Trust continues to review and develop the Board Assurance Framework and a Board facilitated risk workshop was planned for early 2020, however it was postponed due to Covid-19, in line with NHSEI guidance to streamline Board meetings.

The Risk & Safety Committee, which is a committee of the Board, has been established to provide the Trust Board with high quality objective evaluation of the systems and processes in place to manage risks, particularly those associated with patient and staff care and safety. The Committee specifically gives attention to all sources of assurance on patient and staff safety, clinical effectiveness, and patient and staff experience: it ensures that there is evidence of robust governance and assurance processes in these areas. It is assisted in this regard by the Audit and Finance committees of the Board. The Risk & Safety Committee membership consists of Non-Executive Directors, including its chair, and Executive Directors.

The Governance & Quality Committee is a Trust-wide committee with oversight of divisional governance activities and accordingly provides relevant reports and advice to the Risk & Safety Committee. The Governance & Quality Committee is chaired by the Medical Director

(and deputised by the Director of Nursing and Clinical Governance) and provides scrutiny of the Trust's risk management processes against an integrated governance and patient safety agenda. It receives reports on clinical and non-clinical issues from each of the clinical divisions. In addition to managing risks, it identifies examples of both good and poor practice. The Committee ensures that these areas operate to the highest clinical and quality standards. With representation from each of the clinical and non-clinical divisions present at meetings, the Trust is able to share best practice and respond to identified weaknesses.

The Director of Nursing and Clinical Governance has day-to-day operational responsibility for the management of risk and governance practice. Directors across all areas of the Trust take responsibility for risk identification, management and mitigation within their areas of work and practice. Divisions are responsible for their own areas, and this is supported by Divisional Quality & Safety reports which contain a wide range of information including risks, incidents, complaints, clinical outcomes, clinical audits and compliance with best practice.

Training in risk management is available for all staff both at induction, and throughout their career at the Trust. In addition, there are detailed guidance and support resources available through the intranet and through a team of staff trained in risk management, including our emergency resilience team.

To ensure that the Trust undertakes its activities within a safe environment, a health and safety lead has been appointed. The health and safety lead is supported by an external specialist contractor who assists with the monitoring of compliance with health and safety obligations. This contractor also provides specialist advice and training in fire, health, safety and manual handling issues.

The risk and control framework

The Trust recognises that not all risk can be eliminated or avoided, but specific risks can be effectively mitigated and managed. A statement on acceptable risk (risk appetite) is contained within the Board Statement on Risk within the Risk Management Strategy.

The Trust's Risk Management Strategy is available to all staff through the Trust's intranet. It describes the Trust's overall risk management approach, corporate and divisional responsibilities for risk, the risk management process, and the Trust's risk identification, assessment and control system. It includes guidance on the risk assessment matrix used to evaluate risks for inclusion on the Trust's risk registers, and references the Trust's Risk Assessment Policy and Procedure, which details how staff are to identify, categorise and manage risks in the Trust.

The Trust commits to working with patients and their families to ensure that they fully understand the options for treatment including the potential risks, intended benefits, alternatives and effects of no treatment, and that they are assisted in balancing the risks to come to a decision to give fully informed consent for treatment and/or research.

Governance structures, as presented in the Risk Management Strategy, have been established to ensure that a detailed assessment of all identified risks (clinical, research, operational, financial and infrastructure) is performed and managed through the Risk Register, where responsibility for mitigation or management of each risk is identified. The Top Trust Risks are split into two categories: Strategic and Operational. These are monitored and presented at the appropriate committees to provide assurance to the Board.

Risks are subject to review by the Trust Board and its committees to assess mitigating actions, the adequacy of resources directed towards managing the risk, and assurance that the controls are effective. Lower scoring risks are managed within the division/department where they originate and held on the Risk Register.

The Top Trust Risks are kept under review by the Trust Board, via the Risk and Safety Committee. For 2019/20 and into 2020/21 the Top Risks included:

- **Achievement of expected, required standards of clinical care**

  Mitigations include:

  - Medical Director is the Responsible Officer, Divisional Directors/Care Groups Chairs responsible for clinical services;
  - Annual appraisal and established revalidation process for doctors and nurses;
  - Clinical structure based around care groups which focus on disease pathway and needs of patients, rather than staff professions;
  - Lead clinicians in Clinical Risk on each site and divisional directors have a leadership role for quality and safety in their division;
  - Service Level Agreements in place with other trusts to provide specialist input for patients requiring non-cardiothoracic care and treatment;
  - Proactive management strategy to monitor patients on the waiting list for treatment, including – pre-assessment clinics and regular telephone contact by Clinical Nurse Specialists;
  - Reporting from regular Governance & Quality Committee meetings, attended by Divisional Directors (clinical) and Executive Directors, to discuss clinical issues affecting the Trust: underpinned by the divisional Quality & Safety meetings, as well as by groups with a more specialised focus such as the Clinical Practice Committee (to assure the introduction of new procedures), Medicines Management Board, the Tissue Governance Oversight Board, the Research Management Committee and the Medical Devices Safety Group;
  - Medical devices policy and quarterly medical devices safety group meetings attended by trust Medical Device Safety Officer who attends the national group;
  - Monthly clinical governance day, (10 per annum), where non-essential clinical activity is suspended, including a peer review of all patients who die in hospital and review of outcomes and necessary actions;
  - Monthly Clinical Quality Review Group led by commissioners (NHS England);

- **Failure to comply with external regulations**

  Mitigations include:

  - All key targets are monitored and reported to the Trust Board, either routinely or by exception through the Clinical Quality Report;
  - NHS Improvement are aware of the two NHS Oversight Framework Targets at risk during 2019/20; 62-day cancer target and 18-week referral to treatment time
  - Robust bottom-up process of internal control through review of performance information at meetings of the Operational Management Team, Management Committee, Governance and Quality Committee, Risk & Safety Committee and the Trust Board;
  - Regular oversight of key performance indicators by commissioners through the Clinical Quality Review Group.

- **Estates – general maintenance backlog**

  Mitigations include:

- A planned, preventative maintenance (PPM) programme focused on high-risk areas.
- Progress against this plan is being monitored by the COO and through the Capital Working Group
- Maintenance risks are individually listed on the Risk Register
- An appropriate level of funding

- **Failure to execute property redevelopment programme effectively and within budget**

  Mitigations include:

  - Existence of the Redevelopment Advisory Steering Group, an ad hoc Committee of the Trust Board which meets regularly to review progress;
  - Continuous involvement of the Chief Executive and Chief Financial Officer;
  - Appointment of leading property, financial, tax and legal advisors to the project team;
  - Application of, and compliance with, the Trust's SFIs for major capital projects;
  - Application of and compliance with NHS Improvement's requirements for major capital projects;
  - Establishment and maintenance of a detailed project model which includes milestones, cash flows and sensitivities;
  - Phasing of redevelopment such that capital expenditure, wherever possible, is funded from earlier disposals.

- **Cyber vulnerability**

  Mitigations include:

  - Digital Services and Operations (in Technology & Digital Information Division) have implemented a number of technical solutions aimed at preventing, monitoring, detecting and reporting security risks, including an upgraded wired and wireless network and new firewalls.;
  - There has been a significant improvement in patching of systems to ensure protection against the latest security threats. A new patching programme has been introduced and aims to minimise its impact on clinical work, for example by aligning system downtime to clinical governance days.
  - Trust is covered by a cyber insurance policy.

- **Staff recruitment and retention**

  Mitigations include:

  - The Trust recruits using NHS jobs, generalist and specialist agencies, UK and overseas job fairs;
  - We engage directly with universities for newly qualified key professionals;
  - We are commencing the introduction of new roles e.g. Physician Associates;
  - We work with other organisations for secondments;
  - We have started a programme for 16-to-18-year olds to build a future workforce.
  - The Trust has a new Talent and succession planning methodology linked to personal development and learning about to be trialled;

- Our transformation programme is delivering change to enable less service pressure and more efficiency;
- We offer a typical range of staff benefits, including subsidised parking;
- We offer well-established professional development provisions;
- We offer Yoga, Mindfulness and Relaxation classes;
- We have implemented an industry-leading approach to bullying and harassment to continue to address the staff survey findings;
- Leadership programmes in place;
- 'The way we work together' education and training on behaviour.

- **Impact of collapse of King's Health Partners (KHP) collaboration**

  Mitigations include

  - The Trust and King's Health Partners (Guy's & St Thomas' NHSFT, King's College Hospital NHSFT, and King's College London) have committed resources and time to planning and development of detailed proposals for a wide-ranging collaboration;
  - Strong working relationships with commissioners and regulators;
  - Ongoing collaboration with other partners (Royal Marsden NHSFT, Chelsea & Westminster NHSFT);
  - Appointment in July 2019 of full-time, Interim Managing Director for Partnership to head Leadership Team.

The structured mapping of sources of assurance is a fundamental part of our Board Assurance Framework. The risks detailed within the risk register are aligned to the Trust's objectives through the Board Assurance Framework and the Forward Planning process. The Risk Register is designed to reflect risks from all aspects of the organisation and provide details of the controls in place to mitigate the risks and identify where assurance can be found. The Risk Register provides, through ongoing review, assurance to the Board that these risks are being adequately managed and controlled.

The Risk Register recognises, and is informed by, the Trust's wider role and risk profile as a leading centre for the delivery of specialist clinical services, research and innovation activities, and education and training. The views of the Trust's stakeholders are taken into account when managing risk. They include:

- NHSE/I, the main regulator and commissioner for NHS Foundation Trusts (and NHS trusts), assesses the Trust's risk profile throughout the year using the NHS Oversight Framework. Monthly monitoring meetings are held with the Trust's coordinating commissioner, NHS England, to assess performance against the NHS Standard Contract – reported through the Clinical Quality Review Group;

- Meetings of the Partnership Board continued during 2019/20 and included representation from NHS England;

  - The CQC, with whom the Trust undertakes regular engagement and whose, inspectors attend meetings at the Trust in order to keep in touch with standards of performance. The Trust was last inspected in November 2018, and achieved an overall rating of 'good' in the report published in February 2019;

- The External Services Scrutiny Committee of London Borough of Hillingdon and London Borough of Kensington and Chelsea reviews Trust performance;
- Healthwatch in Hillingdon and Central West London: the Healthwatch groups have established a management board and a number of sub-groups focusing on particular health areas. In particular, Healthwatch groups are involved with the development of the Trust's Quality Report, which is currently progressing through draft forms;
- The National Heart and Lung Institute of Imperial College London;
- Imperial College Health Partners, the Academic Health Science Network, of whom we are a founding member; and
- The Trust's joint venture partner in the Institute of Cardiovascular Medicine & Science, Liverpool Heart and Chest NHS Foundation Trust.

A Well-Led Review was undertaken by PricewaterhouseCoopers LLP (PwC), and presented to the Trust Board in January 2017. Changes made as the subsequent action plan included the Finance Committee being constituted as a formal committee of the Trust Board.

Early in 2020, the Trust commenced a tendering process to appoint an external reviewer to undertake a fresh well-led governance review. While the Trust had shortlisted firms for selection interviews, the process was halted with the start of Covid-19 pressures. The Trust has now put the engagement on hold due to the plans for the Trust to merge with Guy's and St Thomas' NHS Foundation Trust.

The CQC inspection conducted in October and November 2018 identified areas for improvement relating to strategic risk oversight by the Board, where documented evidence was not clearly presented in a single coordinated document. This feedback prompted work on the Board Assurance Framework resulting in a more regular in-depth review of both the top Trust risks by the full Board and also progress in the delivery of key Trust strategic objectives.

The Trust is compliant with the 'triangulated approach', recommended by NHS Improvement, to deciding staffing requirements described in National Quality Board's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

High level workforce planning in the Trust has been described in the section above setting out mitigating actions for one of the Top Trust Risks, Staff Recruitment & Retention. The Trust follows the triangulated approach to staffing decisions as evidenced by:

- Right staff: A twice yearly review of nurse staffing establishments using SNC audit and professional judgement. High level peer review of staffing levels using Model Hospital data. Monthly reporting in the Trust's Clinical Quality Report on nurse staffing at a ward level;

- Right skills: A new system to streamline mandatory training is being rolled out in 2020/21. Strong development and education programmes are established and resourced i.e. a 'compassionate care programme'. Embedded Multi-Disciplinary Team working was recognised as a strength in CQC inspection 2018. Recruitment and retention programmes are in place, with lower than average (London) nurse vacancy levels;

- Right place and time: There is full engagement in Trust improvement and efficiency programmes, as well as senior oversight of staff deployment and

working across clinical areas. The Trust had consistently lower than average sickness rates amongst nursing staff; and

- Care hours per NHS patient day data is reported to the Board, as are safety outcome measures like the Safety Thermometer, where the Trust reports consistently higher than average levels of harm free care.

The Board maintains ongoing oversight of compliance with those principles, systems and standards of good corporate governance which would reasonably be regarded as appropriate for a NHS Foundation Trust. The Audit, and Risk and Safety committees have a key role to play in proving assurance, receiving detailed reports to support positive declarations of compliance which are triangulated against internal performance and assurance reporting, internal audit reports and the Board Assurance Framework, with any deviations of risks escalated to the Board of Directors. The Board is also supported by the Finance Committee.

Compliance with Condition FT4 of the NHS Provider Licence was last reviewed by the Trust's internal auditors during 2017/18. The overall report rating was that of significant assurance, being the highest rating that can be achieved on the scale used by KPMG. The systems continued in place during 2018/19, and 2019/20.

The Trust can also assure itself of the validity of its Corporate Governance Statement through regular consideration of organisational risks at the Board of Directors, its committees and deep dives in Board development sessions and at the Risk and Safety Committee; internal audit reports to the Audit Committee on matters relating to governance, financial control and risk management; the review and approval of the Trust Standing Financial Instructions, incorporating the Scheme of Delegation by the Finance Committee and Board, which occurred in February and further in response to Covid-19 in April 2020; and continuous reporting in accordance with the NHS Oversight Framework to the Board of Directors.

The Board made a self-declaration in May in 2018, 2019 and 2020 that it was compliant with the conditions of the NHS provider licence and with no significant risks identified in relation to the corporate governance statement.

Care Quality Commission (CQC)
The Trust is fully compliant with the registration requirements of the CQC.

In July 2019 the CQC undertook an unannounced inspection of Paul Wood Ward at Royal Brompton Hospital. This focused inspection took place in response to independent concerns raised with the CQC. Following the inspection, the CQC published its report setting out its findings, which was an overall rating of 'outstanding' (including 'outstanding' for well-led).

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the Managing Conflicts of Interest in the NHS guidance.

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

rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

Managing Public Money
There are a number of required disclosures which have been covered elsewhere in the Annual Report 2019/20. These include:

- Governance framework, to include the Board's committee structure, attendance records and the coverage of its work;
- Board committee reports;
- An account of corporate governance.

All of these required disclosures are made in section 2, the Accountability Report, which is contained within the main body of the Annual Report 2019/20.

Review of economy, efficiency and effectiveness of the use of resources
Service Line Reporting (SLR) and Patient Level Costing (PLC) are reviewed annually by the Finance Committee, including comparators against national averages. There are quarterly meetings of the SLR Group, with membership including the Chief Operating Officer, senior clinicians, and senior operational and finance managers. The SLR Group prioritise certain pathways for more detailed review using clinical, operational, and financial KPIs, with subsequent follow-up to ensure agreed changes to pathway have been implemented. Finance and performance reports are reviewed monthly by the Committee, including review of delivery against efficiency plans, with updates provided to the Board, which are used to identify opportunities for improving efficiency and profitability.

Information governance
The Trust manages its risks related to data security through a number of different approaches. The Trust has a Board level Senior Information Risk Owner (SIRO). The SIRO has overseen the implementation of a wide range of measures to protect the data we hold. During the year, the Trust IG services were re-established as an in-house service, replacing the outsourced arrangements. An effective IG function has been identified as a critical enabler for analytics, AI and improvement.

In 2018/19 NHS Digital replaced the Information Governance Toolkit with the Data Security and Protection Toolkit. All organisations with access to NHS patient data and systems are required to complete the Data Security and Protection Toolkit self-assessment, testing their policy and processes against the National Data Guardian's ten data security standards.

Due to Covid-19, NHS Digital extended the deadline for submission of the 2019/20 Toolkit to September 2020. However, the Trust has undertaken a range of work during the past year to improve the governance and security of its data and information systems. The self-assessment was submitted in early April, along with an updated improvement plan for a number of areas recognised as requiring further development. The Trust's Toolkit is currently assessed as "Standards Not Fully Met (Plan Agreed)". This grading is given where a small number of items do not yet meet the Toolkit's requirements. Our updated improvement plans

are currently being reviewed by NHS Digital. These plans will be approved if NHS Digital is satisfied that we have a realistic plan to achieve the evidence requirement. Work will continue during 2020/21 to implement the improvements within our action plan.

During 2019/20, there were no incidents classified as a 'Level 2' serious incident. Cyber security risk remained on the register of the Trust's Top Risks and subject to the Trust's risk management processes, and a deep dive on cyber security was presented to the Risk and Safety Committee in November 2019.

Data quality has been kept under review by the Performance and Information Team and policies are in place to monitor data quality which are compliant with NHS guidelines and incident reporting procedures.

Data quality and governance

Quality data is reported to the Board each time it meets while the Risk & Safety Committee maintains oversight and undertakes scrutiny in order to inform the Board of the level of assurance, and the Governance & Quality Committee receives regular updates covering performance against quality and safety metrics at divisional level. Both the Governance and Quality Committee and the Risk & Safety Committee were instrumental is agreeing the quality priorities for 2020/21.

The Risk & Safety Committee has a key role in monitoring the Annual Quality Report's content, the determination of Quality Priorities, their ongoing monitoring and for providing assurance to the Board of Directors that robust quality governance arrangements are in place throughout the Trust and working effectively.

Data included within the report is based on the descriptors set out in national guidance and is subject to data quality checks as part of the Trust's performance assurance process. The Trust's Quality Indicator Assurance Framework (QIAF) tracks risks relating to data quality. An audit of elective waiting time data carried out by Deloitte LLP, led to a modified opinion with regards to the Annual Quality Report in 2018/19. As NHS England waived the external assurance requirements of the 2019/20 Annual Quality Report, a level of assurance on it will not be provided by Deloitte LLP this year.

The Trust continually works to ensure that where there are issues of data quality, they do not constitute a wider reliability issue in terms of data integrity. We have highly defined data structures that fit our regulatory reporting requirements and there are the functional and non-functional specifications that set our data system's quality characteristics. Our data is subject to legal and regulatory requirements, external interfaces, performance tracking, authentication, assurance and external and internal audit.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance Committee and the Risk & Safety Committee, and plans to address weaknesses and ensure continuous improvement of systems are in place.

The Board has exercised its role of oversight of the system of internal control through regular reports made by the Chair of the Audit Committee to the Board. Reports have been provided to the next meeting of the Trust Board following every meeting of the Audit Committee. Further information on the Board committee structure, attendance of members, coverage of work and reports can be found within the Directors Report.

The Audit Committee provides the Trust Board with an independent and objective evaluation of the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that support the achievement of the organisation's objectives. The conclusion of this Committee is that it has discharged its duties appropriately during 2019/20.

As stated, the Risk and Safety Committee provides the Trust Board with independent and objective evaluation of whether the systems and processes in place in the Trust to manage risks, especially patient safety risks, are complete, appropriate, and working as intended. There was one never event during 2019/20. This involved finding a fragment of a vascular sheath, presumed to have been inserted during the previous procedure, which was extracted. The Never Event was reported to NHS England at the time and underwent a full investigation, in accordance with national guidelines. There were seven serious incidents during the year.

Clinical audits are regularly conducted across all clinical services of the Trust. Details of participation in the national clinical audit programme are detailed in the Annual Quality Report. During 2019/20 the Trust participated in the 18 national studies that were of relevance to it.

Internal audit services for the Trust are outsourced to KPMG, who have provided an objective and independent opinion to the Chief Executive, the Board and the Audit Committee. They conducted five reviews in 2019/20 and provided a rating of significant assurance with minor improvement opportunities for reviews on financial controls, mandatory training and GDPR follow up; partial assurance with improvements required were provided on emergency preparedness and the DSP Toolkit.

Due to Covid-19, they were unable to complete the scheduled review of risk management planned for 2019/20. However, after a desk top review they concluded that the mechanism for managing risk within the Trust – the Risk Review Report – was appropriately completed and reviewed within the Trust's governance structure in line with the Risk Management Strategy. The framework in place therefore indicates the Trust has appropriate arrangements in place for managing risk.

KPMG's conclusion set out in its formal Head of Internal Audit Opinion, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control, is that of 'Significant assurance with minor improvements required'.

Deloitte LLP provides the Trust with its external audit assurance and reports on annual accounts.

The Counter Fraud Specialist confirmed that during the course of the year no frauds were subject to investigation that met the materiality threshold for referral to the Trust's external auditors, and no significant system failures or control weaknesses were identified that impact on the Trust's Annual Governance Statement.

Covid-19 Pandemic

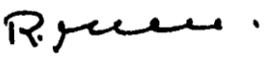
The Board discussed Covid-19 at its February 2020 meeting and noted the Trust's preparations. The Management Committee had previously discussed the anticipated pandemic. The Board has since conducted two extraordinary meetings and an additional briefing for non-executive directors, as well as two special briefings for the Trust governors; all by tele-and-videoconferencing. Covid-19 risks have been added to the Trust Risk Register. The Trust governance structure has been utilised to respond to the challenge and in addition to this an ethics group was established with a non-executive chair and the Trust Medical Director in order to provide governance to making ethical decisions within the current Covid-19 emergency. The group is aligned to the NHS, BMA and GMC guidance and principles, and will ensure it had the appropriate mechanism of compliance with NICE guidelines.

Conclusion

My review confirms that we have a sound system of internal control that supports the achievement of our objectives, and that no significant internal control issues have been identified. All significant areas of risk have been properly managed and are identified in this statement as part of the Risk and Control Framework section and are set out within the Audit Committee disclosures made in the Accountability Report of the Annual Report 2019/20.

I am satisfied that, to the best of my knowledge and using our processes, including having regard to NHS Improvement's Quality Governance Framework (supported by Care Quality Commission information, our own information on serious incidents and patterns of complaints), the Trust has, and will keep in place, effective arrangements for monitoring and continually improving the quality of healthcare provided to our patients.

Signed by the Accounting Officer to verify the Annual Governance Statement



…….. **22 June 2020**

Robert J Bell
Chief Executive

Annex 1

FINANCIAL STATEMENTS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1st APRIL 2019 TO 31st MARCH 2020

FINANCIAL STATEMENTS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1st APRIL 2019 TO 31st MARCH 2020

Accounts for the year 1st April 2019 to 31st March 2020

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INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

Report on the audit of the financial statements

1. Qualified opinion

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements of Royal Brompton & Harefield Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 28.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

2. Basis for qualified opinion

Performance of the physical counting of inventories was impracticable due to safety threats imposed by the Covid-19 pandemic. We were unable to satisfy ourselves by using other audit procedures concerning the inventory quantities held at 31 March 2020, which were included in the balance sheet at £12.6m. Consequently we were unable to determine whether any adjustment to this amount was necessary. In addition, were any adjustment to the inventory balance be required, the performance report would also need to be amended.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

3. Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • NHS revenue and provisions • Valuation of Chelsea Farmers' Market (CFM) • Property valuations • Management override of controls • Limitation of scope in respect of inventory (see basis for qualified opinion section) Within this report, key audit matters are identified as follows:  Newly identified  Increased level of risk  Similar level of risk  Decreased level of risk
Materiality	The materiality that we used for the financial statements was £4.5m which was determined on the basis of approximately 1% of the foundation trust's total revenue recognised in the year ended 31 March 2020.
Scoping	Audit work was performed directly by the audit engagement team, led by the senior statutory auditor. The foundation trust's investments in subsidiaries and joint ventures are not consolidated on the grounds of materiality.
Significant changes in our approach	A new key audit matter has been identified in the current year, Limitation of scope in respect of inventory. See basis for qualified opinion section for details on this. There have been no other significant changes to our approach to the audit in 2019/20 compared to 2018/19.

4. Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where: • the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or • the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.	We have nothing to report in respect of these matters.

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the basis for qualified opinion section, we have determined the matters described below to be the key audit matters to be communicated in our report.

5.1. NHS revenue and provisions

Key audit matter description	As described in note 1.3, Accounting Policies; note 1.26, Critical judgements in applying accounting policies and note 1.26.1, Key sources of estimation uncertainty, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: • the complexity of the Payment by Results regime, in particular in determining the level of overperformance and Commissioning for Quality and Innovation revenue to recognise; and • the judgemental nature of accounting for disputes, including in respect of outstanding overperformance income for quarters 3 and 4. Details of the foundation trust's income, including £351.6m (2018/19: £313.2m) of Commissioner Requested Services, are shown in note 3 to the financial statements. NHS receivables are shown in note 20 to the financial statements. The majority of the foundation trust's income is commissioned by NHS England.
How the scope of our audit responded to the key audit matter	We obtained an understanding of the relevant processes and controls over recognition of Payment by Results income. We performed detailed substantive testing on a sample basis of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
Key observations	We consider the estimates made by the foundation trust to be within an acceptable range.

5.2. Valuation of Chelsea Farmers' Market

Key audit matter description	The most significant judgement in preparing the 2019/20 financial statements is the valuation of the Chelsea Farmers' Market investment property, held at £88.3m at year end (2018/19: £87.3m). This has been identified as a separate Key Audit Matter due to the potential materiality of the valuation movements in respect of this asset. Following granting of planning permission in the prior year, a revaluation gain was recognized. As at the end of the financial year, no decision had been made regarding a possible Crossrail 2 train station at Chelsea. A revaluation gain was recognised, as discussed in Note 1.26, Critical judgements in applying accounting policies and Note 1.26.1, Key sources of estimation uncertainty. Note 17 shows the total net revaluation gain of £1.2m on investment properties (including other smaller sites). Valuation movements on investment properties are recognised in the surplus for the year. As detailed in note 1.26, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19, that historically have acted as drivers of the property investment and letting markets, with major adverse impacts already affecting global stock markets, future economic growth forecasts, and business and consumer confidence.
How the scope of our audit responded to the key audit matter	We obtained an understanding of the relevant controls over the valuation of the Chelsea Farmer's Market, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. We worked with our real estate valuation specialists to evaluate the work of the foundation trust's valuer, including review and challenge of the key assumptions made in the preparation of the valuation. These include the potential timing of a sale and the proceeds that could be achieved based upon the location of a possible Crossrail 2 train station at Chelsea. We have traced the valuation to the year-end accounts movements and tested their arithmetic accuracy and presentation in the financial statements. We have reviewed and challenged the assessment that there were no material movements through to 31 March 2020 from the date of valuation of 31 December 2019. We have reviewed the disclosures in notes 1.26, 1.26.1 and 17 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU and the covid-19 pandemic upon property valuations in

	evaluating the property valuations and related disclosures including the adequacy of the disclosure of the material valuation uncertainty.
Key observations	While we note the increased estimation uncertainty in relation to the valuation of Chelsea Farmers' Market as a result of Covid-19, as disclosed in note 1.26, we consider that the key judgements are within an acceptable range. There were no other matters arising from our work.

5.3. Property valuation

Key audit matter description	The foundation trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £167.4m (2018/19: £158.6m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value as described in notes 1.7, 1.26, 15 and 16. The net valuation movement on the foundation trust's estate shown in note 16 is a revaluation gain of £16.8m (2018/19: £2.8m). As detailed in note 1.26, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19, that historically have acted as drivers of the property investment and letting markets, with major adverse impacts already affecting global stock markets, future economic growth forecasts, and business and consumer confidence.
How the scope of our audit responded to the key audit matter	We obtained an understanding of the relevant controls over property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. We worked with Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the foundation trust's properties including through benchmarking against revaluations performed by other foundation trusts at 31 March 2020. We challenged the foundation trust's assumption that an alternative, lower value, site could be used for part of the estate in calculating a Modern Equivalent Asset value, and critically evaluated whether the alternatives considered would be viable given the nature of the foundation trust's activities. We have traced the valuation to the year-end accounts movements and tested their arithmetic accuracy and presentation in the financial statements. We have reviewed and challenged the assessment that there were no material movements through to 31 March 2020 from the date of valuation of 31 December 2019. We have reviewed the disclosures in notes 1.7, 1.26, 15 and 16 and

	evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU and the covid-19 pandemic upon property valuations in evaluating the property valuations and related disclosures including the adequacy of the disclosure of the material valuation uncertainty. We assessed whether the valuation and the accounting treatment of the revaluation gain was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations	While we note the increased estimation uncertainty in relation to the property valuation as a result of Covid-19, as disclosed in notes 1.26.1 and 16, we consider that the key judgements are within the acceptable range. There were no other matters arising from our work.

5.4. Management override of controls

Key audit matter description	We consider that in the current year there is a heightened risk across the NHS that management may override controls to manipulate fraudulently the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations. The foundation trust has been allocated £29.8m of Provider Sustainability Fund and Financial Recovery Fund funding, contingent on achieving financial and operational targets each year, equivalent to a "control total" for the year of a deficit (adjusted for certain items, including the additional annual leave accrual) of £30.0m. Of the £29.8m of funding, £9.1m relates to Financial Recovery Fund funding allocated in quarter 4 aimed at reducing the trust's deficit. The foundation trust's reported results show the control total was exceeded by £0.2m after factoring in an adjustment for to the control total for an additional annual leave accrual. NHS Trusts and Foundation Trusts have previously been requested by NHS Improvement to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets. Details of critical accounting judgements and key sources of estimation uncertainty are included in notes 1.26 and 1.26.1.

How the scope of our audit responded to the key audit matter	**Manipulation of accounting estimates** Our work on accounting estimates included considering areas of judgement, including those identified by NHS Improvement. In testing each of the relevant accounting estimates, we considered their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of International Financial Reporting Standards. We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the foundation trust. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.
Key observations	We found no matters that were reportable to those charged with governance.

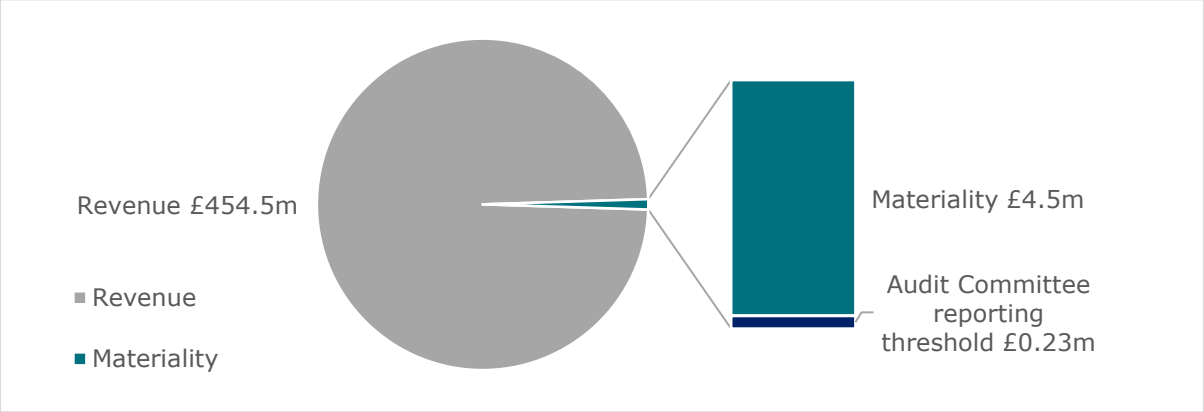
6. Our application of materiality

6.1. Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Foundation Trust financial statements
Materiality	£4.5m (2018/19: £3.9m)
Basis for determining materiality	1% of revenue (2018/19: 1% of revenue)
Rationale for the benchmark applied	Revenue was chosen as the benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements



6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Performance materiality was set at 80% of materiality for the 2019/20 audit (2018/19: 80%). In determining performance materiality, we considered the following factors:

a. the relatively low level determined for materiality;
b. the quality of the control environment; e.g. any significant control deficiencies identified;
c. corrected and uncorrected misstatements identified in the previous audit; their nature, volume and size;
d. whether any significant changes in the business might affect our ability to forecast misstatements; and
e. low turnover of management or key accounting personnel.

6.3. Error reporting threshold

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.23m (2018/19: £0.20m), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

7. An overview of the scope of our audit

7.1. Identification and scoping of components

Our audit was scoped by obtaining an understanding of the entity, its environment and service organisations, including internal control, and assessing the risks of material misstatement. The foundation trust's investments in subsidiaries and joint ventures are not consolidated on the grounds of materiality.

7.2. Our areas of our audit scope

The audit team integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report including the Performance Report and Accountability Report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £12.6m held as at 31 March 2020. We have concluded that where the other information refers to the inventory balance or related balances such as operating expenses, it may be materially misstated for the same reason.

9. Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of

accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

10. Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

12. Matters on which we are required to report by exception

12.1. Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

12.2. Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

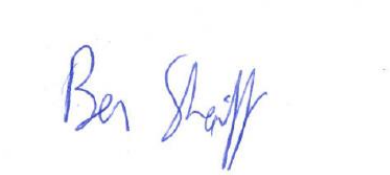
We have nothing to report in respect of these matters.

13. Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

14. Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Royal Brompton & Harefield NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Ben Sheriff FCA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
St Albans, United Kingdom
24 June 2020

The directors are responsible for the maintenance and integrity of the corporate and financial information included on the company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.

Royal Brompton and Harefield NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

Royal Brompton and Harefield NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by Royal Brompton and Harefield NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Robert J Bell**
Job title **Chief Executive**
Date **22 June 2020**

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	399,637	358,236
Other operating income	4	54,841	38,181
Operating expenses	6, 8	(447,217)	(411,712)
Operating surplus/(deficit) from continuing operations		**7,260**	**(15,295)**
Finance income	11	138	173
Finance expenses	12	(1,184)	(1,313)
PDC dividends payable		(8,378)	(7,663)
Net finance costs		**(9,424)**	**(8,803)**
Other gains / (losses)	13	1,119	(7,609)
Deficit for the year from continuing operations		**(1,045)**	**(31,708)**
Deficit for the year		**(1,045)**	**(31,708)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	16	16,782	2,818
total other comprehensive income		**16,782**	**2,818**
Total comprehensive income / (expense) for the period		**15,737**	**(28,890)**

There may be some minor rounding differences between the main accounts tables and supporting notes

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	11,847	12,209
Property, plant and equipment	15	207,308	189,967
Investment property	17	94,846	93,653
Receivables	20	536	-
Total non-current assets		**314,536**	**295,829**
Current assets			
Inventories	19	12,631	10,182
Receivables	20	70,852	49,916
Cash and cash equivalents	21	7,315	20,818
Total current assets		**90,798**	**80,916**
Current liabilities			
Trade and other payables	22	(62,558)	(47,318)
Borrowings	23	(6,205)	(11,115)
Provisions	24	(389)	(3,270)
Total current liabilities		**(69,152)**	**(61,703)**
Total assets less current liabilities		**336,182**	**315,042**
Non-current liabilities			
Borrowings	23	(47,745)	(43,596)
Provisions	24	(1,257)	(374)
Total non-current liabilities		**(49,002)**	**(43,971)**
Total assets employed		**287,179**	**271,072**
Financed by			
Public dividend capital		109,439	109,069
Revaluation reserve		74,187	57,405
Income and expenditure reserve		103,554	104,599
Total taxpayers' equity		**287,179**	**271,072**

Note 1 to 28 form part of these accounts

Name Robert J Bell
Position Chief Executive
Date 22 June 2020

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**109,069**	**57,405**	**104,599**	**271,072**
Deficit for the year	-	-	(1,045)	**(1,045)**
Revaluations	-	16,782	-	**16,782**
Public dividend capital received	370	-	-	**370**
Taxpayers' and others' equity at 31 March 2020	**109,439**	**74,187**	**103,554**	**287,179**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**108,604**	**54,587**	**136,307**	**299,497**
Surplus/(deficit) for the year	-	-	(31,708)	**(31,708)**
Revaluations	-	2,818	-	**2,818**
Public dividend capital received	465	-	-	**465**
Taxpayers' and others' equity at 31 March 2019	**109,069**	**57,405**	**104,599**	**271,072**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		7,260	(15,295)
Non-cash income and expense:			
Depreciation and amortisation	6	20,774	20,765
Income recognised in respect of capital donations	4	(166)	(698)
(Increase) / decrease in receivables and other assets		(22,017)	33,820
(Increase) / decrease in inventories		(2,449)	108
Increase / (decrease) in payables and other liabilities		12,677	(5,811)
Increase / (decrease) in provisions		(1,995)	1,334
Net cash flows from / (used in) operating activities		**14,084**	**34,222**
Cash flows from investing activities			
Interest received	11	138	173
Purchase of intangible assets		(2,428)	(1,197)
Purchase of Propert, Plant & Equipment		(16,074)	(11,104)
Receipt of cash donations to purchase capital assets	4	166	698
Net cash flows from / (used in) investing activities		**(18,198)**	**(11,430)**
Cash flows from financing activities			
Public dividend capital received		370	465
Movement on loans from DHSC	23.1	(3,880)	(3,880)
Movement on other loans	23.1	8,270	(11,498)
Interest on loans		(1,172)	(1,348)
PDC dividend (paid) / refunded		(7,812)	(8,404)
Cash flows from (used in) other financing activities		(49)	(1)
Net cash flows from / (used in) financing activities		**(4,273)**	**(24,667)**
Increase / (decrease) in cash and cash equivalents		**(8,388)**	**(1,874)**
Cash and cash equivalents at 1 April - brought forward		**15,702**	**17,576**
Cash and cash equivalents at 31 March	21	**7,315**	**15,702**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment. Investment properties are valued as investments.

Note 1.2 Going concern

The Directors have carefully considered the financial position of the Trust and its expected future performance given the demanding financial context in which it is operating and forecast financial deficits. Key factors have included:

• Anticipated levels of clinical activity, income, operational costs, planned savings and additional costs due to Covid19;
• The level of planned capital expenditures, including the new imaging centre; and the costs associated with the proposed merger with Guy's and St. Thomas' NHS Foundation Trust and also associated with the collaboration with King's Health Partners;
• The continuing availability of borrowing facilities, including a bridging facility to finance the imaging centre; and;
• A level 4 incident being declared by NHS England, placing the Trust under the command, control and co-ordination of NHS England, the amended NHS financial regime for 2020/21 (and anticipated receipt of Covid19 related funding), including the guidance received from NHS Improvement on planning and forecasting after the current arrangements end (currently confirmed to the end of July). And in extreme circumstances, and subject to approval at the time, the possibility of financial support arrangements from the Department of Health & Social Care to support providers with demonstrable cash needs

These factors have been the subject of sensitivity analysis against which the Trust's capacity to mitigate downside risks has been assessed.

Having made appropriate enquiries, the Directors have concluded that there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. Accordingly, they continue to adopt the going concern basis in preparing the accounts.

With regard to the Covid19 pandemic, there is, and remains, significant uncertainty about the likely demand for hospital services and the impact Covid19 will have on the costs incurred by NHS organisations. In response the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) have announced a series of measures to ensure the continuity of services, including the provision of additional funding to NHS trusts and foundation trusts to cover additional costs/lost income relating to the Covid19 pandemic. In terms of lost income, this includes addressing the adverse impact of the decrease in the treatment of private patients.
Whilst the Trust has made reasonable estimates of the level of additional costs/lost income claimed, and to be claimed, there is no certainty that all of these will be recovered and this has been considered in the sensitivity analysis.

Whilst the Trust has made reasonable estimates of the level of additional costs/lost income claimed, and to be claimed, there is no certainty that all of these will be recovered and this has been considered in the sensitivity analysis.

Note 1.3 Revenue from contracts with customers

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

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

Standard credit terms are 30 days and so payments are expected within one month after satisfying the performance obligations.

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

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

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

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

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. It should also be noted that some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate Emergency tariff (MRET)

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

Note 1.4 Other Forms of Income

Grants and Donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where a grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income, once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship Service Income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on 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.

Pension costs
NHS Pension Scheme
Most past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The scheme is not designed in a way that would allow employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme; the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

NEST Pension Scheme

A small number of staff are members of the National Employment Savings Trust (NEST) scheme. Further information is provided in note 9 c)

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably; and
• the item has cost at least £5,000; or
• collectively, a number of items have an aggregate cost of at least £5,000 and individually cost more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control; or
• the items form part of the initial equipping and set-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.
For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the service being provided. For this Trust, assets held at depreciated replacement cost have been valued on an alternative site basis and/or reduced site area basis as this would meet the location and service requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits (straight line). Freehold land is considered to have an infinite life and is not depreciated. Assets under construction are not depreciated until the asset is brought into use, except where there is doubt over the completion of the construction project.

Impairments
In accordance with the Group Accounting Manual (GAM), impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.7.3 De-recognition

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

The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss on disposal of an asset is the difference between the net sale proceeds and the carrying amount and is recognised as a non-operating item.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

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

Donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Useful economic lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Buildings, including dwellings	25	60
Plant and machinery	4	15
Transport equipment	2	7
Information technology	2	10
Furniture and fittings	4	10

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

Note 1.8 Intangible assets

Note 1. 8.1 Recognition

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

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

Note 1. 8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at market value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Where there is no value in use, the asset must be valued using depreciated replacement cost. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they don't meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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

Note 1 8.3 Useful economic lives of intangible assts

	Min life Years	**Max life Years**
Development expenditure	2	12
Software	2	10
Licences & trademarks	2	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. Work-in-progress comprises goods in intermediate stages of production. Partially completed patient episodes are not accounted for as work-in-progress but as receivables. This is because partially completed patient episodes are verified with NHS providers and commissioners as part of the intra-NHS debtor/ creditor balances agreement exercise. Please also see note 19 regarding the impact of the Covid19 pandemic on the end of year physical inventory count.

Note 1. 10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1. 11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1. 12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

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

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

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

Note 1.13.2 Classification & measurement

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

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

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

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

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

Note 1.13 cont'd

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets measured at fair value through I&E are those that are not otherwise measured at amortised costs or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust is party to an interest rate cap (a type of interest rate derivative) covering the £45m bridging loan (£10m drawndown as at 31st March 2020) in advance of the Chelsea Farmers Market sale. The term of this cap runs until 23rd August 2021

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

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

Expected credit losses are estimated via a provision matrix that assigns differing percentages and timings in terms of categories of debt. These are based on an assessment of: past performance, current/future market and general economic conditions and any other considerations relevent to specific categories of debtor. Credit losses are not normally recognised in relation to other NHS bodies. The Department for Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS Charities).

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

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

Note 1.14 Leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

The Trust leases out investment properties under operating leases as a lessor. Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

The implementation of IFRS 16 leases, in 2021, will remove the distinction between finance and operating leases. From then on most leases will be capitalised in the Statement of Financial Position reflecting the right to use the asset and the liability to pay for it. Exceptions are likely to be leases for under 12 months and leases for low value assets (under £5k).

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

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation as a result of a past event, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31st March 2020.

Clinical negligence costs
The NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 24.1 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays annual contributions to NHS Resolution and in return receives assistance with the costs of claims arising. The annual contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Other Provisions
Other provisions are recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities.

Non-NHS Doubtful Debt

The impairment assessment takes account of historical payment patterns, as well as economic and other risks associated with our customer base.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated, Covid19 related, and grant funded assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

The Trust's activities concern the provision of goods and services relating to healthcare and is not registered as a limited company. On this basis the Trust has no corporation tax liability. The Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this legislation. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988) but this power has not been exercised.

Note 1.20 Foreign exchange

Both the functional and presentational currency of the Trust is £ sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items are translated at the spot exchange rate on 31 March;
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual (FReM).

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

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

Note 1.24 Early adoption of standards, amendments and interpretations

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

Note 1.25 Standards, amendments & interpretations in issue but not yet effective or adopted

IAS 8 requires that the impact of accounting standards that have been issued, but are not yet effective, is disclosed

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRC 4 Determining whether an arrangement contains a lease* and other interpretations, and is applicable in the public sector for periods beginning 1st April 2021. The standard provides a single accounting model for leases, recognising a right of use asset and obligation in the statement of financial position for all leases. The standard also requires the re-measurement of lease liabilities after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS16 changes the definition of a lease compared to IAS17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1st April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of the remaining lease payments discounted at the Trust's incremental borrowing rate The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the liability, adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. no adjustments will be made on 1st April 2021 for existing finance leases (if any).

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

The Trust is in the process of implementing new systems and controls to address the requirements of this lease standard, including education and information for colleagues within the finance and procurement teams, and the wider Trust, and also the introduction of a new specialist lease accounting system.

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

IFRS17 Insurance Contracts

This standard requires a discounted cash flow approach to accounting for insurance contracts. It may come into force for accounting periods commencing on or after 1st January 2021. The Trust considers that it has no contracts which meet the definition of insurance contracts.

Note 1.26 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements. These are disclosed in accordance with IAS 1.122

IFRS 15
Management keep this standard under review, in particular in relation to overseas patients; research income; non-contracted income and the approach to provisioning for non-NHS debtors. For NHS income, the Trust adjusts the revenue recognition to reflect potential impacts of challenges or penalties and treats CQUIN payments as part of the transaction price for performance obligations under the contract. For research contracts under this standard, revenue is recognised as and when performance obligations are met. If there are no specific staged obligations, then revenue is recognised over time.

Provisions
A provision is recognised when the Trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities.

Note 1.26.1 Key sources of estimation uncertainty

The following disclosures are as required by IAS 1.125. These are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

1) The valuation exercise was carried out in December 2019, with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by Covid19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. It is possible that the Covid19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

2) Valuations by qualified surveyors are carried out each year having due cognisance to the latest RICS Guidance. Judgements are made regarding the condition of assets, and estimated remaining lives are also reviewed. Professional estimates are used to assess the fair value of land and buildings assets at each year end, in comparison to the carrying values, which may result in revaluation surpluses or deficits being recognised.

3) One of the properties held by the trust for investment purposes – Chelsea Farmers' Market – had planning permission granted for the site during 2017/18 for residential and retail development, which increased its valuation by £61.9m. The subsequent revaluation in 2018/19 led to a decrease in value, reflecting the general state of the market and economic conditions, although a small upturn in value was then reported for 2019/20. This valuation increase of £1.03m is included in note 17 to these accounts (with a further £0.16m increase relating to other investment properties).

4) Annual revaluation of the Trust's investment properties, in particular Chelsea Farmers Market (CFM), has the scope to cause material movements in the overall Trust position, as referenced in note 1.26 above and note 17.

5) The Trust has capitalised the costs of development work undertaken where it is believed that future economic benefit will be derived from that work. These benefits will be influenced by a range of internal and external factors, or may not materialise, which therefore may require these costs to be expensed to revenue.

6) Estimation of contract income is necessary as the annual accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on actual activity for the first ten months of the financial year. Actual amounts may differ, potentially materially so in total.

7) With regard to Inventory, and as also outlined in Note 19, restrictions on movement in the United Kingdom in March 2020, and Covid19 related operational constraints within the inventory team, meant that the Trust was unable to perform its planned year-end inventory counts, and the auditor has been unable to gain sufficient audit evidence from alternative procedures.

8) The value of provisions covering items for contractual disputes, impairment of receivables, early voluntary retirement pension contributions and injury benefit obligations (which are estimated using expected life tables and discounted at the pensions rate of minus 0.5%) may, in combination, vary materially from actual costs and timing.

9) The provision for impairment of receivables uses the Trust's best estimate of credit losses, although does not assess the credit-worthiness of customers, or past payment profiles.

10) The extent of the impact on the Trust resulting from the UK leaving the EU is not yet clear, including in terms of staff recruitment, access to key suppliers or price increases. However the transition period to 31 December 2020 reduces the possibility that post balance sheet event disclosures may be required for 2019/20 and the potential risk of material adjustments in the next financial year has not been quantified.

11) Many organisations, including this Trust, are responding to the challenges of the Covid19 pandemic. In the short-term NHS England have ensured that Trusts are financially well prepared to deal with the financial aspects of this pandemic. However, the duration is currently unknown and the funding arrangements designed to assist in dealing with this issue are presently only set to run for the first four-months of 2020/21.

Note 2 Operating Segments

The segmental analysis below reflects the format of contribution reporting by the three clinical divisions of the Trust that is made monthly to the Trust Board.

	£000			
2019/20	**RBH Heart**	**HH Heart**	**Lung**	**Total**
NHS clinical income	127,944	102,404	98,233	328,580
Non NHS income	19,647	8,988	4,801	33,436
Non clinical income	1,814	899	859	3,572
Total income	**149,404**	**112,291**	**103,892**	**365,588**
Pay	(79,674)	(58,231)	(35,279)	(173,184)
Non pay	(47,992)	(35,868)	(35,856)	(119,716)
Total expenditure	**(127,666)**	**(94,098)**	**(71,135)**	**(292,899)**
Contribution	**21,738**	**18,193**	**32,757**	**72,688**
Contribution %	15%	16%	32%	20%
Other income & costs, net				**(45,007)**
EBITDA				**27,681**
Capital charges/ other				(28,726)
Deficit for the year				**(1,045)**

	£000			
2018/19	**RBH Heart**	**HH Heart**	**Lung**	**Total**
NHS clinical income	120,526	91,672	89,981	302,179
Non NHS income	17,696	8,443	4,487	30,626
Non clinical income	1,494	897	1,161	3,552
Total income	**139,717**	**101,011**	**95,629**	**336,357**
Pay	(76,547)	(54,999)	(33,895)	(165,441)
Non pay	(42,170)	(36,434)	(31,510)	(110,113)
Total expenditure	**(118,717)**	**(91,433)**	**(65,405)**	**(275,554)**
Contribution	**21,001**	**9,578**	**30,224**	**60,803**
Contribution %	15%	9%	32%	18%
Other income & costs, net				(55,380)
EBITDA				**5,423**
Capital charges/ other				(37,130)
Deficit for the year				**(31,708)**

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2019/20	2018/19
	£000	£000
NHS Care		
Elective income	88,811	83,690
Non elective income	36,510	30,637
First outpatient income	4,827	5,090
Follow up outpatient income	11,746	12,173
High cost drugs income from commissioners (excluding pass-through costs)	45,001	36,954
Other NHS clinical income	156,325	144,649
Other Income		
Private patient income	45,563	41,577
Agenda for Change pay award central funding*	-	2,240
Additional pension contribution central funding**	8,777	-
Other clinical income	2,076	1,226
Total income from activities	**399,637**	**358,236**

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

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

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	284,907	249,315
Clinical commissioning groups	56,834	55,223
Department of Health and Social Care	-	2,240
Other NHS providers	5,805	4,692
NHS other (e.g NHS Wales; Scotland)	4,015	3,963
Non-NHS: private patients	45,563	41,577
Non-NHS: overseas patients (chargeable to patient)	1,911	1,069
Injury cost recovery scheme	87	24
Non NHS: other	514	134
Total income from activities	**399,637**	**358,236**

Operating income includes £3.6m in respect of Covid19, which will be funded by NHS England (£3.2m) and CCG's (£0.4m) (note 6)

Also included is the additional £8.77m additional pension costs directly funded by NHSE.

All income relates to continuing operations

Note 3.3 Overseas visitors (relating to patients charged directly by the Trust)

	2019/20	2018/19
	£000	£000
Income recognised this year	1,911	1,069
Cash payments received in-year	938	908
Amounts added to provision for impairment of receivables	274	221
Amounts written off in-year	217	75

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	2,687	3,082	**5,769**	6,245	-	**6,245**
Education and training	5,752	42	**5,794**	5,980	18	**5,999**
Non-patient care services to other bodies	415	-	**415**	439	-	**439**
Provider sustainability fund (PSF)	5,971	-	**5,971**	10,838	-	**10,838**
Financial recovery fund (FRF)	23,864	-	**23,864**	-	-	
Marginal rate emergency tariff funding (MRET)	428	-	**428**	-	-	
Income in respect of employee benefits accounted on a gross basis	1,750	-	**1,750**	1,651	-	**1,651**
Receipt of capital grants and donations	-	166	**166**	-	698	**698**
Charitable and other contributions to expenditure	-	1,918	**1,918**	-	3,220	**3,220**
Rental revenue from operating leases (note 10.1)	-	956	**956**	-	911	**911**
Other income	7,573	237	**7,810**	8,181	-	**8,181**
Total other operating income	**48,439**	**6,401**	**54,841**	**33,334**	**4,847**	**38,181**
All related to continuing operations			**54,841**			**38,181**

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	351,561	313,193
Income from services not designated as commissioner requested services	102,917	83,224
Total	**454,478**	**396,417**

Note 6 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,049	2,493
Purchase of healthcare from non-NHS and non-DHSC bodies	-	298
Staff and executive directors costs	250,432	228,631
Remuneration of non-executive directors	233	215
Supplies and services - clinical (excluding drugs costs)	67,208	58,622
Supplies and services - general	11,809	12,543
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	56,647	49,172
Consultancy costs	1,004	3,664
Establishment	8,325	7,717
Premises	14,408	13,350
Transport (including patient travel)	2,777	2,665
Depreciation on property, plant and equipment	17,984	18,154
Amortisation on intangible assets	2,790	2,611
Movement in credit loss allowance: contract receivables / contract assets	1,065	836
Increase/(decrease) in other provisions	(720)	1,390
Audit fees payable to the external auditor		
audit services- statutory audit	136	105
other auditor remuneration (external auditor only)	-	11
Internal audit costs	110	165
Clinical negligence	4,071	4,171
Legal fees	286	318
Insurance	331	301
Education and training	895	719
Rentals under operating leases (note 10.2)	2,215	1,694
Termination Benefits	137	653
Car parking & security	5	3
Hospitality	346	285
Other	674	928
Total	**447,217**	**411,712**

Expenditure includes £3.6m incurred in respect of Covid19. This will be reimbused by NHS England, or CCG's, and is also reflected in operating income (note 3).

All expenditure relates to continuing operations

Note 7 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	11
Total	**-**	**11**

Note 7.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £0.5m (2018/19: £2m).

Note 8 Employee benefits

	2019/20	2018/19
	Total	Total
	£000	£000
Salaries and wages	191,768	179,595
Social security costs	20,510	19,341
Apprenticeship levy	901	849
Employer's contributions to NHS pensions	28,926	18,787
Termination benefits	137	653
Temporary staff (including agency)	8,327	10,059
Total gross staff costs	**250,569**	**229,284**
Recoveries in respect of seconded staff	-	-
Total staff costs	**250,569**	**229,284**
excluding Non-Executive Director costs		

Pension contributions include £8.77m additional 6.3% contribution paid directly by NHS England

Note 8.1 Retirements due to ill-health

During 2019/20 there was one early retirement from the Trust agreed on the grounds of ill-health (one in 2018/19). The estimated additional pension liabilities of this ill-health retirement is £24k (£19k in 2018/19).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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

Note 10 Operating leases

Note 10.1 Royal Brompton and Harefield NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Royal Brompton and Harefield NHS Foundation Trust is the lessor.

The Trust owns four investment properties that are leased out under operating leases. From 1 April 2016, new operating leases were agreed, involving a minimum occupancy period of two years, thereafter either party being able to provide six months' notice to terminate.

Each lease is subject to the Landlord and Tenant Act 1954 and the 1995 Landlord and Tenant (Covenants) Act and will be renegotiated at market rate at the end of the lease term. None of the lease agreements provides for an option to purchase.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	956	911
Total	**956**	**911**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year	478	455
Total	**478**	**455**

Note 10.2 Royal Brompton and Harefield NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Royal Brompton and Harefield NHS Foundation Trust is the lessee.

The Trust was a party to 33 operating leases with a total expenditure of £2,215k during the year to 31 March 2020 (23 leases; £1,694k to 31 March 2019). One lease is for buildings (Wimpole Street private outpatient and diagnostic facility); one is for IT hardware, seven are for vehicles and the rest are for plant & machinery. The Wimpole Street lease has a term of 15 years from its inception on 3 July 2015. Terms of renewal or extension to leases are agreed towards the end of the contract terms at market rents. Purchase options are not included in operating lease contracts.

In the case of any dispute between the Trust and the lessor regarding the condition of the assets when returned to the lessor, a jointly appointed expert will be used to arbitrate and to deliver a binding decision. Early termination sums are generally payable in respect of the period up to the end of the full contract, for the full contract price discounted at 4% per annum, and in the event of total loss of the asset, the discounted residual value of the asset.

There is a sub lease to a third party for part of the Wimpole St facility. There were no contingent rents payable.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	2,215	1,694
Total	**2,215**	**1,694**

Operating Leases continued

	2020	2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,290	1,743
- later than one year and not later than five years;	6,195	6,055
- later than five years.	5,115	6,114
Total	**13,600**	**13,912**
Future minimum sublease payments to be received	(70)	(70)

One condition of the lease for the Wimpole Street private outpatient and diagnostic facility is the Trust's obligation for the removal (and consequent reinstatement works to the property) of all tenant fixtures, fittings, furniture and effects. The current lease expires in 2030, with breaks at five year intervals, however it is possible that the lease would be extended or renegotiated and there is also uncertainty around the amount and extent of expenditure that would be required, as this is to be agreed with the landlord at the end of the lease. As a result, there is no provision for dilapidations.

Note 11 Finance income

Finance income represents interest received on assets in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	138	173
Total finance income	**138**	**173**

Note 12 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	933	1,024
Other loans	204	288
Total interest expense	**1,137**	**1,312**
Unwinding of discount on provisions	(3)	2
Other finance costs	50	-
Total finance costs	**1,184**	**1,313**

Other finance costs consists of the arrangement fee for the Revolving Credit Facility of £50k

Note 13 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Losses on disposal of assets	(74)	(53)
Total gains / (losses) on disposal of assets	**(74)**	**(53)**
Fair value gains / (losses) on investment properties	1,193	(7,557)
Total other gains / (losses)	**1,119**	**(7,609)**

Note 14 Intangible assets - 2019/20

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**5,136**	**18,013**	**9**	**23,159**
Additions	-	-	2,428	**2,428**
Reclassifications	707	988	(1,694)	**-**
Valuation / gross cost at 31 March 2020	**5,842**	**19,001**	**743**	**25,587**
Amortisation at 1 April 2019	**3,394**	**7,556**	**-**	**10,950**
Provided during the year	851	1,939	-	**2,790**
Amortisation at 31 March 2020	**4,245**	**9,495**	**-**	**13,740**
Net book value at 31 March 2020	**1,598**	**9,506**	**743**	**11,847**
Net book value at 1 April 2019	**1,742**	**10,457**	**9**	**12,209**

Development expenditure is for IT project management and delivery

Note 14.1 Intangible assets - 2018/19

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**5,065**	**16,905**	**91**	**22,062**
Additions	-	-	1,197	**1,197**
Reclassifications	171	1,108	(1,279)	**-**
Disposals / derecognition	(100)	-	-	**(100)**
Valuation / gross cost at 31 March 2019	**5,136**	**18,013**	**9**	**23,159**
Amortisation at 1 April 2018	**2,720**	**5,719**	**-**	**8,439**
Provided during the year	774	1,837	-	**2,611**
Disposals / derecognition	(100)	-	-	**(100)**
Amortisation at 31 March 2019	**3,394**	**7,556**	**-**	**10,950**
Net book value at 31 March 2019	**1,742**	**10,457**	**9**	**12,209**
Net book value at 1 April 2018	**2,345**	**11,186**	**91**	**13,623**

Note 15 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019	**24,479**	**126,012**	**9,208**	**9,974**	**65,652**	**14,328**	**249,653**
Additions	-	-	-	18,618	-	-	**18,618**
Revaluations	261	3,855	754	-	-	-	**4,870**
Reclassifications	13	4,556	54	(9,521)	3,170	1,729	**(0)**
Disposals / derecognition	-	-	-	-	(750)	(8)	**(758)**
Valuation/gross cost at 31 March 2020	**24,753**	**134,423**	**10,016**	**19,071**	**68,072**	**16,049**	**272,383**
Accumulated depreciation at 1 April 2019	**-**	**1,112**	**1**	**-**	**46,787**	**11,785**	**59,686**
Provided during the year	-	11,986	580	-	4,102	1,316	**17,984**
Revaluations	-	(11,332)	(580)	-	-	-	**(11,912)**
Disposals / derecognition	-	-	-	-	(676)	(8)	**(683)**
Accumulated depreciation at 31 March 2020	**-**	**1,766**	**2**	**-**	**50,213**	**13,094**	**65,075**
Net book value at 31 March 2020	**24,753**	**132,656**	**10,014**	**19,071**	**17,859**	**2,954**	**207,308**
Net book value at 1 April 2019	**24,479**	**124,900**	**9,206**	**9,974**	**18,865**	**2,542**	**189,967**

Capital expenditure includes £941k of Covid19 related costs (£832k capitalised; £109k Assets under Construction). Capitalised spend is split across buildings, plant & machinery and Information Technology.

All capital expenditure is initially accounted for as "assets under construction". When capitalised it is reclassified into the appropiate category.

Costs of assets under construction are shown net of impairments charged in prior years to operating expenses against the value of capitalised professional fees in relation to the intended redevelopment of the Trust's Chelsea campus. These fees total £25,197k at 31 March 2020 (31 March 2019: £16,299k) against which the cumulative impairment stands at £6,312k as at 31 March 2020 (31 March 2019: £6,312k).

£1,552k of accumulated depreciation has been incurred in respect of the Wimpole St leased facility.

Note 15.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**28,590**	**126,703**	**8,432**	**7,860**	**63,202**	**13,920**	**248,707**
Additions	-	-	-	10,651	-	-	**10,651**
Revaluations	(4,111)	(5,135)	534	-	-	-	**(8,711)**
Reclassifications	-	4,444	241	(8,537)	3,344	507	**(0)**
Disposals / derecognition	(0)	-	-	-	(894)	(99)	**(994)**
Valuation/gross cost at 31 March 2019	**24,479**	**126,012**	**9,208**	**9,974**	**65,652**	**14,328**	**249,653**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**672**	**1**	**-**	**42,659**	**10,671**	**54,003**
Provided during the year	-	11,481	488	-	4,971	1,213	**18,154**
Revaluations	-	(11,041)	(488)	-	-	-	**(11,529)**
Disposals / derecognition	-	-	-	-	(843)	(98)	**(941)**
Accumulated depreciation at 31 March 2019	**-**	**1,112**	**1**	**-**	**46,787**	**11,785**	**59,686**
Net book value at 31 March 2019	**24,479**	**124,900**	**9,206**	**9,974**	**18,865**	**2,542**	**189,967**
Net book value at 1 April 2018	**28,590**	**126,031**	**8,430**	**7,860**	**20,543**	**3,250**	**194,704**

Note 15.2 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020							
Owned - purchased	24,753	125,727	9,776	19,071	14,295	2,946	**196,568**
Owned - donated	-	6,929	238	-	3,564	9	**10,740**
NBV total at 31 March 2020	**24,753**	**132,656**	**10,014**	**19,071**	**17,859**	**2,954**	**207,308**

Note 15.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019							
Owned - purchased	24,479	118,333	8,988	9,974	14,600	2,531	**178,906**
Owned - donated	-	6,567	219	-	4,265	11	**11,061**
NBV total at 31 March 2019	**24,479**	**124,900**	**9,206**	**9,974**	**18,865**	**2,542**	**189,967**

Note 16 Revaluations of property, plant and equipment

Land and buildings were valued by Montagu Evans (an independent valuer) as at 31 December 2019, in accordance with International Financial Reporting requirements. The valuer also confirmed that there had been no material movements between this time and 31 March 2020. The assets were valued by reference to the market conditions prevailing at the valuation date. Under IFRS13, the specialised assets classed under Depreciated Replacement cost (DRC) were valued at level 3 (based on unobservable inputs), whereas assets classed under Existing Use Value (EUV) were valued at level 2 (based on observable market data). The Trust's Chelsea campus for operational and support purposes (land and buildings) was valued on an alternative site basis, and the land area valued at both campuses was reduced to reflect a notional adjustment to exclude space that would not be required in the re-provision of a modern equivalent asset. See also note 1.26.

The valuers noted a "material uncertainty" arising from the Covid19 pandemic, but observed that this did not impact on valuations at this time.

The revaluation of land and buildings resulted in a net gain of £16,782k (gain of £2,818k in 2018/19), which is shown in note 15 as the combination of the revaluation adjustment to cost/valuation of £4,870k and to accumulated depreciation of £11,912k. This net gain is reported with other comprehensive income/expenditure on the Statement of Comprehensive Income.

Note 17 Investment Property

	2019/20	2018/19
	£000	£000
Carrying value at 1 April - brought forward	**93,653**	**101,210**
Carrying value at 1 April - restated	**93,653**	**101,210**
Movement in fair value	1,193	(7,557)
Carrying value at 31 March	**94,846**	**93,653**

Note 17.1 Investment property income and expenses

	2019/20	2018/19
	£000	£000
Investment property income	956	911

Investment properties were also valued as at 31 December 2019 by Montagu Evans in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and in accordance with International Financial Reporting requirements. The assets were valued by reference to the market conditions prevailing at the valuation date. Under IFRS13 this valuation is classed as a level 2 valuation (i.e. based on observable market data). The valuer also confirmed that there had been no material movements between this time and 31st March 2020, despite market uncertainties created by the Covid19 pandemic. Also see note 1.26.

Most properties are leased out on tenant repairing leases (meaning that the lessee retains responsibility for repairs and maintenance). The Trust incurs only minor costs in this respect, which are not considered material.

The elements of properties rented out for the purpose of relatives' accommodation are classified as investment property.

Note 18 Disclosure of interests in other entities

The Trust owns 100 per cent of the ordinary share capital of The Chelsea Private Hospital Ltd, a dormant company. The cost of this investment is £100.

The Trust has established, in collaboration with Imperial College and other nearby Trusts, Imperial College Healthcare Partners Limited ('ICHP'), a company limited by guarantee. This company provides central services to the Imperial Academic Health Science Partnership, in which the Trust participates.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. Since November 2011 the Trust has had a 50:50 joint venture in The Institute of Cardiovascular Medicine and Science Limited ('ICMS'), a company limited by guarantee, with Liverpool Heart and Chest Hospital NHS Foundation Trust, being the other 50% holder. The founding partners have each contributed £100,000 in total to the funding of ICMS including their original respective contributions of £50,000.

Using the equity accounting method, the investment would be recognised initially at cost in the Trust's Statement of Financial Position and increased or decreased each year to reflect the Trust's share of the annual surplus or deficit, with the gain or loss being recognised in the Statement of Comprehensive Income.

However, the Trust has decided not to reflect any surplus or deficit from ICMS's activities in its accounts as it deems the impact to be immaterial. The Trust has made £nil contribution to ICMS's operating costs in 2019/20 (2018/19: nil).

Note 19 Inventories

	31 March 2020	31 March 2019
	£000	£000
Drugs	2,857	1,497
Consumables	9,774	8,685
Total inventories	**12,631**	**10,182**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £123,855k (2018/19: £107,794k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

The Trust's inventory balance of £12.63m is material to the Trust's accounts and the Trust is satisfied that this balance is presented fairly in all material respects. However the restrictions on movement in the United Kingdom in March 2020, and Covid19 related operational constraints within the inventory team, meant that the Trust was unable to perform its planned year-end inventory counts, and the auditor has been unable to gain sufficient audit evidence from alternative procedures. Nonetheless, due to the normal management and oversight of inventories, management are confident that the stock levels reported are not materially mis-stated.

As the auditor was unable to attend a year-end inventory count, they have therefore been unable to complete the procedures required by auditing standards, and is required to issue a qualified opinion. We are aware that a number of trusts in the country are affected by the same issue in 2019/20 and we understand NHS Improvement will disclose the extent to which this has impacted the sector in its consolidated provider accounts when published later in 2020.

Note 20.1 Receivables

	31 March 2020	31 March 2019
	£000	£000
Current		
Contract receivables	75,457	54,451
Allowance for impaired contract receivables / assets (note 20.2)	(11,473)	(10,987)
Prepayments (non-PFI)	4,476	4,908
PDC dividend receivable	-	546
VAT receivable	332	423
Other receivables	2,059	575
Total current receivables	**70,852**	**49,916**
Non-current		
Other receivables	536	-
Total non-current receivables	**536**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	34,724	22,013
Non-current	536	-

Contract and other receivables include £3,272k at 31 March 2020 (£4,373k at 31 March 2019) for partially completed patient episodes.

Contract receivables as at 31 March 2020 includes FRF and PSF funding outstanding, totalling £16.2m; and £3.6m of Covid19 revenue funding (note 3.2).

Current - other receivables includes the Clinicians pension tax reimbursement during 2020/21. This liability will be refunded by NHS England when due.

The non-current receivable relates to the Clinicians pension tax reimbursement due beyond 20/21. This liability will be funded by NHS England when due.

Note 20.2 Allowances for credit losses

	2019/20 Contract receivables and contract assets	2018/19 Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**10,987**	**-**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018		10,192
New allowances arising	2,057	2,085
Changes in existing allowances	202	(339)
Reversals of allowances	(1,195)	(910)
Utilisation of allowances (write offs)	(579)	(41)
Allowances as at 31 Mar 2020	**11,473**	**10,987**

Note 21 Cash and cash equivalents movements

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

	2019/20	2018/19
	£000	£000
At 1 April	**20,818**	**20,847**
Net change in year	(13,503)	(29)
At 31 March	**7,315**	**20,818**
Broken down into:		
Cash at commercial banks and in hand	1,117	39
Cash with the Government Banking Service	6,198	20,779
Total cash and cash equivalents as in SoFP	**7,315**	**20,818**
Bank overdrafts (GBS and commercial banks)	-	(5,116)
Total cash and cash equivalents as in SoCF	**7,315**	**15,702**

NB cash as at 31st March 2019 included £5.116m one day "paper only" overdraft due to timing as funds are transferred between bank accounts.

Note 21.1 Third party assets held by the trust

Royal Brompton and Harefield NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Monies on deposit	70	128
Total third party assets	**70**	**128**

These are Tenancy deposits in respect of staff in Trust accommodation

Note 22 Trade and other payables

	2020	2019
	£000	£000
Current		
Trade payables	17,261	10,049
Capital payables	4,984	2,441
Accruals	18,906	16,909
Receipts in advance and payments on account	12,688	9,737
Social security costs	3,036	2,684
Other taxes payable	2,660	2,743
PDC dividend payable	20	-
Other payables	3,003	2,755
Total current trade and other payables	**62,558**	**47,318**
Of which payables to NHS and DHSC group bodies:	7,616	7,735

Trade payables includes Covid19 related expenditure invoiced, but not yet paid.

Accruals include Covid19 expenditure incurred, but not yet invoiced.

Note 23 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Bank overdrafts	-	5,116
Loans from DHSC	4,234	4,268
Other loans	1,971	1,731
Total current borrowings	**6,205**	**11,115**
Non-current		
Loans from DHSC	34,479	38,359
Other loans	13,267	5,238
Total non-current borrowings	**47,745**	**43,596**

Revolving credit facility

The Trust has a £10m Revolving Credit Facility, from HSBC Bank PLC which has a nil balance drawn down at 31 March 2020 (31 March 2019: £0m).

Loans from the Department of Health and Social Care

A £30m loan facility from the Independent Trust Financing Facility, a Department of Health and Social Care funding entity, drawn down to support the Trust's capital expenditure programme from 2014/15 to 2016/17 is set at a fixed rate of 2.54%. Interest is calculated on any outstanding balance being £22.8m at 31 March 2020 (31 March 2019: £25.2m). Repayments on the loan commenced in April 2017 (with final repayment due in April 2029) and the amount due within 12 months is included within the current balance in the table above.

A further £20m loan facility from the Independent Trust Financing Facility drawn down to support the capital expenditure programme from 2015/16 to 2017/18 is set at a fixed rate of 2.06%. Interest is calculated on any outstanding balance being £15.56m at 31 March 2020 (31 March 2019: £17.04m). Repayments on the loan commenced in June 2017 (with final repayment due in June 2030) and the amount due within 12 months is included within the current balance in the table above.

Accrued interest on the above two loans amounts to £352k and is included in the current balance in the table above.

Other loans

A £10m loan facility has been granted by Barclays Bank PLC to fund the costs associated with fitting out and equipping the leased suite of private patient outpatient and diagnostic facilities at Wimpole Street. During the period of the Progress Payment (PP) agreement interest only was payable, at 1.95%pa above base rate. The PP period concluded in January 2017 and the £10m capital balance then rolled into a 5 year amortising 'mortgage-style' loan facility, at an interest rate of 2.76%. Repayments commenced in January 2017 and at 31 March 2020 the balance is £5.2m (31 March 2019: £7.0m). The amount due within 12 months is £1.97m, as included within the current balance in the table above. Equipment assets are pledged as full security against the loan.

A £45m bridging loan from HSBC Bank was taken out in 2019/20 to fund construction of the Trust's new Imaging Centre, of which £10m has been drawn down in-year. This loan is secured against the Chelsea Farmers Market investment land

Note 23.1 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2019	**42,627**	**6,968**	**49,595**
Cash movements:			
Financing cash flows - payments and receipts of principal	(3,880)	8,270	**4,390**
Financing cash flows - payments of interest	(968)	(204)	**(1,172)**
Non-cash movements:			
Application of effective interest rate	933	204	**1,137**
Carrying value at 31 March 2020	**38,712**	**15,238**	**53,950**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2018	**46,543**	**18,466**	**65,009**
Cash movements:			
Financing cash flows - payments and receipts of principal	(3,880)	(11,498)	**(15,378)**
Financing cash flows - payments of interest	(1,060)	(288)	**(1,348)**
Non-cash movements:			
Application of effective interest rate	1,024	288	**1,312**
Carrying value at 31 March 2019	**42,627**	**6,968**	**49,595**

Note 24 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2019	**201**	**423**	**20**	**3,000**	**3,644**
Arising during the year	**-**	**23**	**-**	**1,179**	**1,202**
Utilised during the year	-	(73)	-	(1,202)	**(1,275)**
Reversed unused	**-**	**-**	**-**	**(1,922)**	**(1,922)**
Unwinding of discount	**(1)**	**(2)**	**-**	**-**	**(3)**
At 31 March 2020	**200**	**371**	**20**	**1,055**	**1,646**
Expected timing of cash flows:					
- not later than one year;	20	39	-	**330**	**389**
- later than one year and not later than five years;	80	80	20	**369**	**549**
- later than five years.	100	252	0	**356**	**708**
Total	**200**	**371**	**20**	**1,055**	**1,646**

The provision for injury benefits relates to three former employees. Costs are billed quarterly by NHS Business Services Authority and charged to utilisation

The provision for pensions is calculated using expected life tables and is discounted over the estimated period of the pension. Costs are billed quarterly by NHS Business Services Authority

Other provisions as at 31 March 2020 primarily relate to clinicians pension tax reimbursement (to be refunded by NHSE when due). At 1 April 2019 this category primarily related to service transformation.

Note 24.1 Clinical negligence liabilities

At 31 March 2020, £89,065k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Brompton and Harefield NHS Foundation Trust (31 March 2019: £80,059k).

Note 25 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	25,371	3,898
Intangible assets	45	33
Total	**25,416**	**3,931**

Note 26 Financial instruments

Note 26.1 Financial risk management

International Financial Reporting Standard (IFRS) 7 requires disclosure of the role that financial instruments have had during the year 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 NHS commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by most 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 this Standard mainly applies. 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 manage the risks it faces 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. Treasury activity is subject to review by the Trust's internal auditor.

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 makes some purchases in foreign currency and these are converted to Sterling at the spot rate on the day of payment, and overall the Trust has minimal exposure to currency rate fluctuations.

Interest-rate risk

Where appropriate, the Trust may borrow from Government and commercial sources, as disclosed in Note 23. Interest rates on all three loans are fixed. The Trust therefore has minimal exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other UK public sector bodies, it has low exposure to credit risk. The maximum exposure as at 31 March 2020 is in receivables from other customers, in particular private patient debt with foreign embassies who are traditionally slow payers, as disclosed in Note 20 and adequate consideration of impairment of receivables is made for such debtors on an annual basis.

Liquidity risk

Most of the Trust's operating costs are incurred under contracts with NHS commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital programme from its own resources and donations, and where necessary by accessing loans from government and commercial bodies.

Note 26.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	65,913	**65,913**
Cash and cash equivalents	7,315	**7,315**
Total at 31 March 2020	**73,228**	**73,228**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	44,039	**44,039**
Cash and cash equivalents	20,818	**20,818**
Total at 31 March 2019	**64,857**	**64,857**

Note 26.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	38,712	**38,712**
Other borrowings	15,238	**15,238**
Trade and other payables excluding non financial liabilities	44,154	**44,154**
Total at 31 March 2020	**98,104**	**98,104**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	42,627	**42,627**
Other borrowings	12,084	**12,084**
Trade and other payables excluding non financial liabilities	30,409	**30,409**
Total at 31 March 2019	**85,120**	**85,120**

Note 26.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	50,355	41,663
In more than one year but not more than two years	17,149	5,853
In more than two years but not more than five years	11,640	14,772
In more than five years	18,960	22,833
Total	**98,104**	**85,120**

Management considers that the carrying values of financial assets and liabilities are equal to their fair values.

Note 27 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	4	1	7	1
Bad debts and claims abandoned	58	238	40	107
Stores losses and damage to property	12	92	12	73
Total losses	**74**	**331**	**59**	**181**
Total losses and special payments	**77**	**338**	**59**	**181**
Compensation payments received		-		-

There have been no individual cases in excess of £300k.

These amounts are reported on an accruals basis when identified, but exclude provisions for future losses.

Note 28 Related parties

The Trust is a body corporate established by order of the Secretary of State for Health and Social Care. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust other than receipt of remuneration. The Department of Health and Social Care is the parent department. During the year the Trust has had numerous material transactions with the Department, and with other entities for which the Department is regarded as the parent. These entities include NHS England, Clinical Commissioning Groups, NHS Foundation Trusts, NHS Trusts, NIHR, Health Education England, the NHS Litigation Authority and NHS Supply Chain.

In addition, the Trust had a number of material transactions with other Government departments and other central and local Government bodies. Most of these latter transactions have been with Imperial College of Science, Technology and Medicine (relating to research projects) and The London Borough of Hillingdon and the Royal Borough of Kensington and Chelsea (relating to national non-domestic rates). The Trust operates in close collaboration with the National Heart and Lung Institute of Imperial College of Science, Technology and Medicine to deliver education, research and medical care.

The Trust also had a number of transactions with non consolidated charities with connections to the Trust. Material transactions with the Royal Brompton & Harefield Charity amounted to £2.1m in 2019/20 (£3.9m in 2018/19).

Major Counterparties (>£400k income and/or expenditure in 2019/20)

Department of Health and Social Care
NHS England
NHS Pension Scheme
NHS Resolution
Health Education England
HM Revenue & Customs
NHS Blood and Transplant
The Royal Marsden NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West University Healthcare NHS Trust
NHS Barnet CCG
NHS Bedfordshire CCG
NHS Brent CCG
NHS Buckinghamshire CCG
NHS Camden CCG
NHS Central London (Westminster) CCG
NHS Coastal West Sussex CCG
NHS Croydon CCG
NHS Devon CCG
NHS Ealing CCG
NHS East and North Hertfordshire CCG
NHS East Berkshire CCG
NHS East Surrey CCG
NHS Guildford and Waverley CCG
NHS Hammersmith and Fulham CCG
NHS Harrow CCG
NHS Herts Valleys CCG
NHS Hillingdon CCG
NHS Horsham and Mid Sussex CCG
NHS Hounslow CCG
NHS Kingston CCG
NHS Luton CCG

NHS Merton CCG
NHS Milton Keynes CCG
NHS North West Surrey CCG
NHS Richmond CCG
NHS Surrey Downs CCG
NHS Sutton CCG
NHS Wandsworth CCG
NHS West Essex CCG
NHS West Kent CCG
NHS West London (K&C & QPP) CCG
Welsh Health Bodies - Cwm Taf Local Health Board