NHS
Imperial College Healthcare
NHS Trust

# Annual Report


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2024–25

# Contents



## Recognising and remembering colleagues

Our annual report for 2024-25 is dedicated to the commitment and expertise of all our people.

We pay special recognition to our colleagues who died in 2024-25 and celebrate their lives and contribution to the NHS:

- Jo Burke
- Raul Cardoza
- Mervyn Dukes
- Marian Jalloh
- JoAnn Las Marias
- Janet Macdonald
- Darren Parsons
- Vanya Petkova
- Anne Sodiq
- Aminat Taslim
- Halyna Vergun
- Abraham Yap

# Welcome

**Matthew Swindells, Chair, Imperial College Healthcare and North West London Acute Provider Collaborative**

*Reflections on the Trust as part of the wider acute provider collaborative*

The last year has been one of progress and transformation for the acute providers of north west London.

The NHS has continued to evolve, as we navigate the aftermath of the pandemic and respond to the constant changes in the world around us. And in north west London, we have continued to work together through our acute provider collaborative (APC) to tackle these challenges head-on.

In the summer, we set out our vision for how we can do so most effectively, publishing the new North West London Acute Provider Collaborative Strategy for 2024-27 after extensive engagement with colleagues and patients across our geographical areas.

With a population of 2.2 million people, one in eight of whom live in some of the poorest neighbourhoods in England, we must use our collective resources and experience to raise standards of care equitably and according to the needs of our communities. The strategy sets out our mandate for change and identifies the strengths through which we will achieve that change, from our remarkable people to our outstanding track record in research and innovation.

We have begun to put these principles into practice: over the last year, we have set out 28 clinical specialties common to all four trusts in the APC, and their clinical teams are beginning to align the pathways to agreed best practices to improve outcomes and patient experience. As teams challenge themselves and one another on ways to offer the best possible care through these pathways, we expect to see shorter waiting times, faster diagnoses, and better experiences for our patients as a result.

Such outcomes are already evident at our North West London Elective Orthopaedic Centre (EOC), which recently received accreditation from the national Getting It Right First-Time programme. The EOC offers a state-of-the-art centre of excellence for routine bone and joint surgery, with care based on national standards and best safety practices. So far it has treated more than three thousand patients, with average length of stay just 2.4 days, and 96% positive feedback through the friends and family test.

Safety remains at the core of our work to improve care, and I am very proud that in north west London, we are one of the safest groups of hospitals anywhere in the country based on the summary hospital-level mortality indicator (SHMI) measure. At the time of writing, three of our four trusts sit in the top ten positions on the SHMI, while for all four the measure compares favourably to the NHS average. This impressive achievement reflects the outstanding commitment to patients that we see every day from colleagues across each one of our hospitals.

Throughout our strategy, we welcome the ever-increasing role that technology and innovation must play in providing high-quality care. In north west London, we have been ahead of the curve in making the most of the fresh opportunities offered by the national Federated Data Platform (FDP). A project known as Timely Care Hub, for example, has allowed colleagues on our wards to track patients' status in real time, from expected discharge dates to tasks that still need to occur before someone can leave hospital. This kind of work will be essential in the year ahead, as we seek to provide a combination of greater efficiency, value for money, and exceptional patient care.

It is a mark of our teams' resilience that they have continued to deliver these improvements against a backdrop of enormous operational and financial pressure. A particularly long and challenging winter has placed all our hospitals under great strain, and we recognise the impact that this has

on those of our staff who have been working under what are often extremely stressful conditions.

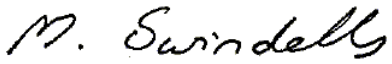
Their hard work has meant, however, that even in the face of this pressure, north west London has consistently performed well, with the system better than the London average on the emergency department four hour waiting time target, the time taken for ambulances to hand over patients to hospital staff, and the number of people referred on urgent cancer pathways having their diagnosis confirmed or cleared within 28 days.

Each of these successes is a tribute to our teams. We are lucky to have such skilled and dedicated people working for the north west London NHS, and it's our responsibility to provide them with the best possible working environment in which they can do their jobs. We have been delighted, therefore, to see that trusts in the APC have seen excellent results in the NHS staff survey this year, reflecting an extensive programme of work on culture, training and wellbeing, as well as targeted local improvements.

In this year of change, we have said goodbye to colleagues as they start on new ventures, and we wish them all well for the future. On behalf of the board in common and from me personally, I must give special thanks to Patricia Wright, who recently stood down as the chief executive of The Hillingdon Hospitals NHS Foundation Trust (THHFT), also to Catherine Jervis, vice chair at THHFT and Steve Gill, vice chair at Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) who both stood down in the autumn. We have also said goodbye to Penny Dash, the chair of the North West London Integrated Care Board (ICB) who left to become chair of NHS England.

I look forward to continuing to work with Lesley Watts in her new role as joint chief executive of Chelsea and Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust, in an appointment that will further strengthen our collaborative approach to providing NHS care in north west London. And, of course, I am excited to continue our work with LNWH and Imperial College Healthcare chief executives Pippa Nightingale and Professor Tim Orchard, who are doing such excellent work in leading their trusts through these times of considerable change.

The last twelve months have demonstrated the extent to which we can make extensive and rapid improvements when we work collectively. Now, with a new vision and strategy, we can look to the year ahead with confidence that the principles they set out will help us steer through its changes together.



**Matthew Swindells, Chair**
**27 June 2025**

# Performance report

This section provides a summary of the Trust's performance for 2024-25. It includes a statement from the chief executive and a synopsis of the Trust's purpose and activities and the key risks and challenges to the delivery of its strategic goals.

# Overview

**Professor Tim Orchard, Chief executive**

With the benefit of a little distance now from 2024-25, it's clear that it was a year of transition. We moved fully into a post-pandemic world, we had a change of Government and, with it, a new approach to fiscal and healthcare policy, and the whole world grappled with the exponential rise in the use of artificial intelligence.

These developments bring much opportunity and challenge. And so, it's helpful to review the past year in terms of how it sets us up to respond to the year ahead as much as what we achieved.

At a headline level, our performance in 2024-25, evaluated against our long-standing strategic goals as well as our shorter-term objectives, puts us in a strong position to achieve even more for – and with – our patients, local communities and staff.

We provided more care than ever before, with around 1.5 million patient contacts. We continued to provide some of the best outcomes in the country while our mortality rates remained among the lowest, based on the summary hospital-level mortality indicator (SHMI) measure. Incident reporting rates increased slightly while harm levels stayed below average, evidence of a positive safety culture.

Further evidence of a positive organisational culture came with the fourth year of staff survey improvements. We have an amazing workforce and so I am delighted that over 70% of our staff now recommend us as a place to work, ten points higher than average. The proportion of staff believing that our organisation provides equal opportunities for career progression or promotion rose by nearly 1.5 percentage points for white staff and three percentage points for staff from all other ethnic backgrounds, against no change to the acute trust average for both groups, moving us above the average for the first time. We are now above the average for acute trusts for eight of the nine staff survey themes, up from seven out of nine in 2023. While we are slightly below average for one theme – 'we work flexibly' – it is the theme which saw the biggest improvement last year.

Operationally, we exceeded key targets for cancer care waits, ambulance handovers and reduction in long waits, although we were unable to achieve all the national standards improvements. We had the most significant challenge in diagnostics, primarily due to increased downtime of our ageing equipment. Our maternity services came under particular pressure too, with a significant increase in self-referrals from outside our sector and neighbouring ones.

Last year was the sixth successive year that we delivered our financial plan, which was to break even. However, this required a huge amount of effort and focus, as well as one-off income and release of the provision for lease dilapidation costs. We did not deliver all the recurrent savings we had planned.

Positively, our private care division recovered further to provide a healthy surplus and is on track to increase performance further next year.

Last year also saw a range of significant developments that are building the foundations for further improvements. We rolled out the new patient safety incident response framework and we helped to pilot the implementation of Martha's Rule, giving patients and their families a key role in helping us spot if a patient is beginning to deteriorate and making sure they get the help they need. We increased our focus on using insights about, and from, our patients, communities, staff and partners to shape improvements, with major programmes to improve outpatient processes and cancer care pathways getting properly underway last year. We kept our estate redevelopment programme broadly on track, despite a disappointing outcome in the latest New Hospital Programme review. Design and planning got underway for the new Fleming Centre at St Mary's Hospital to tackle antimicrobial resistance and we won significant investment for energy efficiency projects to support our Green Plan.

As the largest NHS biomedical research centre, we increased the number of clinical trials we were able to run to 1,300. And many years of high-profile research came to fruition. This includes a world-first gene editing therapy receiving approval for NHS use to treat sickle cell and thalassaemia, following years of work by Trust researchers with international commercial and healthcare collaborators. In February 2025, Queen Charlotte's & Chelsea Hospital was the site of the UK's first birth following a womb transplant. This joyful moment followed decades of pioneering research and innovation by a collaborative team of UK experts led by teams from Imperial College Healthcare, Oxford University Hospitals and The Lister Hospital. Other research highlights last year include several publications evidencing the benefits of using AI to support clinical care.

So, looking ahead to 2025-26, the NHS is facing one of its most challenging years. The additional £22 billion allocated to the NHS nationally has been absorbed by pay awards and the full impact of inflation. To meet the financial gap, NHS trusts are required to spend one per cent less and deliver a four per cent increase in productivity overall. We have also been set targets for reducing our substantive workforce by one per cent, bank staff (our internal staff agency) by 15%, external agency staff by a third and spending on corporate and other 'non-patient facing' roles equivalent to half the growth since 2018-19.

For our Trust, this means delivering a breakeven plan for 2025-26 (with £46m of support from North West London Integrated Care Board), including £80.1m of cost improvements. It also means reducing our workforce by at least 450 full-time equivalent posts, mostly through a reduction in the use of bank and agency staff but also by reviewing vacancies, primarily in non-patient facing roles. This is also in the context of an establishment that has grown significantly since the pandemic, to over 16,000 currently.

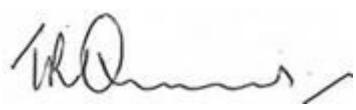
We need to meet a core set of operational performance improvement targets, spanning A&E, referral to treatment, cancer care and diagnostics waits. And we need to continue to progress our key development programmes, not least the desperately needed redevelopment of our estate, particularly St Mary's.

We are focusing on making changes across all our services that will improve care and make us more productive. For example, we have seen a big increase in follow-up outpatient appointments since the pandemic, while waiting times for first outpatient appointments are growing. Our clinicians are exploring how to avoid unnecessary follow-ups by getting the most out of first appointments, for example by arranging diagnostic tests to be carried out beforehand, as well as giving patients control over when they want to be seen as part of ongoing care for long-term conditions rather than having standard intervals between appointments.

Across all these actions, we have agreed a set of principles to help ensure our focus remains on quality and the health and wellbeing of our workforce. And we have processes in place to check that we are sticking to these principles and to monitor the impact of changes. This includes making sure we do not worsen health inequalities nor present any risks to safety, being open and transparent about what is happening and why, and considering the impact of proposed changes on patients, staff, GPs and other stakeholders and involving them directly wherever we can in the change process.

The Government expects reform. Its Ten-Year Health Plan is due to be published later this year, aiming to deliver three key shifts – hospital to community, analogue to digital, treatment to prevention.

Our strategy – and that of the wider acute provide collaborative – is well aligned with this ambition. By improving our productivity and cost control, while staying true to our goals, we will be well placed to help and support the change that is needed. Ultimately, we will be on track to deliver our long-standing promise of 'better health, for life'.



**Professor Tim Orchard, Chief executive**
**27 June 2025**

# About the Trust

At Imperial College Healthcare NHS Trust we provide acute and specialist healthcare to over 1.5 million people a year. We are one of the largest NHS trusts in the country, with over 16,000 staff.

Our five hospitals in central and west London – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – have a long track record in research and education, influencing care and treatment nationally and worldwide. We also provide care remotely and from an increasing number of community facilities. We offer private healthcare in dedicated facilities on all our sites, too.

We are a member of the North West London Acute Provider Collaborative, a formal partnership with the other acute NHS trusts in our sector – Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and London North West University Healthcare NHS Trust. We work together to make the most effective use of our collective resources to provide better care, for more people, more fairly. Between us, we run 12 hospitals, employ approximately 33,000 staff and serve a local population of over 2.2 million.

## Our mission and strategic goals

Our mission is to be a key partner in our local health system and to drive health and healthcare innovation, delivering outstanding care, education and research with local, national and worldwide impact.

We have three overarching strategic goals that, together, will enable us to achieve our vision of 'better health, for life':

- to help create a high-quality integrated care system with the population of north west London
- to develop a sustainable portfolio of outstanding services
- to build learning, improvement and innovation into everything we do.

## Our values

Everything we do is underpinned by our values, which are to be:

- **kind** – we are considerate and thoughtful, so you feel respected and included
- **expert** – we draw on our diverse skills, knowledge and experience, so we provide the best possible care
- **collaborative** – we actively seek others' views and ideas, so we achieve more together
- **aspirational** – we are receptive and responsive to new thinking, so we never stop learning, discovering and improving.

## Our hospitals

We provide care from five hospitals on four sites:

**Charing Cross Hospital, Hammersmith:** provides a range of acute and specialist services including cancer care and a 24/7 accident and emergency department (A&E). It also hosts a hyper acute stroke unit and is an important hub for integrated care in partnership with local GPs and community providers.

**Hammersmith Hospital, Acton:** offers a range of primarily specialist services, including renal, haematology, cancer and cardiology care, and provides the regional specialist heart assessment centre.

**Queen Charlotte's & Chelsea Hospital, Acton:** a maternity, women's and neonatal care hospital. It has a midwife-led birth centre as well as specialist services for complex pregnancies, fetal and neonatal care.

**St Mary's Hospital, Paddington:** provides care across a wide range of specialties and runs one of four major trauma centres in London, including 24/7 adult and children's A&E departments. It also incorporates a maternity centre with consultant and midwife-led services as well as a neonatal unit.

**The Western Eye Hospital, Marylebone:** a specialist eye hospital with an eye A&E department for both adults and children.

We run nine renal dialysis units across the sector and beyond, two community diagnostic centres and one community eye care centre. We also provide services from an increasing number of community facilities, often in partnership with other health and care providers.

## Private care

Our private care division offers a range of services in dedicated facilities across our sites. These include the Lindo Wing at St Mary's Hospital, Thames View at Charing Cross Hospital, the Sainsbury Wing at Hammersmith Hospital, Clayton Ward at Queen Charlotte's & Chelsea Hospital and the Western Eye Hospital. Our private care division allows us to extend our offer to those who are not eligible for NHS services or who choose to have private care. The private care division generated £52.5m in 2024-25, income which is reinvested into all our services.

## Our academic partners

Imperial College London is our main academic partner – we help provide education and training for undergraduate medical students and postgraduate trainees. With Imperial College London, we also run the largest of the 20 Biomedical Research Centres established by the National Institute for Health and Care Research.

Our partners as an Academic Health Science Centre (AHSC) are: The Institute of Cancer Research, London, The Royal Marsden NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust. We also work in partnership with other universities, including Buckinghamshire New University, Brunel University and King's College London to support education and training for nurses, midwives, allied health professionals and others.

## Our charity partners

We work closely with Imperial Health Charity (the Charity), which helps us do more through grants, arts, volunteering and fundraising.

In 2024-25, the Charity invested approximately £5.6m in a wide range of healthcare initiatives for the benefit of patients and NHS staff.*

The Charity:

- provides extra support by funding improvements to hospital buildings and facilities, pioneering research and advanced medical equipment
- awards emergency hardship grants for patients and their families at times of financial crisis
- supports the arts in healthcare managing a museum-accredited hospital art collection and an arts engagement programme, providing creative activities for patients, NHS staff and the wider community
- manages a community of over 1,000 hospital volunteers, whose contribution helps to improve the overall experience of care for our patients and visitors

We also have invaluable support from:

- COSMIC, which raises funds for our children's and neonatal intensive care units
- each of the charitable 'Friends' organisations for Charing Cross, Hammersmith and St Mary's hospitals.

*Figure may be subject to change. Full audited accounts will be available in the Charity's annual report in autumn 2025. The figure covers all grants made to the Trust or other NHS bodies in the year, along with the cost of the arts and volunteering programmes. It does not include the charity's staff or administration costs.

## Strategic lay forum

The strategic lay forum is the centre of patient and public involvement at the Trust, setting and championing a clear vision for effective involvement. It works to ensure the Trust understands and responds to the needs and preferences of patients and local communities.

It was established in November 2015 and consists of up to 14 lay partners plus up to 10 senior Trust staff and representatives from Imperial College London and Imperial Health Charity. More information about the strategic lay forum is available in the latest annual review of patient and public involvement, which can be found on our website.

## North West London Integrated Care System

The North West London Integrated Care System (ICS) brings together all health and care organisations in the eight boroughs of north west London. Over 30 NHS, local authority and voluntary sector partners, including our Trust, are working together to improve health and care for the population of north west London through one of London's five integrated care systems.

The North West London ICS has four key objectives, to:

- improve outcomes in population health and health care
- prevent ill health and tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader economic and social development.

The integrated care board (ICB) in north west London is called NHS North West London. It is the statutory NHS organisation responsible for developing a plan that meets the health needs of the local population, managing the NHS budget and arranging for the provision of health services in north west London. Of our income:

- around 42% is from services commissioned by NHS North West London
- around 33% is from specialist services commissioned by NHS England
- the remainder is earned from other sources including other NHS bodies, local authorities, research and private healthcare.

# Trust in numbers 2024-25

## Our services

1,475,017 in 2024-25

1,374,000 in 2023-24

Patient contacts

(including inpatients, outpatients and day cases)

314,925 in 2024-25

298,000 in 2023-24

Emergency attendees

(including A&E and ambulatory emergency care)

9,843 in 2024-25

9,500 in 2023-24

Babies born

36,809 in 2024-25

33,400 in 2023-24

Operations

96% in 2024-25

96% in 2023-24

Positive overall rating of care for inpatients

# Our staff

2,153
Admin and clerical

887
Allied health professionals (qualified)

129
Allied health professionals (support)

1,077
Ancillary

30
Doctors (career grade)

1,381
Doctors (consultant)

2,184
Doctors (training grade)

4,842
Nursing and midwifery (qualified)

1,276
Nursing and midwifery (support)

171
Pharmacists

9
Physician associates

974
Scientific and technical (qualified)

536
Scientific and technical (support)

880
Senior managers

16,529
Trust total

## Our students

3,705

Medical students

671

Nurses in education

## Our research

1,289

Active clinical research studies

39,100

Patients involved in research studies

## Our finances

£0.1M

Surplus (adjusted)*

£1.9B

Actual turnover (£1.7B in 2023-24)

£1.7B

Turnover budget (£1.5B in 2023-24)

£63.4M

Efficiencies (£53.4M in 2023-24)

£128.3M

Gross capital investments including buildings, infrastructure and IT (£98.3M in 2023-24)

*NHS England monitors NHS trust financial performance using an adjusted measure, which is derived from its surplus or deficit but is adjusted for impairments – and reversal of prior year impairments – to property, plant, equipment, transfers by absorption and elimination of income and expenditure arising from donations and donated assets, as these are not considered to be part of the organisation's operating position.

# Performance analysis

We have three overarching strategic goals that will enable us to achieve our vision of 'better health, for life':

- to help create a high-quality integrated care system (ICS) with the population of north west London
- to develop a sustainable portfolio of outstanding services
- to build learning, improvement and innovation into everything we do.

To help us take measurable steps towards these strategic goals, we set four objectives for 2023-25:

1. To build a values-led organisational culture.
2. To improve outcomes for patients and local communities.
3. To reduce waits and delays for our patients.
4. To achieve sustainable, financial balance.

We must also deliver our annual operational plan which incorporates detailed financial, operational and quality performance targets agreed with NHS England and NHS North West London.

The Trust measures performance in operational areas against key national indicators. Performance indicators are reported monthly to highlight risks and uncertainty in specific areas of service.

This section summarises progress during 2024-25 against our four organisational objectives including our key risks to achieving these. There are more detailed reports on progress against our:

- financial targets in "Achieving sustainable financial balance" on page 22
- operational targets in "Reducing waits and delays" on page 20
- quality targets in our annual quality account for 2024-25, available on our website: https://www.imperial.nhs.uk/about-us/how-we-are-doing/quality-and-performance-reports/quality-accounts

# Risks and challenges in achieving our strategic goals

Key risks to the achievement of our strategic goals are:

- risk of not delivering improvement in the equity of care we provide at the Trust, thereby not contributing to reducing health inequalities in the population we serve
- failure to transfer medically optimised patients to mental health inpatient settings due to lack of available beds, impacting on patient safety and experience
- inability to provide appropriate condition of buildings and infrastructure on the St Mary's site, impacting on patient, visitor and staff safety and effective clinical delivery
- risk of delays in patient access, reputation and operational performance due to poor data quality across people, process, systems and reporting
- risk of not delivering an improvement in the underlying deficit and achieving a sustainable financial position
- inability to secure national funding from the New Hospital Programme for the redevelopment programme resulting in the continued provision of services from inadequate estates and suboptimal clinical configurations, potentially compromising the quality of care, operational efficiency, and the ability to meet future healthcare demands
- risk of a safe operational delivery, performance, finance, quality, reputation and safety of people during or following a pandemic.

Our risks are set out in detail in the annual governance statement, which begins on page 59. Our risks are recorded within the board assurance framework and corporate risk register. Risks are reported quarterly to the Trust standing committee and are set within the context of the Board's risk appetite statement on page 59.

# How we're doing against our organisational objectives

## 1. Building a values-led culture

Our investment in building and embedding a values-led organisational culture has yielded measurable results. In the 2024 NHS Staff Survey, we saw improvement for the fourth year in a row. We achieved our highest-ever response rate, with nearly 1,000 more staff completing the survey compared to 2023. Our 65.2% response rate is significantly higher than the acute trust average of 49%.

We achieved statistically significant improvements in three themes – 'we are safe and healthy', 'we work flexibly' and 'morale'. Meanwhile, the previous year's improved scores for the remaining six themes held steady. We are now above the average for acute trusts for eight of the nine themes, up from seven out of nine in 2023. While we are slightly below average for one theme – 'we work flexibly' – it is the theme which saw the biggest improvement.

The proportion of staff who would recommend the Trust as a place to work also saw a statistically significant improvement, to 70.7%. This is now ten percentage points higher than the acute trust average. And, while the proportion of staff who say they would be happy with the standard of care we provide if a friend or relative needed treatment remained steady at 74.5%, this is now 13 percentage points above the acute trust average (up from ten percentage points in 2023).

Continuing this journey, in 2024-25, we've strengthened and diversified our staff recognition offer, creating more opportunities to recognise colleagues who make a difference. We introduced new policies to support flexible working and better people management. And we ran major programmes to:

- address violence and aggression in our hospitals
- co-design our commitments to become an anti-racist and anti-discriminatory organisation.

But crucially, efforts to create a values-led organisational culture go beyond centrally led, people initiatives. Through our growing staff networks, our people are helping to shape their own workplaces. Examples include:

- members of our nursing race equality network leading the development of more inclusive patient haircare
- staff-led content and events to mark key awareness dates and cultural celebrations that matter to them most.

We also made progress in ensuring patients and local communities help shape everything we do. We want to do more to listen and respond to their feedback. Specific user experiences contributed to the major improvement programmes for 2024-25 – including those to transform outpatient care and cancer services. We agreed our first formal patient voice remuneration policy, to help groups within our diverse communities get involved without facing financial barriers. And we worked with local health and care partners and Imperial College London to develop a shared approach to relationship-building with community organisations.

For our nurses and healthcare assistants, achieving Pathway to Excellence accreditation demonstrated real progress in ensuring we create a positive practice environment, with a major focus on shared decision making.

### Anti-discrimination and anti-racism commitments

We launched our anti-discrimination and anti-racism commitments in 2024-25. We drew on discussions with 1,200 staff and 11 community groups to build a shared understanding of what equity and inclusion means for us in practical terms.

Our organisational commitments are underpinned by a clear organisational action plan. It works alongside the individual commitment that every member of staff is expected to make, supported by

a new interactive self-assessment tool, resources and training.

## Staff recognition

In 2024-25 we refreshed our staff recognition offer in response to staff feedback. Our new approach launched in September 2024. It includes new ways to make recognition easier and fairer and is more aligned to our organisational priorities and values.

Shout Out is our new online tool allowing staff to give instant feedback to their colleagues. There have been over 2,200 instant recognition Shout Outs to individuals and teams since its launch in May 2024.

Make a Difference, our formal staff awards scheme, has been refined to shine a spotlight on individuals and teams locally, with a special focus every quarter.

Our Long Service Award scheme was expanded to include anyone with 20 or more years of continuous service.

We've also consolidated the different ways that patients, visitors and carers can give positive feedback and thanks. This is alongside the pilot of the My Thank You digital offer in some buildings at St Mary's and the Western Eye hospitals.

## Staff networks

Our growing staff networks help support equity and diversity. They provide opportunities for staff to connect with each other and generate ideas to improve the organisation.

The staff disability network I-CAN now works with our estates team to improve accessibility across our sites. It helped inform improvements to how disabled staff and those with long-term conditions can access reasonable adjustments.

A pilot initiative to offer more inclusive haircare for inpatients was launched by the nursing and midwifery race equality network in late 2024. This included creating a training video and guidance, procuring inflatable "sinks" for hair washing and soothing haircare products formulated for a diverse range of hair types. We expect the initiative to expand to other inpatient areas in 2025-26.

South Asian Heritage Month, East and Southeast Asian Heritage Month and Black History Month were marked by a series of cultural showcases, talks, blogs, and other activities, organised by the multidisciplinary race equality network during 2024-25.

The I-CAN network led a Schwartz Round to raise awareness of disability and lived experiences and encourage disability confidence. Schwartz Rounds are one-hour sessions for staff from all disciplines to discuss difficult emotional and social issues arising from patient care.

## A new approach to people policies

Our commitment to equality, diversity and inclusion means ensuring every member of staff is supported to achieve their full potential. This has guided new approaches to managing health and attendance (previously known as sickness absence), performance and flexible working. These were launched in January 2025. I-CAN helped design the refreshed health and attendance policy, which is helping to ensure better practical support and more consistency across the organisation.

## Countering violence and aggression

A new multidisciplinary taskforce was set up in response to increasing incidents of violence and aggression. Chaired by our chief executive, it oversaw the development and rollout of a range of new initiatives. These include:

- a training package to help promote positive behaviours and ensure staff know how best to protect themselves. This builds awareness and understanding of mental health issues, conflict

resolution and dementia, with a focus on approaches that identify risks and 'de-escalate' situations as early as possible
- increased CCTV coverage and increased visibility of security staff, as well as expanding the use of body-worn cameras
- updated and promoted guidance for patients and visitors on the use of social media, filming and photography, as well as where to get more help. These are all issues found to create or escalate situations
- expanded access to emotional and psychological support through our CONTACT programme

As part of wider efforts to create less stressful environments, we installed 65 digital screens across our sites to share real-time information for patients and visitors. We also ran 'a power of kindness' campaign.

Weekly executive reviews of reported incidents are now helping to identify trends and track the impact of responses.

### Community engagement

We want to build two-way, trust-based relationships with our communities, directly with individuals and via community leaders and organisations. In 2024-25, we used community engagement principles, co-designed in 2022, to develop a shared approach to managing contact with community organisations and building relationships across the Trust, with other health and care partners and Imperial College London.

We also deepened our relationship with 11 local community organisations that represent a diversity of groups within our local communities. They first became engaged through the development of our anti-racism and anti-discrimination commitments.

### Pathway to Excellence accreditation

In July 2024, Charing Cross Hospital received the prestigious Pathway to Excellence designation for nursing. It is the first acute hospital in London and within the Shelford Group to gain this international recognition. Pathway to Excellence is an international programme which recognises hospitals which demonstrate a commitment to creating a positive practice environment for nurses. It includes improvements and initiatives focused on nursing wellbeing, safety, leadership, decision-making, quality and professional development. Plans are underway to extend this approach to all our hospitals, starting with Hammersmith Hospital.

### Looking ahead

In 2025-26, we will continue to draw on the results of the annual NHS staff survey to focus on improvements for our people. We know there is much more to do to improve equity and inclusion in particular. Our priorities include:

- practical improvements to aid accessibility
- expanding our training offer
- extending our inclusive recruitment initiatives

We will also continue our programmes to address violence and aggression, create local, integrated improvement plans that draw on the full range of patient as well as staff feedback and views, and promote our values in everything we do.

## 2. Improving outcomes for patients and local communities

In 2024-25, our mortality rates continued to be among the lowest in the NHS, as reported through the summary hospital-level mortality indicator (SHMI) and hospital-standardised mortality ratio (HSMR). More information about these indicators is available in our quality account.

We made progress on reducing waits and took further steps to be more person-centred, expanding

our ability to involve patients, carers, families and the wider community in shaping our work. We had put in place the new national Patient Safety Incident Response Framework (PSIRF) at the start of 2024-25. Over the rest of the year, we aligned all our processes for managing and investigating patient safety incidents to ensure our patients' needs and views are central. This was supported with new training and support for staff as well as refreshed governance structures. Our five patient safety partners have been integral to shaping our overall safety programme and to the delivery of specific safety initiatives, including the rollout of Call for concern.

In response to patient and other feedback, we launched major programmes to improve services, most notably in cancer and outpatient care. We made good progress with our quality and safety improvement priorities, including improvements in hand hygiene, falls prevention and safety for patients on insulin or anticoagulation medication.

We have also implemented strategies to improve care for our patients when they are most vulnerable, including at the end of their life, during periods of mental health crisis, and when transitioning from children's into adult services. We also expanded our suite of public health initiatives. More information is available in our quality account for 2024-25.

We had a mixed year when it comes to one of our biggest risks to safety and quality – the poor condition of our estate. We faced a setback when our main funding from the Government's New Hospital Programme was delayed until at least 2035. However, despite this, we secured funding for 2025-26 to enable us to progress detailed design and planning for a new St Mary's Hospital and continued with a more strategic approach to interim estate improvements.

## Martha's Rule and Call for concern

In May 2024, our hospitals were included in the first sites to test and rollout Martha's Rule.

Martha's Rule was named in memory of Martha Mills, who died in hospital from sepsis at age 13. It aims to provide a consistent and clear way for patients, carers and families to get urgent help if they feel staff locally are not recognising or responding to potential clinical deterioration as they should.

We had already introduced our Call for concern service in January 2024. This provides 24/7 telephone access to senior clinicians who can carry out urgent clinical reviews. In 2024-25, our Call for concern service received 197 calls. Of these, 102 were non-clinical – mostly concerning communication issues – while 95 required clinical review. Reviews, conducted in person, led to interventions such as bedside nursing support, oxygen therapy, pain management, and IV fluid or electrolyte support. Fortunately no one required transfer to higher-level support such as intensive care.

We are now working on the next phase: systematically recording daily feedback from patients and their carers and families, to ensure any concerning changes in behaviour or condition are identified.

## Improving cancer care pathways

We gathered insights from over 200 patients, carers and staff to help us review our cancer care pathways, working in partnership with the Helix Centre, part of Imperial College London. We identified several key themes to inform improvements. These included:

- delays in diagnosis and starting treatment
- gaps in follow-up care
- some poor communication across the whole pathway.

The full phase one report is available on our website. Together with patients and staff, we are now working up a detailed work programme to begin implementation in 2025-26.

## Smoking cessation

Over 1,000 patients who had told us that they were currently smokers engaged with our new health improvement advisors from when they started work in August 2024 until the end of 2024-25. Our advisors provide one-to-one specialist support to help patients become smokefree during their hospital stay and, if possible, for the longer term. Over 80% of patients agreed to some level of support and the team made over 500 onward referrals to local smoking cessation services to enable continued support and treatment. More than 200 patients reported being smokefree 28 days after being discharged from hospital. Focus for the team in 2025-26 includes improving screening rates and offering nicotine replacement therapy, as well as collaborating with RM Partners our local cancer alliance, to provide specialist support to outpatients on cancer pathways.

## Domestic violence

A pilot programme at St Mary's Hospital called ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments) received referrals for 94 patients experiencing domestic abuse or sexual violence, or both, in 2024. The programme offers specialist assessment and support for survivors. It also trained 65 staff members within the hospital's sexual health service to identify and help patients who may be affected. Developed and piloted by social enterprise IRISi, the programme is co-managed at St Mary's Hospital by the Trust and the domestic abuse charity Advance.

## Quality reviews

When we identify concerns about quality of care which cannot be resolved through our usual governance channels we arrange a series of quality review meetings. For example, if we identify an unusual number of incidents or a new type of concern in a particular service. These meetings provide a way for the relevant teams to come together to share and review information, identify actions and provide support.

In 2024-25, we carried out quality review meeting processes with cardiac, emergency care and infection prevention and control that resulted in improvements in performance. These are set out in more detail in our quality account.

Two quality review meetings processes are still under way as of April 2025. We are working with neurotrauma to clarify roles and responsibilities within the team after incident investigations highlighted concerns about governance processes and pathway issues. We are also working with our neurosurgery service to address complex challenges affecting quality, education and long waits for elective care. In March 2025, we temporarily paused the neuro-oncology service following an invited review by the Royal College of Surgeons. This was in response to concerns raised internally. An improvement plan and external expert support are in place, along with regular meetings with the medical director to oversee progress.

We have undertaken a full review of the neurosurgery specialty. New governance and leadership posts have been put in place and a business case developed to address staffing and rota issues. We have also responded to feedback from resident doctors with changes to clinic templates, theatre allocation and office space. The quality review meetings will continue for the foreseeable future.

## Hospital redevelopments and estate improvements

Our redevelopment plans had a setback in early 2025, when the outcome of the Government's New Hospital Programme review saw St Mary's, Charing Cross and Hammersmith hospitals included in the third wave of schemes. This means building would be delayed until 2035 at the earliest. Following discussions, and with huge support from our local authorities and MPs, we were able to confirm that we would still be funded for 2025-26 to progress detailed design and planning for St Mary's, the most urgent of our schemes. This gives us around two years to work with our partners to try to identify additional, alternative funding mechanisms and sources to enable

building to start on the new hospital as soon as we have planning consent. We are still exploring how quickly we can continue master planning for the Charing Cross and Hammersmith sites.

Meanwhile, we are using our regular capital funding – as well as support from Imperial Health Charity – to make the most of our existing estate alongside addressing urgent maintenance issues. This includes a major refurbishment of the ground and first floors of Charing Cross Hospital due to start later in 2025-26.

A similar approach taken to our 2024-25 capital funding and support from the Charity enabled us to make a range of important improvements to our estate. This included the opening of the Lord & Lady Paul Education Centre at St Mary's Hospital in September 2024. The space incorporates the library for the St Mary's campus of Imperial College London as well as upgraded rooms for training, group study or independent work, and comfortable lounges for staff and students.

A new staff lounge, and refurbished cafe opened at St Mary's Hospital in July 2024, marking the conclusion of the £2.5 million staff spaces improvement programme supported by the Charity. Also at St Mary's, the children's play and therapy room on Great Western ward was transformed and reopened in May 2024 thanks to a £251,000 investment from the Charity. In addition, the Charity oversaw the restoration of artist Keith Grant's Millenium New World One and Millenium New World Two, stained glass artworks at the front and rear entrances to Charing Cross Hospital.

We also benefitted from £41.8m of grants from the Public Sector Decarbonisation Scheme (PSDS) for maintenance backlog and major schemes at Hammersmith and Charing Cross hospitals to improve energy efficiency and reduce our carbon footprint.

We were able to progress plans to build the Fleming Centre, a new research and engagement facility to help tackle antimicrobial resistance, on the St Mary's campus. In January 2025, we announced Stanton Williams as the winning architect following a design competition run in partnership with the Royal Institute of British Architects. Due to open in 2028, to coincide with the centenary of the discovery of penicillin at St Mary's, the Fleming Centre is part of the Fleming Initiative. This is a partnership between the Trust and Imperial College London, chaired by Professor the Lord Darzi of Denham. We will begin public engagement on the designs in June 2025.

### Looking ahead

It will be especially important to maintain our focus on quality and safety as we respond to the financial challenge of the year ahead. We are looking to focus on changes that deliver efficiencies as well as better patient experience and outcomes.

We will continue to embed PSIRF and to deliver our quality and safety improvement priorities, which are focused on improving the quality of care provided to our patients in our most significant areas of clinical risk, as well as better engaging with and involving patients and their families and our staff in learning responses and improvements. More information can be found about these in our quality account. This will be supported by work with partners across the North West London Acute Provider Collaborative to implement a shared system for reporting incidents as well as new national safety standards for management of deterioration and sepsis and to align clinical pathways to best practice.

The improvement programmes in outpatients and cancer pathways will continue, as will further work to embed Martha's Rule and Call for concern. We will also further expand our user insight and user experience design approaches to identify and shape additional service improvements.

## 3. Reducing waits and delays for our patients

The legacy of the COVID-19 pandemic continues to shape how we work, with growing need and longer waits for planned and emergency care, as well as cancer and diagnostic services.

We have made some progress: as of March 2025, 58.1% of patients waiting for elective treatment have been seen within 18 weeks, compared to 55% in March 2024. And 2.53% of patients were

waiting over 52 weeks for care as of March 2025, compared to 3.7% in March 2024. But we have fallen behind in cancer care, with fewer patients than in 2023-24 receiving a diagnosis or starting treatment on time.

Transformation programmes in outpatients, cancer care and theatres have all made some progress in 2024-25 and pilots in outpatients and diagnostics have shown real promise. We have also responded to a sustained increase in demand for our maternity services.

## Outpatient improvement programme

A new approach to booking outpatient appointments saw hospital-initiated cancellations fall by over 11 percentage points, and patient-initiated cancellations drop almost four percentage points. The proportion of patients who do not attend their appointment also fell by over four percentage points.

The 'choice booking' approach, piloted for over 2,000 follow-up appointments between January and April 2025, is one of the key workstreams in our outpatient improvement programme. It involves offering patients a choice of dates and times, only six to eight weeks in advance of their appointment. Giving patients a choice of slots, relatively close to their appointment time, means they are less likely to have clashes or forget to attend. And for clinical teams, it means that holidays and other scheduling factors are considered before appointments are offered.

With two thirds of appointment bookings currently cancelled or not attended, the new approach has huge potential to improve patient and staff experience while also reducing wasted resource and costs. The pilot has been designed carefully to make sure we communicate with patients in the way that suits them best, and that no one gets lost in the system.

Work is already underway to introduce a digital 'self-serve' option instead of the telephone call, which allows patients to book a suitable appointment time themselves. Patients will also be able to use this option to rearrange or cancel their appointment. Some of the savings in admin time will be reinvested to provide support to patients who are not able to use digital platforms easily or who have additional needs.

## Extended MRI scanning hours

The Wembley Community Diagnostic Centre team launched a pilot in January 2025 to extend MRI scanning hours with the latest scanning technology. Patients can get MRI scans up until midnight, helping to reduce waiting times and enabling earlier diagnosis.

In its first month, the pilot helped 306 extra patients between 8pm and midnight. The feedback from patients has been very positive, with many appreciating the flexible appointment times and the kindness of the staff. The scheme is also the first in the NHS to use remote scanning technology, enabling some staff to work off site.

## Responding to maternity service demand

We had to make temporary changes to the self-referral process for our maternity services in February 2025, in response to sustained increase in demand that was causing unacceptable waits at peak times.

Following extensive engagement with partners and comprehensive communications, routine self-referrals are now limited to individuals in NHS North West London or NHS North Central London. In addition, our maternity services no longer accept late (30 weeks or more) self-referrals to transfer care from any other maternity units. We continue to accept referrals from GPs and other maternity units where there is a clinical need for complex pregnancy care.

The changes were necessary to ensure safe and high-quality care and to maintain sufficient capacity for complex pregnancies and births given the significant and unanticipated increases in demand,

especially from outside our sector and our neighbouring sector. We delivered over 700 more babies than planned in 2024-25, and nearly 360 more than in 2023-24. This was in the context of falling birth rates across London.

We are monitoring the impact of these changes to ensure equity of access to maternity services. We are also exploring a range of options for a longer-term, more strategic response to changes in demand for maternity care.

### Looking ahead

In 2025-26, we will launch a new programme to achieve a step change in operational flow. This includes plans to do more to streamline complex discharges, strengthen engagement with primary care and community partners, implement criteria-led discharge to accelerate discharge where appropriate, and scale our existing virtual ward capacity to ensure we are supporting as many eligible patients as possible.

The extended MRI scanning hours pilot will continue through the summer of 2025, at which point we will assess the impact and look at long-term planning for diagnostic availability. The outpatient improvement programme's appointment booking pilot will also continue through summer 2025.

In the meantime, we will also continue to review outpatient clinics to ensure the appropriate follow-up interventions are in place for patients who need ongoing review. We will make more use of the 'patient-initiated follow-up' (PIFU) approach for patients who are suitable. Outpatient teams will also work more closely with diagnostics to front-load diagnostic tests before or during first appointments, meaning more efficient care for patients and staff. We will also introduce additional digital solutions to complement the booking process and free up more time to support patients who need additional help.

We will continue to use improvement methodology to ensure these changes do not come at the cost of quality or safety.

## 4. Achieving sustainable financial balance

We delivered our financial plan for the sixth consecutive year in 2024-25, posting a small surplus of £0.1m against a breakeven target on a turnover plan of £1.7m. This included £63.4m in cost improvement plans, though a significant proportion of these savings were non-recurrent or relied on bringing in more income through additional activity. It also included one-off benefits that we will not be able to replicate this year.

One key area of sustainable growth was our private care division which saw a 23% increase in turnover with a return to pre-pandemic levels of activity. Our theatres efficiency programme is gaining strength, with progress in 2024-25 laying the groundwork for significant gains in 2025-26.

### Private care

Our private care services performed well, bringing in £52.5m, £9.9m more than 2023-24. We introduced a new online invoicing system, which offers a smoother payment process for patients as well as for our teams. We have also launched new marketing campaigns which have helped drive referrals and increase revenue, particularly in maternity. Behind-the-scenes stories about our private services are also helping to de-mystify private healthcare for people who wish to learn more about it. All income from our private care business is reinvested into the Trust.

### International partnerships

The Imperial College Healthcare International Affiliate Network brings together dynamic healthcare organisations around the world, sharing knowledge and expertise to advance patient care. In March 2024, two new organisations joined our network: Athens Medical Group in Greece, and Novacare Hospital in Pakistan. In addition to sharing expertise, the network agreement facilitates

the transfer of patients from affiliate hospitals to the Trust's private care facilities in London in specialist cases. Looking ahead, we are exploring opportunities for new affiliations in Africa, China, India and Saudi Arabia.

## Theatre efficiencies

In theatres, we have maximised use of the elective recovery fund since the pandemic to increase our capacity, introducing weekend lists to meet previous financial and performance targets. We are progressively increasing our theatres capacity – our March 2025 theatres utilisation rate was 86.8%, up slightly from 86.6% in April 2024. But we recognise that we can do more work to reduce avoidable cancellations, work within our means, and still meet the national benchmark of 85-90% utilisation.

## Looking ahead

We are confident that investment in our private care business is laying the groundwork for continuous growth. We are also seeing the benefits from sector-wide procurement and management of digital services, both of which create efficiencies that are shared across north west London.

But we are being asked to do more in 2025-26 to tackle the big productivity and financial challenges facing the whole of the NHS.

In 2025-26, we will need to achieve £80.1 million of cost improvements in order to deliver a breakeven plan, with £46 million support from the North West London Integrated Care Board. We have increased the value of some of our 'block contracts,' such as for maternity, to reflect 2024-25's over-performance against block services. But the income we can earn for planned care has been capped to 115.5% of pre-pandemic elective activity levels, so we will not be able to increase capacity to generate more income, which is something we have done in the past. We also need to meet core operational improvement targets across A&E, referral to treatment times, cancer care and diagnostic waits.

To deliver our operational plan, we will focus on seven key change programmes that should increase efficiency while improving the quality and safety of our care: outpatient improvement; theatres efficiency; cancer care improvement; advancing equity and inclusion; improvement for all; integrated patient flow programme; and estates optimisation, redevelopment and life sciences. Some of these programmes have already begun to benefit the way we work.

From April 2025, we will be running our theatres Monday through Friday to maximise use of our core operating hours. Our theatres productivity transformation programme will carefully plan lists through 642 planning processes and list review meetings, working closely with surgical, finance and workforce teams to optimise scheduling. Booking operations in advance and at a higher percentage will help us ensure capacity is fully utilised, as well as giving patients more notice of their surgery. This will help patients make the necessary arrangements for their surgery and maximise pre-operative preparation. We will also implement reminder text messages to help further reduce late cancellations. In addition, theatres teams will work with academic anaesthetists at Imperial College London to explore new data-driven approaches to enhance efficiency.

The booking pilot in the outpatient improvement programme, mentioned on page 24, has already shown promise and will continue into the summer 2025. The programme team aims to quickly embed lessons learned from the pilot and roll this approach out widely.

In 2025-26, we will work to get on top of waiting times and cost control as part of our improvement work. We will ensure we maintain our progress thus far while carrying forward only the most effective, efficient and sustainable improvements.

# Research and innovation

Patients at Imperial College Healthcare benefit from care at the cutting edge of scientific and clinical discovery. The NIHR Imperial Biomedical Research Centre (BRC) anchors our translational research partnership with Imperial College London, overseeing nearly 1,300 active clinical studies in 2024-25, almost 200 more than in 2023-24, involving over 39,000 patients.

Our commitment to embed research and innovation in our everyday work has led to important advances in 2024-25, including a high-impact study on prostate cancer screening, AI-supported clinical care, and a world-first gene-editing treatment for people with blood disorders, which has now been recommended by NICE for use in the NHS, as well as a UK-first baby born following a womb transplant. We also made progress in our efforts to make research more accessible to all, with the expansion of the Imperial Health Knowledge Bank.

## Progress for Paddington Life Sciences

In October 2024, Paddington Life Sciences marked its first year with an inaugural symposium, which included talks from Lord Vallance, Minister of State for Science, Research and Innovation, and Professor the Lord Darzi of Denham.

Throughout 2024-25, Paddington Life Sciences Partnerships announced several new members, including medical technology company Convatec, biopharmaceutical company Ipsen and the AI data cloud company Snowflake, bringing the total to 20 partners committed to generating healthcare innovation alongside health, economic and social value centred in Paddington.

These ambitions were recognised in February 2025 when the office of the Mayor of London announced the London Growth Plan, a blueprint to kickstart innovation, investment, economic growth and job creation across the capital. Paddington Life Sciences was named alongside the White City Innovation District and South Kensington as part of the WestTech London, one of the city's key industrial innovation hubs and an area for economic growth.

## UK first womb transplant

The first woman to receive a womb transplant in the UK gave birth to a baby girl at Queen Charlotte's & Chelsea Hospital in early 2025. Grace Davidson underwent her womb transplant in 2023, in an operation co-led by surgical teams from the Trust and Oxford University Hospitals NHS Foundation Trust. This success is the culmination of 25 years of collaborative research and innovation co-led by Hammersmith Hospital's Professor Richard Smith.

## Imperial Health Knowledge Bank

The Imperial Health Knowledge Bank, supported by the Imperial BRC, is a comprehensive database of patients who have consented to be contacted about clinical trials and studies relevant to their health conditions. It also collects and stores health information and samples, including blood samples, from routine clinical care. The expansion of the Knowledge Bank across the Trust in 2024 allows every Trust patient to participate in research – over 38,000 people are now registered.

In September 2024, the Knowledge Bank opened to applications from researchers, who can apply to access anonymised data and samples to use in studies that will help us better understand health and further medical science. To date, two applications have been received – as this develops, the data and samples are expected to play a crucial role in developing new treatments, drugs and tests, potentially transforming patient care.

## Using artificial intelligence (AI) to support clinical care

In December 2024, we launched a strategic framework to guide our approach to making the most of AI. It details a set of people-centric, multidisciplinary principles that allow us to explore the wide

range of potential benefits of AI for our patients, staff and communities, while ensuring equity and integration with current processes.

A collection of papers published in 2024-25 show evidence for the benefits of using AI to support clinical care. For example, to improve care and support after cataract surgery, to help pinpoint stroke timing to improve treatment, and to help guide successful egg collection for IVF treatment. Research looking at the use of AI analysis of simple ECGs to identify future health risks will begin clinical trials across our hospitals later in 2025. Researchers believe this work is so promising, we could see AI-enhanced ECGs in NHS hospitals in just a few years to help clinicians develop bespoke lifestyle, diagnostic, treatment and prevention plans for individual patients, allowing them to treat disease earlier or even prevent it altogether.

## Prostate cancer screening

Multiple prostate cancer screening studies funded by partners including Prostate Cancer UK advanced to the next stage in 2024-25. This includes the national TRANSFORM study, led by Trust surgeon, Professor Hashim Ahmed, which will see hundreds of thousands of men across the country invited to participate in a study looking at the best way to screen for prostate cancer. Researchers believe the study could lead to the development of a national screening programme for the disease, which could save thousands of lives each year.

## World-first gene-editing treatment for blood disorders

Researchers at our Trust have been working as part of an international collaboration for decades to trial breakthrough treatments for sickle cell disease and transfusion-dependent beta thalassaemia. In 2024-25, this work led to important milestones for people living with these diseases, which are more common in people with an African or Caribbean family background.

Following MHRA approval in 2023, a new gene therapy, known as exa-cel or ‘Casgevy’, was recommended by NICE for NHS use in specific cohorts of patients over the age of 12 with severe sickle cell disease and transfusion-dependent beta thalassaemia. Based on the CRISPR gene editing tool, exa-cel is a potential cure for both diseases, which cause painful, debilitating, life-long symptoms. The treatment for both diseases will be available for qualifying patients at specialist NHS centres in London, Manchester and Birmingham. Around 50 such patients are expected to receive the treatment each year.

## Looking ahead

As well as providing support to hundreds of ongoing clinical trials via the infrastructure supported by the NIHR Imperial BRC, in 2025-26, work on the Fleming Centre will continue, with detailed design development, public consultations, and the submission of a planning application in collaboration with Westminster City Council. We will also work with our research partners on a new website for our shared resources, to help members of our community get more involved in shaping our research as well as supporting health professionals beyond medicine to conduct their own studies.

# Chief financial officer's report

## Introduction and overview

Despite increasing pressures on NHS finances in the 2024-25 financial year, the Trust has continued its positive track record of good financial performance, delivering an adjusted operating income and expenditure surplus of £0.1m (£0.1m better than the breakeven plan) and remaining within its delegated capital departmental expenditure limit of £118.7m (£83.1m in 2023-24).

In January 2025, the Government announced a revised planning timeline for the New Hospital Programme (NHP) which confirmed that all three of the Trust's main sites would be in the third wave of the programme, with construction not expected to commence until 2035-2038. This was a real disappointment for the Trust. As set out elsewhere in the annual report, we have been very clear with NHS England and the Department of Health and Social Care that we do not believe some of the current estate will be able to continue operating for another 20 years, and that earlier redevelopment remains crucial to the Trust's ongoing plans. We are continuing to work with the national team to secure further funding and examine alternative approaches to delivering the redevelopments required, in particular at St Mary's Hospital in Paddington.

During 2024-25, the Trust was able to settle a historic lease dilapidations liability relating to the occupancy of the former Ravenscourt Park Hospital site by the Trust (and its predecessor trust) between 2002 and 2017. The agreement of a settlement enabled the Trust to release the associated provision. The settlement agreement received HM Treasury approval in May 2025.

## Our financial performance 2024-25

### Performance against income and expenditure plan

The Trust's plan for 2024-25 was to achieve a breakeven position against the adjusted financial performance measure. This excluded certain 'below the line' items such as capital donations, depreciation on donated assets and market-based valuations movements on land and building assets.

On an accounting basis, the Trust reported a £29.6m deficit. After adjusting for the 'below the line items' outlined above, the Trust was able to report an adjusted surplus of £0.1m against the breakeven plan. This position included some one-off items including the release of the provision for lease dilapidation costs and system support funding received from the North West London Integrated Care Board.

The tables below set out the actual income and expenditure performance as of 31 March 2025. They include comparative information for 2023-24 and track this against the Trust agreed plan.

| Statement of comprehensive income | 2024-25 £'m | 2023-24 £'m |
|---|---|---|
| Income | 1,875.5 | 1,714.7 |
| Expenditure | (1,894.9) | (1,724.7) |
| Net financing income | 4.4 | 7.5 |
| Loss on disposal of assets | (0.5) | (1.1) |
| Public dividend capital payable | (14.1) | (12.6) |

| | | |
|---|---|---|
| **Deficit before revaluations and impairments** | **(29.6)** | **(16.2)** |
| Other comprehensive income* | 6.7 | 4.2 |
| **Total comprehensive expense for the period** | **(22.9)** | **(12.0)** |

| Performance against plan | 2024-25 £'m | 2023-24 £'m |
|---|---|---|
| **Surplus/(deficit) for the financial year as per annual accounts** | **(22.9)** | **(12.0)** |
| Donated asset adjustment | (12.4) | (12.0) |
| Adjust for revaluation and impairment** | 35.4 | 23.0 |
| Adjustment for (gains) / losses on transfer by absorption | 0.0 | 1.1 |
| **Adjusted surplus** | **0.1** | **0.0** |
| Planned position | 0.0 | 0.0 |
| **Performance against plan** | **0.1** | **0.0** |

*Other comprehensive income includes the impact of revaluations and impairments charged to the revaluation reserve
**Adjustment for the impact of revaluations and impairments driven by the annual valuation exercise which do not affect the Trust's adjusted financial performance against plan

## Efficiency

To achieve the breakeven plan, the Trust had an efficiency target of £63.4m at the start of the financial year. This was allocated across the Trust's clinical and corporate divisions and included a number of planned sustainable cost improvement schemes that would seek to enhance the efficiency of the services provided during and beyond the 2024-25 financial year.

The Trust was able to meet its efficiency target in full at the end of the year through a mixture of recurrent and non-recurrent (one-off) initiatives. These included:

- the efficient and effective use of theatres
- non-pay procurement activities
- growth in the contribution from private care
- in-year elective income over-performance
- vacancies and movement in provisions

The Trust continues to enhance its approach as to how it oversees the delivery of its efficiency programme and has reset the previous governance arrangements by creating a financial efficiency board. The refreshed terms of reference seek to strengthen the scrutiny associated with the delivery of in-year schemes, as well as overseeing the continued identification of other business as usual or larger transformational opportunities availed through the use of external data sources such as Model Health System, National Cost Collection Index (NCCI), corporate benchmarking reports and national productivity indicators, alongside reviewing the opportunities presented through the Trust's close working relationship with the other three acute north west London partner trusts as part of the acute provider collaborative.

## Income

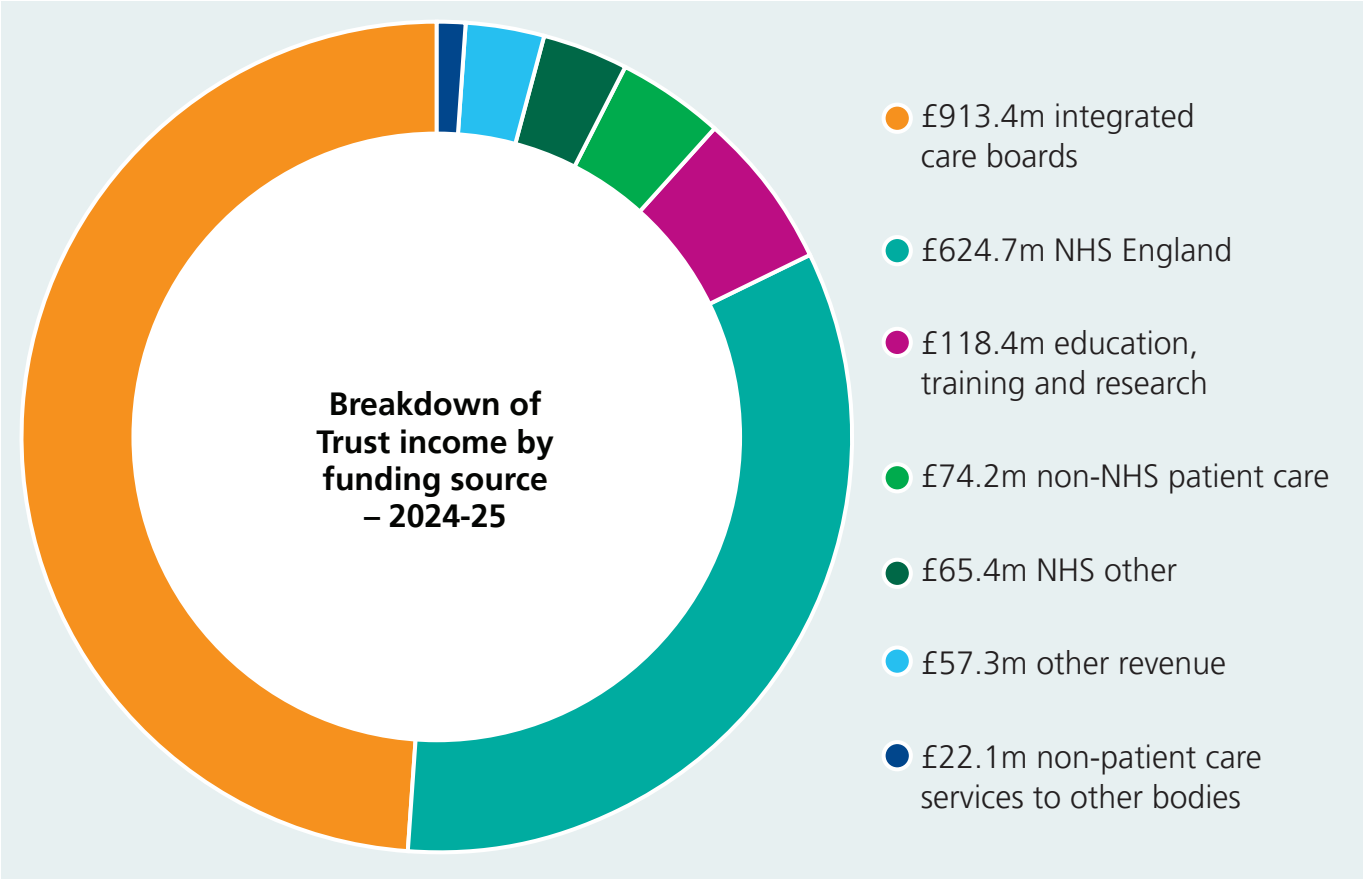
The largest proportion of the Trust's income is health service income from the provision of healthcare in England, with a small amount of other income streams supporting the delivery of healthcare services. We can therefore confirm that for 2024-25, in accordance with Section 43(2A)

of the NHS Act 2006, the income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. The work required to receive the non-health care income has had no adverse impact on the provision of goods and services for the purposes of the health care. Further detail is provided in notes 3 and 4 of the accounts.

Our total income amounted to £1,875.5m for 2024-25 (£1,714.7m for 2023-24). Most of this funding comes from integrated care boards (previously clinical commissioning groups) and NHS England for the delivery of NHS clinical patient care services. Funding levels are set in conjunction with the North West London Integrated Care System and income is earned under the NHS Payment Scheme (NHSPS); which sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare under the aligned payment and incentive (API) contract.

The chart below provides a breakdown of the key sources of income received by the Trust. Of this, education and training income (£62.5m) is primarily provided by NHS England to support the costs of training doctors, nurses and other healthcare professionals and this supports the quality of care provided at the Trust.

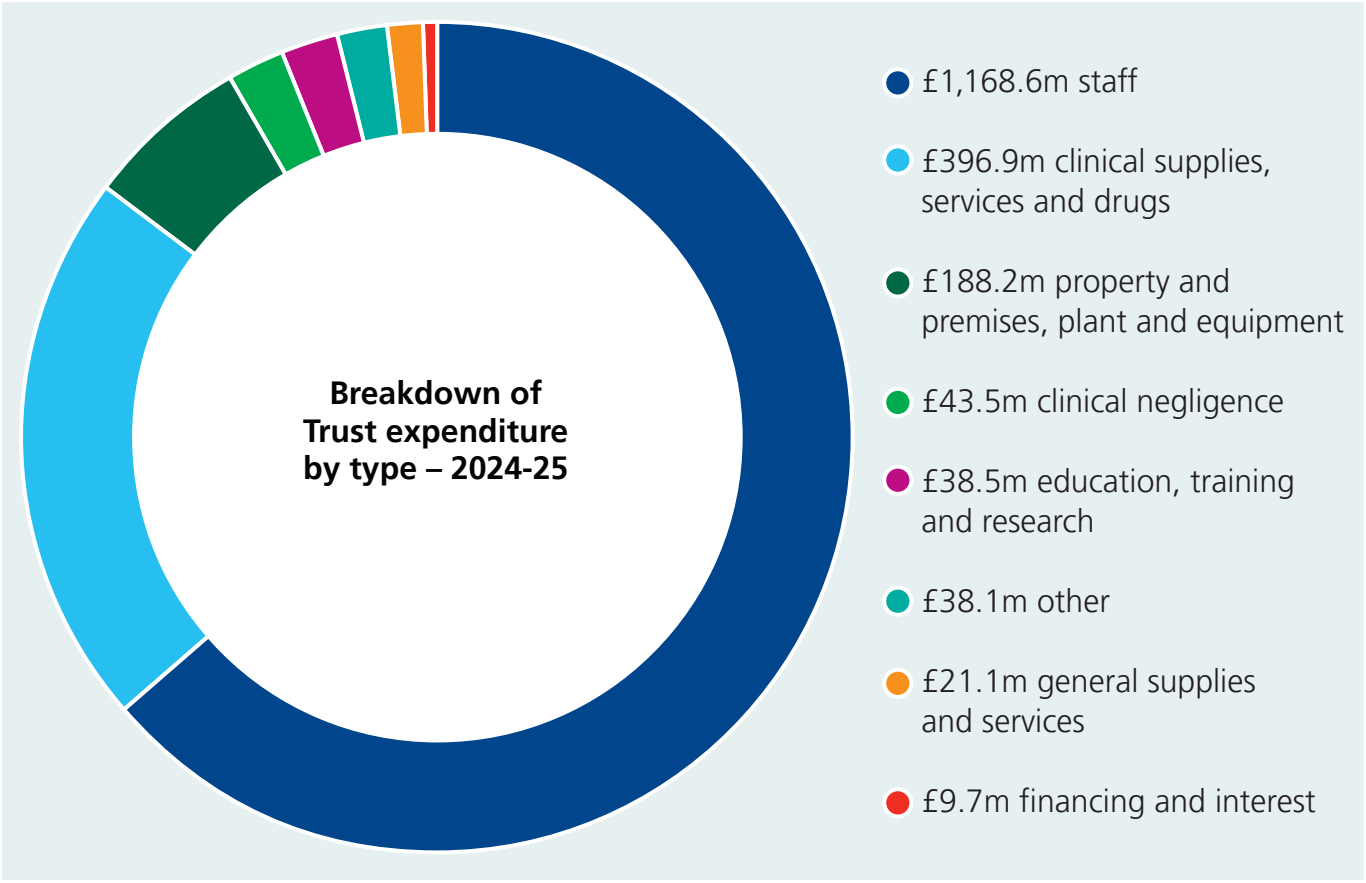
Research and development income (£55.8m) relates to both government and commercially funded research carried out by the Trust, with non-NHS care income (£74.2m) primarily earned through the provision of healthcare to private patients and overseas visitors.




## Expenditure

Excluding financing and interest costs, the Trust expenditure for 2024-25 was £1,894.9m (2023-24 was £1,724.7m). Staff costs account for 62% of this spend which includes the costs associated with those staff undertaking education, training and research activities.

Other key elements of spend relate to clinical supplies and drug costs, with expenditure categorised as 'Other' including several smaller cost elements such as legal fees; consultancy; operating leases and the provision of bad debts.




## Capital expenditure

The Trust had a gross capital plan of £134.4m during the year. Of this, £118.7m represented the Trust's allocated capital resource limit (CRL), including externally generated cash or 'cash-backed' public dividend capital. £15.7m was funding from grants, charitable donations, rebates and asset disposals.

At the end of the year, the Trust incurred a total gross capital expenditure of £128.3m against the gross capital plan of £134.4m, resulting in a £6.1m underspend. This underspend was almost entirely due to a decision to pause elements of the NHP works, following the government's announcement of revised project timelines in January 2025. This decision was made in line with guidance from the NHP team.

Excluding the NHP element results in a revised underspend of £17k, which is in line with the expectations agreed via the North West London Integrated Care System capital working group.

The programme and funding sources are shown below:

| Source of Funds | Annual £m |
|---|---|
| Internal Financing (Depreciation and IFRS 16 cover) | 73.2 |
| Internal Financing - Use of Trust's cash | 8.0 |
| Public Dividend Capital (PDC) | 37.4 |
| **Total Capital Resource Limit (CRL)** | **118.7** |
| Charitable donations | 2.9 |
| Decarbonisation grant | 12.3 |
| Disposal of Assets & VAT reclaim | 0.5 |
| **Total Disposal and Donation/Charity income** | **15.7** |
| **Total Gross Capital Plan** | **134.4** |

| Use of Funds | Annual £m |
|---|---|
| Backlog Maintenance (inc Fire Safety) | 32.0 |
| ICT | 19.5 |
| Replacement of Medical Equipment | 14.3 |
| Decarbonisation (including lighting efficiency project) | 22.5 |
| Other Capital Projects | 28.3 |
| IFRS16 Lease Impact | 11.7 |
| **Total Gross Capital Expenditure** | **128.3** |
| **Underspend to the Gross Capital Plan** | **6.1** |

The 2024-25 capital programme was significantly higher than historic trends, primarily due to the Trust successfully securing a range of additional funding on top of its core capital programme. This included £25.3m in decarbonisation grant funding to support £12.3m investments in the decarbonisation of our buildings and £13.0m for the replacement and modernisation of lighting systems across our main sites, leading to reductions in both energy usage and maintenance costs.

Other key investments include:

- new information and communication technology (ICT) data centres, which will improve organisational resilience and efficiency
- new diagnostic and treatment facilities including opening the Stowe Eye Care centre near Paddington
- the expansion of the oncology service at Hammersmith
- reconfiguration of the urgent treatment centre at St Mary's
- the completion of the new staff resource library at St Mary's, supporting our ongoing work with the Faculty of Medicine at Imperial College London

This is on top of maintaining our programmes of ongoing replacement of medical equipment and ICT assets, and maintaining our buildings to manage the ongoing challenge of an ageing estate, including:

- the roof replacement, window renewal and structural repairs of the Clarence Wing façade and roof at St Mary's
- structural works, refurbishment, and fireproofing of the car park ceiling as part of the refurbishment of the Albert Ward building at St Mary's
- lifecycle upgrade to energy-efficient burners, supporting sustainability and emission reduction as a part of the Hammersmith burner replacement carbon reduction project
- fire safety programme upgrades to passive fire compartmentation and alarm systems across our sites, prioritised in collaboration with the fire safety team
- significant unplanned capital expenditure across our sites to address urgent breakdowns and major repairs, ensuring the estate's continued functionality

Throughout the financial year, Imperial Health Charity has contributed to several projects, including the relocation and refurbishment of the Trust's staff resource library and education centre at St Mary's, investment in medical equipment (including the extracorporeal membrane oxygenation or ECMO console) and other investments to refurbish both staff spaces and family room facilities across the Trust. We extend our sincere thanks and gratitude to the Charity for its ongoing fundraising efforts and the financial support it provides the Trust.

As noted above, the redevelopment of the Trust's sites remains a top priority despite delays to the overall New Hospital Programme. We continue to work with stakeholders across the NHS and London on moving this forward as a priority.

As part of the re-phasing of the New Hospital Programme outlined above, a number of providers were required to assess whether it remained appropriate to hold capital expenditure incurred on the programme (on areas like design, planning and specification) on the balance sheet. Having reviewed the expenditure incurred and held as an asset under construction balance, it was concluded that the full balance held by the Trust (totalling £14.7m) should be impaired.

The impairment of this expenditure is an accounting judgement at the reporting date and does not mean that the expenditure was capitalised incorrectly at the point it was incurred. With the re-phasing of the NHP scheme meaning that construction is potentially more than a decade away, the work will likely no longer directly support the creation of the eventual asset, though it may still inform future iterations of the redevelopment, particularly if an earlier route to construction can be found.

## Cash

The Trust ended the year with a cash balance of £92.9m, which reflects a £43.8m reduction in cash from the opening cash balance. The 2024-25 plan forecast a reduction in cash as known liabilities were unwound. However, the actual reduction exceeded the plan, primarily due to additional cost pressures in the revenue budget that were offset by one-off accounting adjustments (relating to provisions and other items) and other movements in working capital.

Despite the closing balance of £92.9m being higher than historical levels, this is not considered 'free cash' for the Trust. The balances are required to settle known balance sheet liabilities and anticipated cash movements going forward. The Trust anticipates that cash balances will continue to reduce in 2025-26, and a sustainable cash position going forward depends on achievement of the revenue breakeven plan through cash generating efficiencies.

## Better Payment Practice Code

Under the public sector Better Payment Practice Code (BPPC), the Trust is required to pay 95 per cent of all valid undisputed invoices by the due date or within 30 days of satisfactory receipt of

goods and services, whichever is later. In 2024-25, 97.3% of invoices by volume and 91.3% of invoices by value were paid within this target. Therefore, the Trust met its 95% volume target but did not meet its 95% value target. Work has taken place between the finance team and operational managers during 2024-25 to help improve the Trust's performance; and this will be continued and enhanced in 2025-26. The Trust's performance in paying non-NHS suppliers is generally stronger than for NHS bodies, and 92.2% of non-NHS invoices were paid within target by value (97.7% by volume).

## Declarations

The Trust is committed to providing and maintaining an absolute standard of honesty and integrity in dealing with its assets. We are committed to the elimination of fraud and illegal acts within the Trust and ensure rigorous investigation and disciplinary or other actions are taken as appropriate. We strive to adopt best practice procedures to tackle fraud, as recommended by the NHS Counter Fraud Authority (NHSCFA) and contracted with our outsourced provider (KPMG LLP) during 2024-25 to provide the Trust its specialist counter-fraud services.

We have continued to publish our policies and procedures for staff to report any concern about potential fraud and this has been reinforced by sharing of fraud notices, delivery of training and general awareness raising by the local counter fraud specialist. Any concerns are investigated by our local counter fraud specialist or the NHSCFA as appropriate with all investigations reported to the audit, risk and governance assurance committee.

At the time of writing the report, so far as all directors are aware, there is no relevant audit information of which the Trust's auditor is unaware, and they have taken all the steps that are necessary as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury, has met the income disclosures as required by section 43(2A) of the NHS Act 2006 and did not make any political donations during 2024-25.

## Going concern

Under accounting rules, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a 'going concern'.

The Trust board has considered the advice in the Department of Health and Social Care's group accounting manual that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

The Trust has the reasonable expectation that it will continue to have access to adequate resources to service its operational activities in cash terms for at least the next 12 months, and continues to be confident that both the North West London Integrated Care Board and the NHS more widely, will provide resources (if required) and continue to support the delivery of the Trust's activities.

# 2025-26 looking ahead

Although 2024-25 represents a significant achievement for the Trust, the submitted 2025-26 Trust plan indicates operational, workforce and financial challenges ahead, which include:

- **efficiency:** the Trust has an increased efficiency target of £80.1m in 2025-26, which it must deliver to ensure financial sustainability. As in previous years, there is a risk that the schemes identified to meet this target cannot be fully delivered in year, or that mitigations to fully offset any emerging gap cannot be identified. Such delays would impact on our ability to meet the financial targets for the year, alongside ensuring that more of our efficiency target is delivered through recurrent savings that reduce the cost base on an ongoing basis and support cash resilience
- **clinical activity and income risk:** given the cap on elective funding, the Trust will effectively be operating in a fixed funding envelope for NHS services. This requires the Trust to both, deliver the activity levels assumed in the 2025-26 plan, and manage the costs of delivery appropriately. Should activity not match planned levels, the Trust will need to ensure that swift action is taken to address these variations to ensure the impacts on financial and operational performance are appropriately balanced
- **cost control:** delivering the 2025-26 financial plan (including the efficiency target) also depends on the Trust's ability to manage its day-to-day operational costs. The Trust must ensure it can either generate more value with the same resources or maintain the same level of value (as in previous years) using fewer resources
- **capital:** the Trust has an even more substantial capital programme in 2025-26 than in 2024-25. Delivery of a larger programme will need to be closely managed to ensure that spend is maximised within the available budget. As ever, delivering a planned programme whilst accommodating unexpected costs arising from the age and condition of the Trust's estate will be a priority
- **redevelopment programme:** the estate continues to pose a significant risk in terms of the level of backlog improvements required and the need to manage the risk of critical failures. Continued progress on working with partners to deliver an earlier redevelopment timeline is vital
- **Integrated Care Board:** we are mindful that the roles and responsibilities of the integrated care board in 2025-26 will be reset, with a greater focus on strategic commissioning with a significant proportion of current responsibilities devolved to regions and providers. This will fundamentally shift the current working relationships and the operating model utilised to date and will therefore require a thoughtful and careful transition plan that ensures the Trust is well placed to manage the proposed changes. The focus remains in ensuring that the north west London health economy delivers the best possible healthcare to the population we serve, having secured the right level of funding due to the population of north west London.

# North West London Acute Provider Collaborative review

The four acute trusts in north west London approved the appropriate delegation of authority to establish the North West London Acute Provider Collaborative (APC) in July 2022. With a chair and board in common, the Collaborative came into being on 1 September 2022.

The organisational structure for the APC is a collaborative of four statutory organisations. The four trust boards therefore continue to be the core governance mechanisms for each Trust, responsible for setting strategy and delivery of statutory and regulatory requirements. As a Collaborative, the four boards work together to deliver common strategic priorities where those priorities add collective value. However, each trust board remains responsible for the delivery of their respective trust duties.

This approach means each trust remains an independent organisation, working closely with our local authorities, patient groups, and other partners, while also being able to make more effective use of our collective resources to provide better care, for more people, more fairly.

In July 2024 we agreed our first APC strategy focused on how we will use our collective expertise, resources, and partnerships to:

- set and raise the standards of care for our patients
- offer the best care available to everyone, and
- be one of the best places to work in the NHS

The strategy was developed through engagement of over 1,300 staff, along with patient groups, executive leadership, and our partners. Within our strategy we agreed priorities for how we would align to best practices across our ways of working. One example of this is that 28 specialties across the APC have each chosen one pathway to align to best practice in this financial year (pathways implementable from April 2025), led by a specialty leadership group with representatives from each trust and overseen by one of the APC chief executives.

There has been particularly strong clinical engagement on opportunities to align best practice across specialty leadership networks. Examples have included improvements changing practice to reduce avoidable hospital admissions, expand one-stop-shop clinics to reduce the time patients have to wait between diagnosis and treatment and expanding digital health support.

## Achievements

Over the past year, our collaborative approach has helped us to:

- continue to deliver care as one of the safest group of hospitals in the NHS as measured by summary hospital-level mortality indicator (SHMI), with three of our four trusts in the top 10 nationally on the SHMI and all four trusts better than the NHS benchmark
- a focused approach to tackling health inequalities and improving equity of access to outpatient services across north west London, particularly for populations facing barriers to care. Introduced a collaborative approach across the acute trusts to a standardised methodology for analysing patient treatment lists (PTL) to identify and address inequities
- supported improvements in care quality and outcomes, including supporting shared learning across teams on the implementation of Martha's Rule (a national policy change giving patients and families a way to seek an urgent review if a patient's condition deteriorates and they are concerned this is not being appropriately responded to), supporting inpatients with mental health needs in our hospitals and agreeing a common incident and risk management system
- continue to offer patients waiting for an operation in a trust where capacity for a particular service is limited, the chance to have their operation sooner, in a hospital managed by one of the other partners where there is more capacity for that service
- moved all trusts onto a single electronic patient record (EPR), the largest single record in the NHS, so patients can move between hospitals. National development partner for the Federated Data Platform (FDP) significantly improving productivity and patient experience across the acute trusts

- across the Collaborative over the last two years all elements in the NHS staff survey have seen improvements, in some areas there have been significant improvements in our results
- the North West London Elective Orthopaedic Centre (EOC), open for a year, and has been awarded accreditation as part of the Get It Right First Time (GIRFT) programme to ensure the highest standards in clinical and operational practice to achieve better outcomes for patients
- the final new community diagnostic centre (CDC) for north west London, at Ealing opened which joins centres at Willesden and Wembley, allowing GPs to make direct referrals to the CDCs. Offering a faster and more convenient service as well as helping reduce unnecessary hospital trips. They will help us bring down waiting times while also ensuring fairer access to services
- continue to perform with four hour waiting times (all type) in A&E at 76.9% in north west London compared to 75.2% across London; ambulance handover times to hospital staff, 20 minutes in north west London compared to 26 minutes across London; and cancer 28 days' faster diagnosis' standard (people referred on an urgent suspicion of cancer having their diagnosis of cancer confirmed or clear within 28 days) – 81.5% in north west London compared to 78.4% London average*.

*these are key national indicators agreed with NHS England and NHS North West London

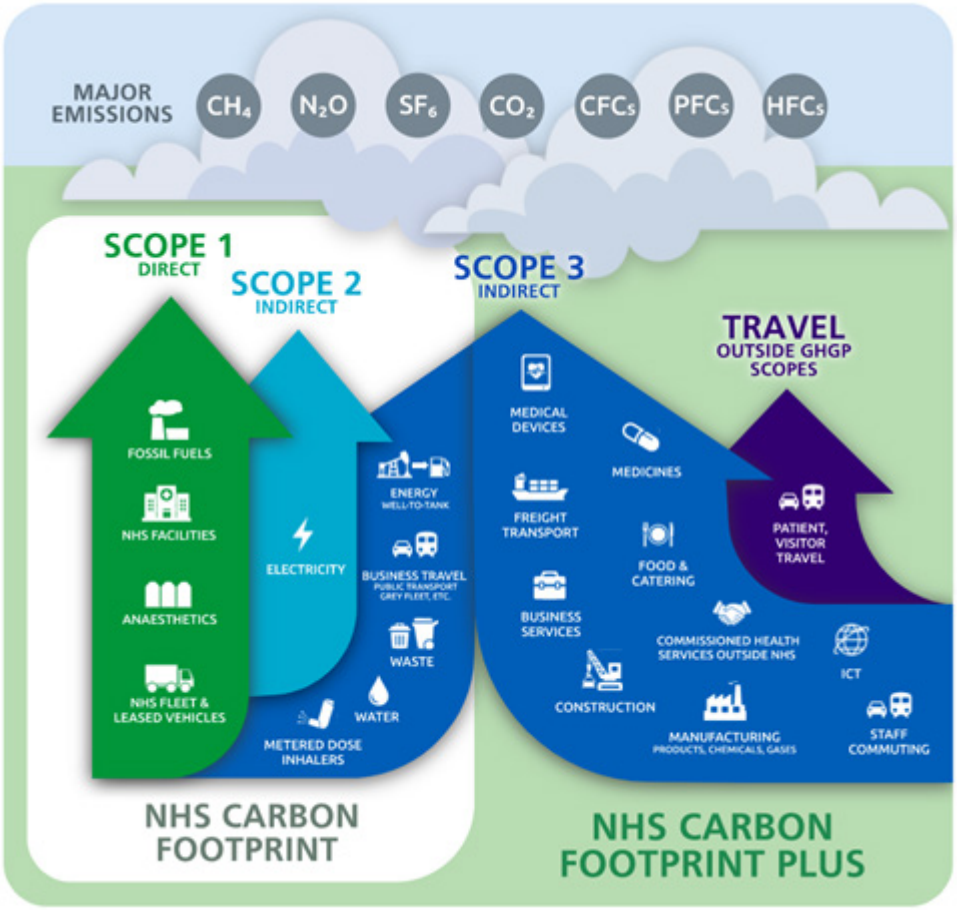
# Sustainability

On 1 July 2022, the NHS became the first health system in the world to embed environmental requirements into legislation. This commits us to reducing our NHS Carbon Footprint Plus, with a goal of reaching net zero by 2045.

The graphic below shows the major NHS sources of greenhouse gas emissions. The NHS Carbon Footprint – which includes scope 1, 2 and a small number of scope 3 greenhouse gas emissions – is the carbon footprint that NHS organisations have the greatest direct control in reducing.

The remaining scope 3 emissions include medicines, medical equipment, other supply chain and staff commuting, plus patient and visitor travel emissions. These are greenhouse gas emission sources that the NHS has limited direct control over reducing, but can influence them through, for example, greener procurement, contract management and partnerships with suppliers. Combined, these represent the NHS Carbon Footprint Plus.

## Greenhouse Gas Protocol (GHGP) scopes in the context of the NHS




Source: Greener NHS: Delivering a net zero National Health Service

## Our Green Plan 2024-25 to 2026-27

In March 2024 our board approved a refreshed three-year Green Plan which will move us closer to delivering two nationally set targets, against a baseline of 2019-20. Those targets are:

- to reduce emissions by at least 47% by 2028-2032 for emissions we control directly (the NHS Carbon Footprint), putting us on track to reach net zero emissions by 2040
- to reduce emissions by at least 73% by 2036-2038, for emissions we can influence (the NHS Carbon Footprint Plus), based on 2019-20 emissions, putting us on track to reach net zero emissions by 2045.

In February 2025, NHS England published new green plan guidance, which we reviewed against our three-year Green Plan. We are confident that our Green Plan already incorporates all the new NHSE guidance.

Information about our Green Plan and our latest carbon reduction plan is available on our website imperial.nhs.uk/about-us/our-strategy/green-plan.

## Task Force on Climate-related Financial Disclosures (TFCD)

The Department of Health and Social Care Group Accounting Manual (GAM), has adopted a phased approach to incorporating the Task Force on Climate-related Financial Disclosures (TCFD) recommended disclosures as part of the sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024-25. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

## Governance of climate-related risks and opportunities

Our governance arrangements and risk and control framework are detailed in the corporate governance report and annual governance statement (see page 71).

The Trust board delegates climate-related oversight to the redevelopment committee, which approves the Green Plan, monitors and reviews the Trust's performance against national and local targets and approves updates and changes to the plan as needed.

The executive management board receives biannual Green Plan updates from the green team, which include progress against national targets, identification of high-level risks, and mitigating actions. These updates are escalated to the redevelopment committee and then summarised to the Trust board via the Trust standing committee, ensuring a clear line of accountability and board-level visibility.

The green team is responsible for the Green Plan, led by net zero board lead Dr Bob Klaber. The team works alongside a Green Plan advisory group, which includes our senior leadership team, a lay partner, and four operational working groups. The delivery leads within the working groups – estates and facilities, travel and transport, models of care, and procurement – provide summary updates to the advisory group, which go on to form the basis for the Green Plan and climate-related updates to Trust boards and committees.

Across the sector, the North West London Acute Provider Collaborative estates and sustainability committee provides oversight on climate-related issues across all four acute trusts. The green team provides oversight updates to the committee four times a year. Climate-related issues and Green Plan progress are also a reoccurring agenda item on the monthly North West London Integrated Care Board estates directors working group. Overarching review and decision-making of climate-related issues and green plan progress takes place in the quarterly North West London Integrated Care Board's estates infrastructure and sustainability programme board, which in turn provides updates to the North West London Acute Provider Collaborative's board in common via the collaborative estates and sustainability committee.

## Risk management

The annual governance statement describes our risk and control framework at the Trust and its associated governance structure, and this approach is applied to climate-related risks. This section also describes our ageing estate and redevelopment plans, which are part of our response to climate-related risks.

Climate-related risks pose significant challenges, impacting both infrastructure and patient care. Climate change exacerbates respiratory and cardiovascular conditions, and this along with more frequent extreme weather and poor air quality often disproportionately impact the most vulnerable people in our communities contributing to widening health and wellbeing inequalities. Extreme weather events, such as heatwaves and floods also place a strain on our scarce hospital resources and disrupt services. Flooding is damaging our hospital buildings and critical infrastructure, leading to costly repairs and service interruptions.

Climate change is a risk area in our board assurance framework, and within this climate-related risks have been identified and assessed, alongside actions to remove gaps in control and assurance. The assigned risk appetite – the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives – is classified as low with actions in place to mitigate the risk. Our Green Plan contains the actions needed to reduce climate-related impacts and our environmental impact in line with nationally set targets. The climate change risk on the board assurance framework is reviewed with all our risk areas, and in particular, 'poor condition of estates' and 'New Hospital Programme funding and affordability.'

Redevelopment of our three major hospitals remains a key facilitator for achieving our net zero ambitions. The space and configuration limitations of our ageing estate make it challenging to respond to increasing and changing healthcare demands and opportunities such as decarbonising our estate and adaptation planning in response to climate-related risks.

In January 2025, the New Hospital Programme review pushed all three of our redevelopments into wave three, which means construction would not begin until 2035 at the earliest. We are stepping up our work to develop options for reducing the amount of New Hospital Programme funding required for construction, aiming to be able to bring forward the start date.

Delays to our long-term redevelopment and tackling our massive day-to-day backlog maintenance liability makes it difficult for us to assess risks, uncertainties, and viability of current and long-term plans in relation to climate-related risks. As part of our Green Plan, we are committed to developing a Trust climate change mitigation and adaptation plan which will set out the mitigation and adaptation actions for the current and future impact of climate change.

Despite these challenges, we are committed to investing in further cutting our carbon emissions to reduce the environmental impact of our operational activities. We can achieve this through securing external grant funding, delivering our estates strategy, supporting and empowering our staff to make greener local choices, forming partnerships to have wider impact, and ensuring that social-value and net zero principles are embedded into our procurement processes.

## Metrics and targets

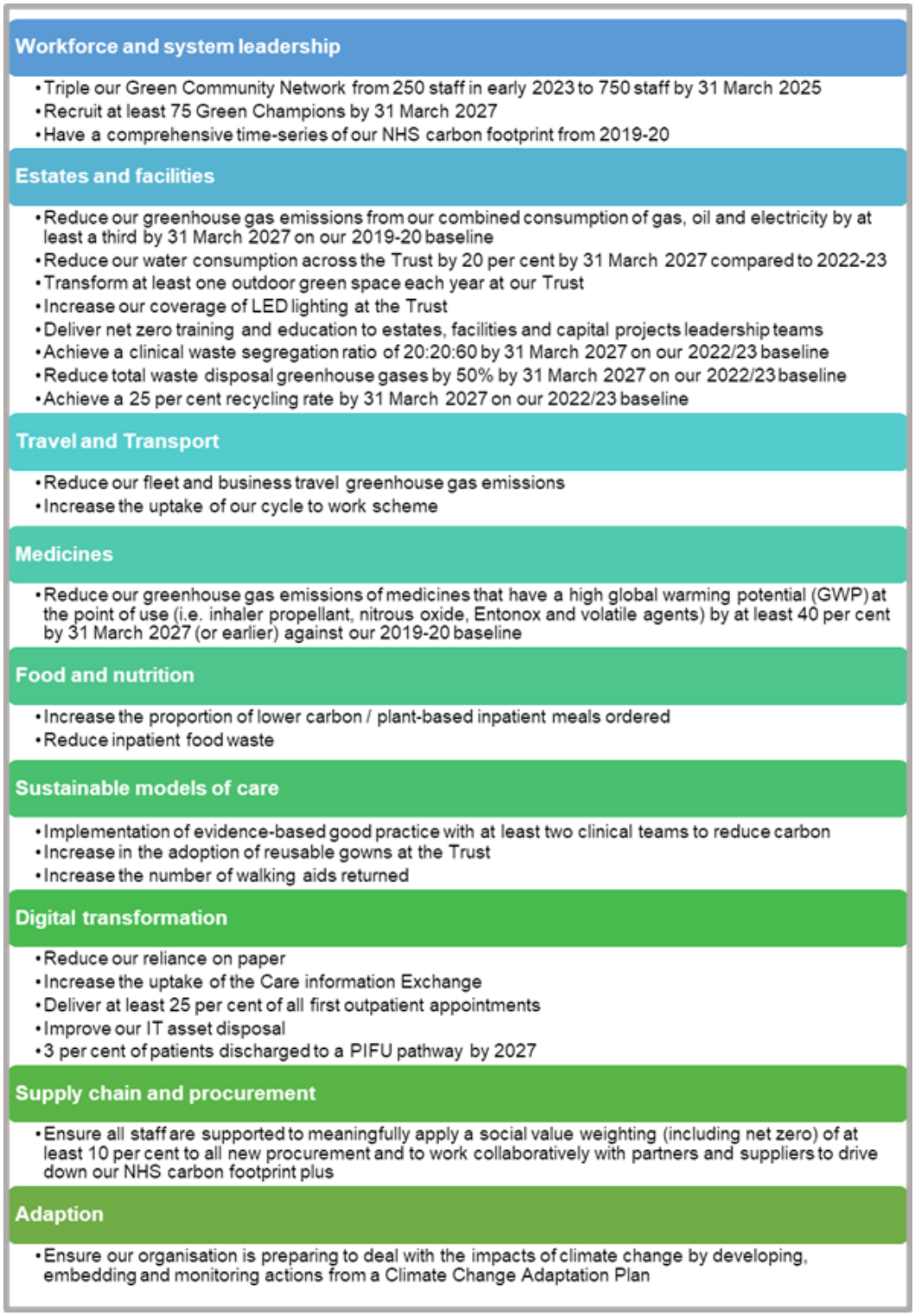
Our three-year Green Plan sets out actions to reduce our NHS carbon footprint by 34% by 2026-27, against the 2019-20 baseline. Achieving this will put us on a solid path to achieving the NHS interim target for our NHS Carbon Footprint to reduce by at least 47% by 2028-2032.

Disclosure of Scope 1, 2 and 3 emissions is not required for NHS bodies as this is reported by NHS England. Our NHS Carbon Footprint Plus, computed nationally by NHS England, stood at 274,888 tCO2e in 2019/20.

We plan to produce a standalone Green Plan progress report in quarter two of 2025-26 which will present an update of our NHS Carbon Footprint for the year 2024-25.

Our Green Plan has 26 success metrics and we will continue to work with stakeholders through 2027 to ensure these are fit for purpose. Our six core success metrics and targets are:

- to reduce our greenhouse gas emissions from our combined consumption of gas, oil and electricity by at least a third by April 2027 compared to 2019-20
- to reduce our water consumption across the Trust by 20% by April 2027 compared to 2022-23 levels
- to achieve a clinical waste segregation ratio of 20:20:60 by April 2027 compared to 2022-23 levels
- to reduce total waste disposal greenhouse gas emissions by 50% by April 2027 compared to 2022-23 levels
- to reduce our greenhouse gas emissions of medicines that have a high global warming potential at the point of use (including inhaler propellant, nitrous oxide, Entonox and volatile agents) by at least 40% by April 2027 compared to 2019-20 baseline
- to reduce our fleet and business travel greenhouse gas emissions.




Source: Imperial College Healthcare NHS Trust

Between 2021 and April 2025, we have secured £98 million from the Public Sector Decarbonisation Scheme (PSDS), and in February 2025, we secured funding from the NHS National Energy Efficiency Fund (NEEF) of £12.88 million to implement lower carbon LED projects and to upgrade our buildings management systems. This, along with additional Trust funding, will allow us to invest £120 million by 2028 on heat decarbonisation and energy efficiency projects at Charing Cross and Hammersmith hospitals. These investments are estimated to reduce our annual NHS Carbon Footprint by 20,233 tCO2e in the long term.

## PSDS and NEEF grants to decarbonise our estate as of April 2025

### ICHT: Public Sector Decarbonisation Scheme (PSDS) and NHS National Energy Efficiency Fund (NEEF)

NHS
Imperial College Healthcare
NHS Trust

The Public Sector Decarbonisation Scheme provides grants for heat decarbonisation and energy efficiency measures. The NHS Energy Efficiency Fund provides grants for energy efficiency projects that reduce NHS estate operating costs.

| Project description | Date of award | Size of award (£) | Total funding within the scheme | Percent of total funding secured | Additional Trust contribution | Estimated annual carbon impact (tCO2e) |
|---|---|---|---|---|---|---|
| Heat pumps at CXH to serve the tower blocks (PSDS) | Jan-21 | £26.9 million | £1,000 million | 2.7% | 0 | 8,172 tCO2e |
| De-steam and heat pumps at HH. Additional heat pump at CXH (PSDS) | Jan-22 | £22.9 million | £553 million | 4.1% | £2.9 million | 3,359 tCO2e |
| Heat pump at CXH. Ground source heat pumps and Solar PV at HH (PSDS) | Feb-24 | £41.8 million | £530 million | 7.9% | £5.7 million | 5,219 tCO2e |
| LED and BMS upgrades (NEEF) | Feb-25 | £12.88 million | £80 million | 16.1% | 0 | 2,576 tCO2e |
| Cascaded heat pump at CXH (PSDS) | April-25 | £6.43 million | £630 million | 1.0% | £0.88 million | 907 tCO2e |
| **TOTAL** | – | **£110.91 million** | **£2,793 million** | **3.97%** | **£9.48 million** | **20,233 tCO2e** |


Once these projects have been completed the environmental benefit realised will represent a 43 per cent reduction on the Trust's 2020/21 building energy emissions.

**20,233 tCO2e is .....**

- equivalent to the energy used to power and heat 8,085 average GB homes for a year
  - 8,085 homes is equivalent to almost 9 out of every 100 dwellings in Hammersmith and Fulham

**20,233 tCO2e is .....**

- equivalent to around 762,000 trees growing for a year and absorbing carbon dioxide
  - 762,000 trees is around 192 Hyde Park's worth of trees

**20,233 tCO2e is .....**

- equivalent to a small car driving almost 110 million miles
  - this is the same as driving to the moon and back 228 times, which at the UK motorway speed limit of 70 mph would take you almost 1.5 million hours to do without a break!

Source: Imperial College Healthcare NHS Trust

Our computer power management solution, installed in early 2023, has reduced our greenhouse gas emissions by around 591 tCO2e in 2024-25, simultaneously generating a £578,000 cost avoidance through reducing wasted electricity.

Our capital projects team are incorporating more sustainable materials for hospital refurbishments and upgrades. For example, our Hammersmith Hospital oncology refurbishment project won 2024 Sustainable Project of the Year at the inaugural Forbo Awards thanks to its extensive use of marmoleum flooring, which is a sustainable and natural product.

Our green community network now has 682 members, thanks to ongoing staff engagement and empowerment work. Our green champions programme, launched in April 2024, now includes 80 green champions across our Trust that lead and contribute towards making local greener changes. We have also worked with the Sustainable Healthcare Academy to secure three sustainability apprentices, starting in 2025, for 15-month placements.

Other key highlights in 2024-25 include our staff having:

- implemented estates decarbonisation solutions that have reduced our greenhouse gas emissions from our combined consumption of gas, oil and electricity by 8.2% on the previous year and

21% since 2019-20
- acted to reduce our water consumption across the Trust by 4.2% on the previous year and 3.7% since 2022-23
- acted to improve our clinical waste segregation ratio (incineration waste volume: infectious waste volume; offensive waste volume) to 10:51:39 from 11:65:24 in 2022-23
- changed clinical practice to reduce our greenhouse gas emissions of medicines that have a high global warming potential at the point of use (i.e. inhaler propellant, nitrous oxide, Entonox and volatile agents) by 7.6% on the previous year and 56.9% since 2019-20
- secured approval to implement a nitrous oxide waste mitigation project at the Western Eye Hospital by decommissioning the manifold supply
- embedded Green Plan scoring metrics into our Trust-wide ward accreditation programme
- collected 957 walking aids, with around 80% being re-issuable
- made local green clinical product switches
- introduced a new patient dining menu designed to 'nudge' choice towards lower carbon food options
- contributed to over 200,000 trees being planted globally, since mid-2023, by using Ecosia to search the internet
- surveyed staff travel and transport experiences
- delivered a programme of 21 Dr Bike maintenance check events (seven at each of our major sites throughout the year) that checked 286 staff bikes
- installed bike lock racks and fixed the permanent bike pumps at each of our bike sheds
- successfully reaccredited as a gold cycle friendly employer with Cycle UK.

Finally, we worked with local partners on some exciting developments, including:

- a three-year air quality partnership with Hammersmith & Fulham Council and Imperial College London resulting in us deploying real-time air pollution displays at our three main hospital sites
- forming the Circular Economy Healthcare Alliance with six other healthcare trusts
- hosting two sustainability workshops with Paddington Life Sciences Partners
- supporting a theatres-based 'Gloves Off' research project with Imperial College London to investigate the overuse of non-sterile gloves
- formed and co-chair a north west London-wide social and sustainable procurement working group.

## Reducing health inequalities and improving population health

Building and maintaining good health goes far beyond the work that happens within hospital walls. To achieve our vision of 'better health, for life,' we must do our part to give local communities the best chance to have happy and healthy lives.

In 2024-25, we built on existing collaboration through the North West London Acute Provider Collaborative and coordinated efforts to improve health across the four partner trusts. Together, we can share learnings, and scale and spread successful work aligned to our local priorities.

**Our 2024-25 response to NHS England's statement on information on health inequalities** (duty under section 13SA of the National Health Service Act 2006)

NHS England's statement on information on health inequalities, published in 2023, requires organisations like ours to report on the population we serve, how they access our services, and what we are doing to meet their needs. You can read the full report on our website, but we've included a brief summary here.

In our 2024-25 response to the statement, we analysed the planned care waiting list and planned and emergency activity and compared planned care activity to pre-pandemic levels. Each indicator has been compared by stated gender, age group, level of deprivation and stated ethnicity. In addition, a summary of the inpatient smoking cessation services on offer has been included.

Analysis suggests that patients from the most deprived areas make up a greater proportion of our emergency admissions than our planned care admissions. Patients that identify as Black also make up a greater proportion of our emergency admissions than our planned care admissions. As of January 2025, there was a slightly greater proportion of people that identified as female waiting longer than 18 weeks for planned care compared to those that identified as male. A slightly greater proportion of adults aged 50-69 wait longer than 65 weeks compared to younger age groups. We are taking steps to investigate these findings further in individual services.

No other statistically significant differences were identified between age groups, stated ethnicity, stated gender or deprivation quintiles for the emergency and planned care indicators requested in NHS England's statement. We continue to monitor for any changes in these trends over time.

Next year, we intend to go beyond the analysis of overall Trust activity and take a deeper dive into planned, urgent and maternity care for specific population groups.

# Our priorities

## Improving equity of healthcare

We know that not everyone has the same opportunity to live a healthy life, with some groups experiencing unfair and avoidable differences in their health and wellbeing. Through our work to improve the equity of our care, we are actively working to identify, understand and improve inequity of access, outcomes and experience.

- **Improving access to outpatients:** We are working to reduce the inequalities seen between different patient groups and their appointment attendance. Pilot initiatives have been co-produced and trialled across the financial year in response to challenges identified by community members. The pilots were run with the support of Imperial Health Charity volunteers who spoke with almost 1,000 patients in the three-month pilot period. The pilots included:
  - sending additional supportive text messages, signposting people to travel reimbursement schemes and what to expect at their appointment
  - calling patients in advance of their appointment.

  We have begun a project to identify patients who require accessible information formats to support management of their appointments, and patient groups, such as the local frailty population, who have a high need for our services but may be disadvantaged by our more standard processes.
- **Reviewing our services for equity:** As part of meeting our equalities duties we undertook a review of three patient services to understand how well they were meeting the needs of their current and potential users. Using protected characteristics and other inclusion groups as a lens to identify inequalities, each service was reviewed across key areas including access, experience, and harm. The findings were shared with a diverse panel of patient and public members for evaluation. The review highlighted Trust-wide areas for improvement in the recording of protected characteristics data and identified further opportunities to collaborate with the voluntary and community sector. Services involved in the review have also begun equity-focused initiatives in response to panel feedback. These include assessing how well the Wembley Community Diagnostic Centre is reaching local residents in areas of high deprivation, and increasing patient involvement in the design and evaluation of the fibroids service to ensure fairness.
- **Addressing health inequalities faced by our staff:** In 2024-25, we began a health and wellbeing improvement project specifically for our facilities staff, recognising the additional challenges certain staff groups face in terms of health equity. For example, some groups experience higher sickness absence rates, live with more long-term health conditions and spend years working with ill health. Over 200 facilities staff have provided feedback on what matters most to them with regard to their health. Throughout 2025 we will be co-designing

some bespoke opportunities which addresses their specific needs, in addition to the Trust's health and wellbeing offers for staff.

- **Interpreting:** Our patient experience team is working with the Helix Centre at Imperial College London to better understand the communication needs of our patients. This project will help inform improvements to our interpreting services and help us bring our information in line with the Accessible Information Standard (AIS), which ensures that patients who have a disability, impairment or sensory loss have their communication and information needs met. In addition to this project, the patient interpreting improvement programme is helping services introduce additional interpreting options, including an on-demand video interpreting solution for A&E and urgent maternity and neonatal services. Maternity services have introduced additional measures to ensure language support during labour and birth, including for patients who use British Sign Language.

- In 2025-26, the team plans to introduce more training resources to ensure staff know how to access the right interpreting service at the right time. Plus, the Helix Centre project will conclude with clear recommendations for further improvements that will enable us to understand our language support requirements through better visibility of available patient information and co-design future interpreting services with staff, patients and our community groups and partners.

## Prevention of ill health

To improve health, we must think about preventing, as well as treating illness. By encouraging healthy behaviours, we aim to support our patients, staff and wider community with opportunities to reduce the need for ongoing healthcare.

- **Launch of our inpatient tobacco dependence treatment service:** Since beginning in August 2024, our team of health improvement advisers have engaged with over 1,000 smokers by March 2025. Our advisers provide personalised, one-to-one specialist support to help patients be smokefree during their hospital stay, and where possible, for the longer term. Over 80 per cent of patients seen by the advisers agreed to some level of support to be smokefree and over 500 onward referrals by the team have been made to different local stop smoking services, enabling patients to receive continued support and treatment after discharge. Of these, more than 200 patients reported being smokefree 28 days after being discharged from hospital. Focus for the team in 2025-26 includes improving screening rates and the supply of nicotine replacement therapy to patients, as well as collaborating with RM Partners, our local cancer alliance, to provide specialist support to outpatients on cancer pathways.

- **Investing in community-based interventions:** Our collaboration with the Chelsea Football Club (FC) Foundation leverages the interplay between sport, health and wellbeing. 200 patients have now engaged with 'Bridging the Blues'. This provides 12-week healthy lifestyle programmes covering long term health conditions such as minor-stroke, cardiac, respiratory and cancer. The programme was a finalist for the 2025 London Sport Awards health and wellbeing category due to its impact on supporting patients following their discharge from hospital. For example, 92% of the minor-stroke participants improved their high-level mobility and assessment tool score. In 2025, both Chelsea and Westminster Hospital NHS Foundation Trust and Central and North West London NHS Foundation will join our strategic partnership with the Foundation.

- **Supporting our staff to stay active:** Trust staff have benefitted from our partnership with the Chelsea FC Foundation, with over 200 staff engaging in the weekly staff football sessions which launched in May 2024. Twenty-three per cent of attendees are female and 66.7% are from global majority groups, whilst 85 per cent of participants reported their overall wellbeing has strongly improved due to the sessions. Fifteen of these staff are training to gain Football Association Level 1 qualifications to help lead the sessions thanks to funding from Imperial Health Charity.

## Collaborating with partners to address wider determinants of health

Our hospitals are anchored in local communities and influence health and wellbeing just by being there. As a Trust, and with our partners, we are thinking creatively about how we can embrace this anchor role to drive positive change.

- **Maximising our anchor institution influence:** As a key institution in our local area, we run initiatives to positively influence the underlying social, economic and environmental conditions which support an equitable, healthy and prosperous local community. There has been a particular focus on access to employment throughout 2024-25, with continued efforts in our apprenticeships, work experience and volunteering initiatives. The volunteer employment programme, supported by Imperial Health Charity, has seen 80 out of 115 volunteers gain employment at the Trust in 2024-25. Since launching in 2023, our community recruitment work has supported 537 employees from the north west London population into work, significantly contributing to the total percentage increase of the Band 2 and Band 3 workforce residing in north west London.

- **Life science partnerships:** We continue to bring together community, government, health provider and industry partners across Westminster to improve digital inclusion for Paddington residents. We co-chair the Westminster Digital Inclusion forum in partnership with Westminster City Council which sees us bring together organisations from across public, private, and voluntary and community sectors to co-produce initiatives to support our local communities to become more digitally enabled. In October 2024, we published the life sciences' skills mapping report with Bloomberg Associates which showcased the skills needed to strengthen the life sciences' workforce and provide access to careers for residents in Paddington. And in February 2025, Paddington Life Sciences was named in the Mayor of London's London Growth Plan, as part of WestTech London, one of the city's key industrial innovation hubs. WestTech London also includes the White City Innovation District and South Kensington.

- **Improving air quality:** Alongside Hammersmith & Fulham Council and Imperial College's Environmental Research Group we are aiming to co-create initiatives to reduce public exposure to air pollution and improved air quality in north west London. In September 2024 the AWAIR pilot was launched to raise public awareness about air quality in London through real-time air quality displays, providing live and forecasted pollution levels. Following its success, AWAIR signs have now been installed at all three of our hospital sites, alongside surveys to evaluate awareness among staff, patients and visitors. These will soon be expanded to five GP practices across Hammersmith & Fulham to further educate and empower patients and healthcare professionals about the health risks of air pollution and aid the development of practical resources on protecting health from air pollution exposure.

## Looking forward

The 10 Year Health Plan for the NHS will present exciting opportunities for the Trust and our population health work. Through shifts to move care from hospitals to communities, make better use of technology and a focus on preventing, not just treating sickness, we intend to scale our collaborative efforts towards 'better health, for life'. Over the next year we will play an active role in improving neighbourhood health across north west London and supporting diverse communities with the greatest health and care needs.

**Professor Tim Orchard, Chief executive**
**27 June 2025**

# Accountability report

# Corporate governance report

## Directors' report

### Governance arrangements in the North West London Acute Provider Collaborative

The North West London Acute Provider Collaborative (the 'Collaborative') came into being from September 2022, following approval of the trust boards of the four acute trusts; Chelsea and Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Hospitals NHS Trust, also from Chelsea and Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust Council of Governors, London Region and National NHS England. The four acute trusts remain as statutory bodies who also continue to work with other partners in the north west London Integrated Care System to deliver health to the population of north west London.

The governance arrangements have been developed based on core principles of corporate governance in a collaborative system, including adhering to the principle of subsidiarity while ensuring collaborative decision-making and holding each other to account and ensuring the continuation of public accountability and stakeholder involvement and engagement at trust level as well as at the level of the collaborative.

To support the Collaborative model, governance arrangements were established, including key elements:

- Trust-level committees providing local oversight across quality, workforce and finance and performance as well as the statutory committees; audit and risk committee, and nominations and remuneration committee
- collaborative committees, covering the domains of quality, workforce, finance and performance, digital and data, and estates and sustainability
- bringing the four trust boards together to form a board in common – four trust boards meeting together at the same time and same place with a common agenda
- a model of shared non-executive directors across trusts
- lead chief executives for strategic priorities across the Collaborative.

In 2024-25 we introduced Trust standing committees to ensure there is local oversight and scrutiny on Trust issues.

The board in common meets in public and is collectively responsible for setting the strategy for the Collaborative. It is comprised of the four trust boards and meets four times per year. To ensure agility in decision making and to maintain oversight, the four trust boards (as the board in common) delegates some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the board in common is not meeting. The meetings of the board in common cabinet are reported to the board in common.

Each statutory entity has a responsibility to maintain its own system of internal control, including a robust risk management framework. The audit and risk committees remain independent in each trust and retain responsibility for ensuring that a system of internal control is maintained across the trust, to ensure that risks are being identified and managed, and appropriate assurance mechanisms are in place. The audit and risk committees provide a summary of committee matters to the Trust standing committee.

The governance arrangements for the Collaborative continue to develop and evolve and the four trust boards agree any amendments to the scheme of delegate authority as appropriate. We introduced trust standing committees to the governance structure for each trust following the governance review in 2022-23, which seeks to strengthen the level of local engagement and oversight and to ensure individual trust issues are discussed adequately.

Each trust has its board committee structure, and committees review the key risks aligned with their

functional domain and receive assurance regarding the management of risk for those risks, via regular reports or risk and assurance deep dives where appropriate. Trust committee chairs report on matters for escalation, including risks, to the respective collaborative committee.

The board in common receives summary reports from the collaborative committees and trust standing committees, as well as more detailed reports where required including reports from each chief executive, from which each board takes assurance that there are effective systems in place to ensure risks are being identified and managed at the appropriate level.

## The Trust board and its committees

The Trust board is accountable, through the chair, to NHS England and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The Trust board as of 31 March 2025 consisted of the chair, vice chair, six independent non-executive directors, chief executive, medical director, chief nurse, chief financial officer and chief operating officer, as outlined below.

The membership of the Trust board is balanced and appropriate; biographies for each of the Trust's board directors are available on the website at: https://www.imperial.nhs.uk/about-us/how-we-are-run/our-board More information about our board's register of interests is available in the annual governance statement on page 59.

The performance of all directors is reviewed in an annual appraisal which forms the basis of their individual development plan: for executive directors, by the chief executive; for non-executive directors and the chief executive by the chair in common; and for the chair in common via a process managed by NHS England.

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust board directors have been assessed as being fit and proper persons to be directors of the Trust.

The Trust board, and each of the committees, undertake an annual self-assessment of performance and effectiveness, using a questionnaire developed for this purpose. The results of these self-assessments are presented to each committee as part of the committee annual report, and the findings used to inform the development plans for each committee.

## Trust-level governance

The Trust governance operates in the context of the collaborative governance arrangements outlined above.

The Trust board during 2024-25 was as follows:

| Board member | Role | Attendance at board meetings |
|---|---|---|
| Matthew Swindells | Chair in common | 4/4 |
| Robert Alexander | Vice chair | 4/4 |
| Nick Gash | Non-executive director | 4/4 |
| Sim Scavazza | Non-executive director | 2/4 |
| Linda Burke | Non-executive director | 3/4 |
| David Moss | Non-executive director (designate) | 4/4 |

| | | |
|---|---|---|
| Carolyn Downs | Non-executive director (until 30 September 2024) | 1/2 |
| Neena Modi | Non-executive director* (until 31 July 2024) | 0/2 |
| Loy Lobo | Non-executive director | 2/4 |
| Aman Dalvi | Non-executive director (designate) | 4/4 |
| Helen Stephenson | Non-executive director (from 1 October 2024) | 2/2 |
| Catherine Williamson | Non-executive director* (from 20 January 2025) | 0/0 |
| Professor Tim Orchard | Chief executive | 4/4 |
| Professor Julian Redhead | Medical director | 4/4 |
| Professor Janice Sigsworth | Chief nurse | 4/4 |
| Jasbir Kaur (Jazz) Thind | Chief financial officer | 4/4 |
| Claire Hook | Chief operating officer and deputy chief executive | 4/4 |

Designate non-executive directors are voting non-executive directors of one of the other trusts in the collaborative and are members of trust committees in the Trust. They cannot be appointed as members of the Trust board due to limitations on the number of non-executive directors as specified in the Trust establishment order and legislation.

*This non-executive director is the appointed representative of Imperial College London.

## Trust board meetings: 1 April 2024 – 31 March 2025

The Trust board met four times in regular session as the board in common as part of the governance structure in place within the North West London Acute Provider Collaborative.

At Trust level, the board has a Trust standing committee that meets quarterly and is chaired by the vice chair and six committees which meet regularly and are chaired by a non-executive director. A number of board responsibilities are delegated either to these committees or individual directors. The Trust board approves the terms of reference which detail the remit and delegated authority of each committee.

Committees routinely provide a report to the Trust standing committee and to the audit, risk and governance committee, showing how they are fulfilling their duties as required by the Trust board and highlighting any key issues and achievements. A summary of these Trust level committees, their purpose and membership are detailed below.

## Trust standing committee

The purpose of the newly established Trust standing committee is to oversee the delivery of the Trust strategy and strategic priorities, the achievement of constitutional and regulatory standards, and to provide assurance to the Trust board that Trust risks and issues relating to this are being managed.

The Trust standing committee also oversees and provides assurance to the Trust board via the board in common on operational, finance, quality and workforce performance; the corporate risk register and board assurance framework; board committee chair's reports and statutory reports that are reported on at the board in common.

The Trust standing committee met three times in 2024-25.

| Trust standing committee member | Role | Attendance at Trust standing committee |
|---|---|---|
| Robert Alexander, committee chair | Vice chair | 3/3 |
| Nick Gash | Non-executive director | 3/3 |
| Sim Scavazza | Non-executive director | 3/3 |
| Linda Burke | Non-executive director | 2/3 |
| David Moss | Non-executive director (designate) | 3/3 |
| Carolyn Downs | Non-executive director (until 30 September 2024) | 1/1 |
| Neena Modi | Non-executive director* (until 31 July 2024) | 0/1 |
| Loy Lobo | Non-executive director | 2/3 |
| Aman Dalvi | Non-executive director (designate) | 1/3 |
| Helen Stephenson | Non-executive director (from 1 October 2024) | 2/2 |
| Catherine Williamson | Non-executive director* (from 20 January 2025) | 0/0 |
| Professor Tim Orchard | Chief executive | 3/3 |
| Professor Julian Redhead | Medical director | 3/3 |
| Professor Janice Sigsworth | Chief nurse | 3/3 |
| Jasbir Kaur (Jazz) Thind | Chief financial officer | 2/3 |
| Claire Hook | Chief operating officer and deputy chief executive | 3/3 |

## Trust audit, risk and governance committee

The terms of reference of the audit, risk and governance committee are available upon request.

The audit, risk and governance committee has both mandatory and non-mandatory roles. As the audit committee, it provides the Trust board with independent and objective assurance that an adequate system of internal control is in place and working effectively. It is also responsible for providing assurance on the Trust's annual report and accounts; the work of the internal and external auditors; local counter fraud providers and any actions arising from that work; and, as the auditor panel, for the appointment of external auditors. It also has a governance role in relation to financial reporting – to facilitate this part of its role, the committee is provided with regular briefing papers from management covering key accounting treatments and judgements included in the annual financial statements. For this part of the meeting, membership is made up of the non-executive members detailed below.

In its broader, non-mandatory role, the committee oversees and seeks assurance that risk management and corporate governance arrangements are in place and working effectively. It undertakes reviews of areas of activity which may expose the Trust to particular risk and seeks assurance that appropriate management action is being taken. In such matters, it is cognisant of the work of other committees and receives reports from these meetings which highlights the business overseen by the committee and key highlights from the meetings.

It also receives annual reports from each committee as well as an overarching committee effectiveness report each year. For this part of the meeting, the medical director, chief financial officer and director of nursing are also members.

The audit, risk and governance committee assess the independence and effectiveness of the external audit process through several safeguards:

- by reviewing any non-audit work commissioned from our audit firm, to ensure their independence is not compromised – there has been no non-audit work in 2024-25
- by ensuring that auditors have no financial interest in the organisation
- we regularly re-tender the audit function, including internal and external auditors
- the audit, risk and governance committee review the reports from the external auditor and actions they take to comply with the professional and regulatory requirements

Deloitte LLP acted as the Trust's external auditors in 2024-25, having been appointed in April 2017 for an initial three-year period that was extended. KMPG acted as the Trust's internal auditors, having been appointed for an initial period of three years from April 2022.

| Audit, risk and governance committee member | Attendance (actual/possible) |
|---|---|
| Nick Gash, non-executive director (committee chair) | 6/6 |
| Loy Lobo, non-executive director | 4/6 |
| Linda Burke, non-executive director | 6/6 |
| Jazz Thind, chief financial officer | 6/6 |
| Professor Julian Redhead, medical director | 4/6 |
| Professor Janice Sigsworth, director of nursing | 6/6 |

## Trust remuneration and appointments committee

On behalf of the Trust board, the committee is responsible for decisions concerning the appointment, remuneration and terms of service of executive directors and other very senior appointments. The committee also monitors the performance and development of executive directors and ensures that equality and diversity have appropriate priority in leadership development and succession in line with the NHS Workforce Race Equality Standard (WRES).

Each appointment to the board is considered in the context of the skills required and the current composition of the board, informed by regular skill mix reviews completed at acute provider collaborative and Trust level. As well as the Trust equality, diversity and inclusion (EDI) strategy, the Collaborative has established an EDI improvement steering group, comprising non-executive director, executive and EDI expert membership from across the Collaborative, to develop recommendations to accelerate progress and surpass the NHS EDI High Impact Actions, including agreeing EDI objectives at board level.

Workforce composition relating to gender, age, ethnicity and disability are reported to the people committee through the annual WRES and Workforce Disability Equality Standards (WDES) reports, which are then published on the Trust website. The Trust EDI work programme, overseen by the board people committee, includes a commitment to deliver on the WRES Model Employer goals.

The committee met once in person during 2024-25 with two meetings held via e-governance.

| Remuneration and appointments committee member | Attendance (actual/possible) |
|---|---|
| Robert Alexander, vice chair (committee chair) | 3/3 |
| Linda Burke, non-executive director | 3/3 |
| Sim Scavazza, non-executive director | 3/3 |

## Trust quality committee

The quality committee is responsible for seeking and securing assurance that the Trust's services are delivering – to patients, carers and commissioners – the high levels of quality performance expected of them by the Trust board. It also seeks assurance in relation to patient and staff experience. Performance is monitored in relation to the five quality domains (safe, effective, caring, responsive, well-led) set by the Care Quality Commission, and ensures that there is a clear compliance framework against these.

| Quality committee member | Attendance (actual/possible) |
|---|---|
| Helen Stephenson, non-executive director (committee chair from 1 October 2024) | 3/3 |
| Carolyn Downs (committee chair until 30 September 2024) | 3/3 |
| Neena Modi (Member until 31July 2024) | 1/1 |
| Catherine Williamson, non-executive director (from 20 January 2025) | 1/1 |
| Aman Dalvi, non-executive director | 5/6 |
| Professor Janice Sigsworth, chief nurse | 6/6 |
| Professor Julian Redhead, medical director | 5/6 |

## Trust finance, investment and operations committee

The committee is responsible for receiving assurance that the Trust achieves financial performance targets set by the Trust board and also for ensuring the Trust's investment decisions support achievement of its strategic objectives. We also focus our operations and transformation activities to monitor progress, add support and understand risks and opportunities in these areas which are important in achieving our strategic goals.

| Finance, investment and operations committee member | Attendance (actual/possible) |
|---|---|
| Robert Alexander, vice chair (committee chair) | 9/9 |
| Aman Dalvi, non-executive director | 9/9 |
| David Moss, non-executive director | 8/9 |
| Jazz Thind, chief financial officer | 9/9 |
| Claire Hook, chief operating officer | 7/9 |

## Trust redevelopment committee

The committee oversees all aspects of the redevelopment programme, including achievement of workstream milestones and deliverables, and risks associated with the overall programme and support to any commercial negotiations or procurement processes required for redevelopment.

| Redevelopment committee member | Attendance (actual/possible) |
|---|---|
| Robert Alexander, vice chair (committee chair) | 2/2 |
| Sim Scavazza, non-executive director | 1/2 |
| Professor Tim Orchard, chief executive officer | 2/2 |
| Jazz Thind, chief financial officer | 2/2 |
| Matthew Tulley, director of redevelopment | 2/2 |

## Trust people committee

The committee monitors, reviews and provides assurance to the board on the cultural and organisational development of the Trust. This includes the organisation's understanding of strategic workforce needs, key human resources controls, recruitment and retention, performance management, and the achievement of key deliverables in relation to the equality, diversity and inclusion plan.

The committee identifies the strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the locality, and provides assurance around strategic issues relating to ethics and duty of care in the conduct of Trust affairs (including whistleblowing) and to the Trust's equality duty. The committee also focuses on staff wellbeing as one of the key people priorities. Sources of assurance that inform the committee's work includes the staff survey results, staff stories, whistleblowing and freedom to speak up concerns, and NHS Workforce Race Equality Standard data.

| People committee member | Attendance (actual/possible) |
|---|---|
| Sim Scavazza, non-executive director (committee chair) | 5/6 |
| Linda Burke, non-executive director | 5/6 |
| Loy Lobo, non-executive director | 6/6 |
| Kevin Croft, chief people officer | 6/6 |

## Collaborative committees with decision-making

As outlined in the summary of the collaborative governance arrangements, in addition to the Trust committees detailed above, there are some collaborative meetings that have decision-making authority delegated by the Trust board, via the board in common.

## Board in common cabinet

The board in common delegates some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, which meets in the months when the board in common is not meeting. These responsibilities include the approval of business cases, where there is an urgent need for a decision that can't wait until the next board in common meeting.

## Collaborative finance and performance committee

The collaborative finance and performance committee meets quarterly and is comprised of a vice chair, who chairs the meeting, the non-executive director chair of each of the four trusts' finance and performance committees, the chief executive lead for collaborative finance and performance, the chief financial officers from each of the four trusts and the chief operating officers from each of the four trusts.

The committee has a responsibility to review financial and operational performance at collaborative level, to identify collaborative-level projects or actions that would assist in managing Trust-level risks in finance or operational performance, and to consider collaborative business cases – those cases that affect more than one trust in the collaborative. The committee will approve collaborative business cases between £1m and £5m and recommend collaborative business cases to the board in common for approval where the value is above £5m.

## Code of governance compliance statement

An updated code of governance for NHS provider trusts setting out an overarching framework for the corporate governance of trusts was published by NHS England in October 2022 and came into effect in April 2023. The code covers both foundation trusts and NHS trusts and is based on the principles of the UK Corporate Governance Code. The Trust has applied the provisions of this code on a 'comply or explain' basis. The purpose of the Code of Governance is to assist trusts in improving governance practices by bringing together the best practice of public and private sector corporate governance. As a Trust, we are committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver mandatory goods and services.

During the year, we have completed the comply or explain self-assessment exercise in relation to the code which was reviewed and considered by the audit, risk and governance committee.

The self-assessment for the Trust covered 64 lines of enquiry and was conducted on a 'comply or explain' basis. The self-assessment covered the following domains:

- board leadership and purpose
- division of responsibilities
- board composition, succession and evaluation
- audit, risk and internal control
- remuneration

Schedule A of the Code of Governance sets out the clauses on which each trust must report in the annual report and can be found at the following link: https://www.england.nhs.uk/long-read/code-of-governance-for-nhs-provider-trusts/#schedule-a-disclosure-of-corporate-governance-arrangements

The table below references where these disclosures can be found in this annual report.

| Code reference | Section |
|---|---|
| Section A, 2.1 | How the board operates with the acute provider collaborative is disclosed within the directors' report and collaborative strategy is disclosed within the North West London Acute Provider Collaborative review |
| Section A, 2.3 | How the board monitors culture is disclosed in the people committee section in the accountability report. |
| Section A, 2.8 | Governance arrangements for the Trust and north west London are disclosed in the directors' report which describes how interests of system-based partners are considered in discussion and decision making. |

| Code reference | Section |
|---|---|
| Section B, 2.6 | Non-executive director disclosures are included within the directors' report. All non-executive directors are independent. |
| Section B, 2.13 | Board frequency and attendance has been disclosed within the directors' report. |
| Section C, 4.2 | Link to biographies which detail skills, expertise and experience of directors is included in the directors' report. |
| Section C, 4.7 | We completed the internal audit review of the APC in 2023 using the well-led framework, therefore we do not expect to conduct a developmental review in the next three to four years, in line with the standard which is every three to five years.<br>In the meantime, we conduct annual well-led self-assessments. Detail of these are included in the accountability report. |
| Section C, 4.13 | The work of the remuneration and appointments committee is included in the accountability report. |
| Section D, 2.4 | The work of the audit, risk and governance committee is included in the accountability report. |
| Section D, 2.6 | The annual reporting responsibilities are included within the statement of directors' responsibilities in respect of the accounts. |
| Section D, 2.7 | Disclosures on risks have been included in the performance report and annual governance statement. |
| Section D, 2.8 | The board of directors monitor the Trust's risk management and internal control systems and, a review of their effectiveness for the year has been disclosed in the annual governance statement. |
| Section D, 2.9 | Going concern disclosure included in annual accounts and chief financial officer's report within the performance report. |
| Section E, 2.3 | Where a trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether the director will retain such earnings. This has not occurred in 2024-25 so it is not applicable. |

The Trust was assessed as being compliant with 61 points of inquiry and partial compliance with three areas. These areas remain partially compliant and updates on progress against these are provided to the audit, risk and governance committee on a regular basis.

| Provision | Action required to be fully compliant |
|---|---|
| **Board leadership and purpose** | |
| *Provision A, 2.5*<br>The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, such as from the internal audit function, to provide an adequate and reliable level of assurance. | To continue the work to establish reporting the relevant metrics and ensure performance reports are disaggregated by ethnicity and deprivation where relevant. This is in progress. |

| Provision | Action required to be fully compliant |
|---|---|
| **Division of responsibilities** | |
| *Provision B, 2.13*<br>The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. | Whilst we publish the responsibilities of the board and committees annually within the annual report we do not currently publish these responsibilities on our website. |
| *Provision C, 1.1*<br>Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. | As a trust we are compliant with this disclosure however identified that it would be best practice to harmonise the terms of reference of the remuneration and appointments committee across the Collaborative. |

## Compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

## Political donations

The Trust did not make any political donations during 2024-25.

## The Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier. Details of our performance against the code are contained in the note 36 to the financial statements.

## Well-led framework

As part of its current regulatory framework for NHS trusts the Care Quality Commission (CQC) continues to undertake inspections of well-led at trust level. Since the Trust last had a well-led inspection in April 2019, the methodology for these inspections has changed from being focused on the structure functioning of trust executive teams and boards, to a more iterative process whereby the executive and board are also evaluated in relation to findings from the CQC's inspections of trust services.

The Trust assures itself that it has robust and effective governance from ward to board, that there is effective and timely oversight of services at executive and board level, and that robust and effective systems and processes are in place for decision-making at executive and board level that impacts clinical services.

Achievement of the CQC's well-led standards within services is independently evaluated via the Trust's ward accreditation programme, internal and external peer reviews, national audit, staff and patient surveys, and so on. The outcomes of these are used to inform service level CQC self-assessments, with improvement progress and the sustaining of good performance monitored by the improving care programme group, an executive level meeting chaired by the chief executive.

Additionally, a self-assessment against the CQC's well-led standards at Trust level was carried out during the autumn and winter of 2024-25. The self-assessment incorporates both the NHS Code of Governance for trusts and NHS England's insightful board guidance. A report encompassing all of the findings and recommendations for improvement relating to well-led will be used to develop a briefing pack for executives and non-executive directors as part of the preparations for the next

CQC well-led inspection. The outcomes from the self-assessment and the subsequent briefing pack will be presented to the Trust's standing committee at its meeting in July 2025.

An overview of service governance at executive and board level is included in the Trust's annual governance statement and quality account, covering safety, quality, operational performance and finance; this is in line with the comprehensive approach the CQC uses when evaluating whether services and organisations are well-led. Representatives from the CQC continue join the Trust's quarterly system oversight meetings.

As well as routine contact from the CQC in relation to queries (concerns and complaints raised directly with the CQC by others, which the Trust is asked to respond to), the CQC re-introduced formal engagement meetings during 2024-25 and these were held quarterly with the Trust. At the engagement meeting in September 2024 the Trust delivered a comprehensive presentation to provide assurance about its performance against key aspects of the well-led standards. At both our system oversight meetings and engagement meetings the CQC has continued to advise that the Trust is considered 'low risk' for the CQC's purposes.

*Information on personal data related incidents that have been formally reported to the Information Commissioner's Office (ICO) are detailed in the annual governance statement on page 68.

## Directors' assurance

The directors have been responsible for preparing this annual report and the associated financial accounts. The directors are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance and strategy.

To the best of the directors' knowledge, there are no known material inconsistencies between:

- the annual governance statement
- the corporate governance statement and annual report
- CQC insight reports and any consequent action plans

## Disclosure of information to Trust auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

## Income disclosures

The Trust has met the requirement of Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that its income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provisions of goods and services from other purposes. The impact of other income which the Trust has received has been invested in the provision of goods and services for the purposes of the health service in England.

**Professor Tim Orchard, Chief executive**
**27 June 2025**

# Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items in comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

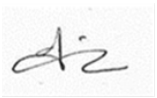
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts. The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Trust board

**Professor Tim Orchard, Chief executive**
**27 June 2025**



**Jazz Thind, Chief financial officer**
**27 June 2025**

# Statement of the chief executive officer's responsibilities as accountable officer for the Trust

The chief executive of NHS England has designated that the chief executive should be the accountable officer of the Trust.

The relevant responsibilities of accountable officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

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

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

**Professor Tim Orchard, Chief executive**
**27 June 2025**

# Annual governance statement

## Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, while 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 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 Trust Accountable 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 policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

Risk is managed at all levels in the organisation, from ward to board. Due to the size and complexity of the Trust, there are three main levels of leadership in risk management: directorate, divisional and corporate. These mirror the Trust organisational structure and risks are escalated to the next management level based on the impact they can have and the capacity to manage them.

Risk management training is available via e-learning to all managers across the organisation.

The Trust board, operating as board in common, takes collective responsibility for setting out the strategic direction of the Trust, including setting the risk appetite.

The Trust board is accountable for upholding high standards of governance and probity. The chairman and non-executive directors provide strategic guidance and support.

## The risk and control framework

The Trust has a system of internal control, ensuring effective reporting and escalation mechanisms. This includes divisional and directorate level management and quality groups, as well as specialist committees (for example health and safety and infection prevention and control), where quality, safety and performance reports are reviewed and issues or risks escalated, as appropriate.

The Trust control framework is in continuous evolution and grows with the risk management culture of the organisation. Aligned with the control framework is the Trust risk management framework, which consists of the:

- risk appetite statement which sets the amount of risk that the Trust is prepared to accept or tolerate for each area of risk
- risk management policy which seeks to ensure that appropriate systems of internal controls are in place to oversee, monitor and manage risk
- risk registers which document risks at each level of the Trust, including actions to control, mitigate or resolve
- corporate risk register, which contains the most significant operational risks and issues for the

Trust
- board assurance framework, which contains the strategic risks to the achievement of the Trust priorities

The risk management framework supports the development of an organisational approach to risk management, whereby effective risk management is an integral part of providing healthcare and day-to-day decision making.

Implementation of the risk management framework is overseen by the executive management board monthly. The audit, risk and governance committee oversees the effectiveness of the system of internal control, including the implementation of risk management at the Trust, via the board assurance framework, committee reports and the risk and assurance deep dives process.

The Trust risk appetite is agreed by the board, taking into account current risk exposure, strategic objectives and risk capacity. The appetite is then cascaded to the whole organisation.

The risk management policy describes the approach that the Trust takes to identifying, managing and mitigating risk. Each directorate and division maintain a risk register with clinical and non-clinical risks. The divisional management committees ensure that staff identify and mitigate risk appropriately; scoring risks using a standardised matrix, which includes likelihood and consequence. If risks cannot be satisfactorily resolved or managed, they are considered for escalation on to the divisional registers. In turn these risks are reviewed for escalation onto the corporate risk register as appropriate, if they have a risk score of 16 or above and are classified as extreme risks.

Risks are identified from various sources including proactive risk assessments, strategic planning, performance data, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, whistleblowing, stakeholder/partnership feedback and internal and external assurance from stakeholders such as the Care Quality Commission and NHS England.

Risk management is embedded within the organisation and is actively included in key business processes, such as business and capital planning, and quality impact assessment for cost improvement programmes.

The reporting and feedback mechanisms are in place as outlined below.

The executive management board (EMB) meets monthly to review progress against strategic objectives, setting and deploying strategy, managing performance, prioritising initiatives against organisational capacity, ensuring it supports the Trust's overall promise of 'Better health, for life', and aligns with our clinical and corporate strategies and the north west London sustainability and transformation plan. The EMB also acts as the Trust executive risk committee but delegates the monthly review of the corporate risk register and the board assurance framework to the EMB risk committee, which then reports to the EMB.

The EMB provides assurance to the Trust board that mitigations are effective and risks are adequately controlled and monitored. Clinical audits, the internal audit programme and external reviews and inspections of the organisation are additional sources used to provide assurance that these processes are effective and risk management is fully embedded.

The board assurance framework and board committee risk and assurance 'deep dives' provides a high-level assurance process for the management of key risks. This enables the Trust to focus on the risks to delivering its strategic priorities and the ways in which assurance is given that these risks are mitigated or managed to an acceptable level.

Compliance with the NHS provider licence is routinely monitored through the NHS Oversight Framework but, on an annual basis, the licence requires the Trust to self-certify as to whether the organisation has effective systems, governance arrangements, and the resources required to ensure compliance. The 2024-25 self-certification processes concluded that the organisation had taken the necessary precautions as were necessary in order to comply with the conditions of the licence, any

requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. Risks to our continued compliance with the licence provisions were considered as part of this review, including the principal organisational risks held on the board assurance framework.

The Trust's principal risks are included in the board assurance framework and managed by the executive management board risk committee. Principal risks are defined as those risks where the overall rating (likelihood x impact) is 16 or over.

The principal risks are summarised below.

| Description (Impact) | Score | Trust Committee | Controls in place to mitigate risk |
|---|---|---|---|
| **Strategic goal 1:** To help create a high quality integrated care system with the population of north west London | | | |
| **Health inequality in our population:**<br>Risk of not delivering improvement in the equity of care we provide at the Trust, thereby not contributing to reducing health inequalities in the population we serve | 16 | Quality | • a health equity team has been established who are developing a health equity framework to guide and focus our work in this area; this is linked with and informs wider work across the acute provider collaborative and integrated care board<br>• digital and data strategy focusing on the availability of data to enable areas of inequality to be identified<br>• utilising existing quality expertise and infrastructure at directorate, divisional and Trust level to ensure monitoring and, where necessary, improving our population's access to, experience of and outcomes from the care we provide |
| **Mental health delays for medically optimised patients:**<br>Failure to transfer medically optimised patients to mental health inpatient settings due to lack of available beds impacting on patient safety and experience | 20 | Quality | • mental health performance dashboard<br>• escalation to the emergency department delivery board, ICS CEOs meetings and at system oversight meetings<br>• regular surveillance at mental health steering group and between teams<br>• increased registered mental health nurse workforce with enhanced security presence and dedicated consultant lead<br>• escalation of delays in real time with partners within the ICS |
| **Poor condition of estates:**<br>Inability to provide appropriate condition of buildings and infrastructure on the St Mary's site, impacting on patient, visitor and staff safety and effective clinical delivery | 20 | Redevelopment | • planned preventative maintenance programme<br>• hard facilities management (FM) contract<br>• water safety and ventilation group and medical gases committee overseeing compliance with safety standards<br>• touch point for proactive management of emerging issues<br>• backlog maintenance programme<br>• urgent jobs prioritised as P1<br>• business continuity plans and estates contingency planning |

| Description (Impact) | Score | Trust Committee | Controls in place to mitigate risk |
|---|---|---|---|
| **Data quality:**<br>Risk of delays in patient access, reputation and operational performance due to poor data quality across people, process, systems and reporting | 20 | Audit, risk and governance | • a number of mitigations are in place such as audit, validation and key data quality indicators<br>• where patient safety concerns are identified these are escalated to the medical director's office via the clinical harm assurance group<br>• data quality strategy and improvement programme underway<br>• data quality improvement programme focusing on outpatient data quality, supported by the Trust transformation team<br>• data quality strategy/priorities overseen by the audit, risk and governance committee |
| **Strategic goal 2:** To develop a sustainable portfolio of outstanding services | | | |
| **Financial sustainability:**<br>Risk of not delivering an improvement in the underlying deficit and achieving a sustainable financial position | 20 | Finance, investment and operations | • tracking of underlying position<br>• overseeing identification and delivery of organisational cost improvement plans<br>• provider collaborative working to establish recurrent and non-recurrent funding and review of income funding |
| **NHP funding and affordability:**<br>Inability to secure national funding from NHP for the redevelopment programme resulting in the continued provision of services from inadequate estates and suboptimal clinical configurations, potentially compromising the quality of care, operational efficiency, and the ability to meet future healthcare demands | 16 | Redevelopment | • regular meetings with councils, Greater London Authority (GLA), NHS England and New Hospital Programme with stakeholder engagement plans including internal communication plans<br>• timely submission of business cases for funding approval<br>• regular engagement with clinicians through models of care work |
| **Strategic goal 3:** To build learning, improvement and innovation into everything we do | | | |
| **Operational consequences of a pandemic:**<br>Risk of a safe operational delivery, performance, finance, quality, reputation and safety of people during or following a pandemic | 20 | Audit, risk and governance | • Trust emergency, preparedness, resilience, and response (EPRR) framework with business continuity plans at service level<br>• national and international horizon scanning.<br>• FFP3 mask fit testing programme<br>• Imperial College Healthcare communication arrangements<br>• pandemic plan assessed and approved by NHS England<br>• robust command and control plan<br>• capability of virtual clinics and meetings<br>• staff redeployment plan<br>• collaborative planning approach with both NHS, multi-agency and site partners |

The audit, risk and governance committee oversee and monitor the effectiveness of the risk management framework, informed by internal auditors undertaking reviews and providing assurance to the committee on the systems of control operating within the Trust.

The condition of the Trust estate and the need to redevelop our hospital sites has also been identified as a significant risk facing the Trust through 2024-2025 and as it enters 2025-26:

## Estates and redevelopment

During 2024-25 the Trust continued to pursue the strategy agreed with the New Hospital Programme (NHP) of advancing the design and town planning for the new St Mary's Hospital to gain a town planning consent. A business case for the funding to advance the hospital design was approved in July 2024. However, following the general election the Secretary of State called for a review of the NHP and the release of the funding was delayed.

The outcome of the NHP review was announced in January 2024. Disappointingly the construction start date for all three of our schemes, St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital have been delayed beyond 2035. This timing is inconsistent with the very significant clinical and estates risks that our infrastructure poses with the chance of a catastrophic estates failure ahead of our new estate now a real possibility. There was some positive news as the Trust has secured £16.4 for 2025-26 to progress detailed design and planning for St Mary's Hospital.

Following the NHP review the Trust, Westminster City Council, Imperial College Healthcare and the Imperial Health Charity in partnership with our local MPs, have established a joint funding taskforce. The purpose of the taskforce is to identify alternative funding mechanisms that will bring forward the construction date for the new St Mary's.

The Fleming Centre project gathered pace during 2024-25 culminating in December with the public architectural competition to select the project architects. Five high quality submissions were received and the process ended with the selection of Stanton Williams. The project is now progressing through the design phases. It is anticipated a planning application will be submitted towards the end of 2025 with an anticipated construction start date of September 2026.

In addition to our redevelopment plans, the Trust had a very busy operational capital programme, summarised in the following table:

| Category | 2024-25 investment £M |
|---|---|
| Backlog maintenance | 32.0 |
| Digital/ICT | 19.5 |
| Medical equipment and clinical engineering | 14.3 |
| Decarbonisation and energy efficiency | 22.5 |
| Refurbishments and other capital projects | 28.3 |
| Leased assets (IFRS16) | 11.7 |
| **TOTAL** | **128.3** |

## Backlog maintenance

The backlog maintenance programme successfully navigated a complex landscape earlier in the year, addressing a surge in urgent works and proactively brought forward expenditure from 2025-26 to mitigate potential underspending across the capital programme. Key highlights of the 2024-25 backlog maintenance and capital programme include:

- St Mary's Hospital Clarence wing fabric upgrades

- St Mary's Hospital Albert ward refurbishment
- Hammersmith Hospital energy centre burner replacement (carbon reduction project)
- fire safety upgrades
- significant unplanned capital expenditure to address urgent breakdowns and major repairs, ensuring the continued functionality of the Trust's estate and infrastructure

**Digital/ICT** – three key projects were delivered that both strengthened the Trust's infrastructure and laid a solid foundation for future technological growth and operational efficiency across the Trust:

- the network replacement project which commenced in 2019 was completed, bringing improved resilience, security, and scalability despite COVID-19 delays.
- the server and storage solution enhanced performance, efficiency, and sustainability while reducing costs. Phase 1 of the data centre strategy that established a co-location facility at Cody Park, ensuring robust connectivity, with full migration set for completion by December 2025

## Medical equipment and clinical engineering

Strategic planning and effective negotiations resulted in over £1.0m in revenue savings through various equipment replacement investment portfolios, multiyear warranty extensions, and pooled resource models. The standardisation of equipment across services also led to reduced equipment downtime and increased availability, showcasing the value of effective and excellent collaboration with clinicians and suppliers. Clinical engineering were not only able to deliver against the core replacement schedule, but also to support the wider capital position by bringing forward several equipment replacement programmes including new Drager pendants for our critical care beds in Hammersmith Hospital.

## Decarbonisation and energy efficiency

The Trust continued to work with decarbonisation partner, Dalkia, on projects at Charing Cross and Hammersmith hospitals, substantially funded by grants from the Public Sector Decarbonisation Scheme. A total of £22.5m was invested across both sites in 2024-25 and when complete, the programme will save the Trust 5,219 tonnes of CO2 emissions – the equivalent of driving 31.3 million miles in the average diesel car.

## Refurbishments and other capital projects

The capital projects team was able to progress and deliver a number of projects in the year, including:

- the Health at Stowe ophthalmology diagnostic hub
- Hammersmith Hospital oncology expansion
- the staff resource centre at St Mary's Hospital
- St Mary's Hospital flagship food and retail refurbishment
- reconfiguration of the St Mary's urgent treatment centre

## Care Quality Commission regulatory framework

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The Trust was compliant with the requirements of its CQC registration and was not subject to any enforcement action during 2024-25.

The CQC did not carry out any inspections of the Trust or its services during 2024-25.

We participated in routine engagement meetings with the CQC during 2024-25, responded to routine requests for data and information, and responded to general enquiries from the CQC (complaints or concerns about the Trust are raised either directly by the CQC in response to their

intelligence or by others such as patients, families, members of the public, and so on). The CQC attends the Trust's system oversight meetings (SOMs), and we continue to be advised that all of these activities continue to indicate that the Trust is 'low risk' for the CQC's purposes, and that no individual services flag for them as being higher risk. The Trust participated in one national review carried out by the CQC during 2024-25 which related to safety and quality of children's hearing services, based on an improvement initiative launched by NHS England in 2022; the review included submission of data and information, and an on-site visit. The CQC confirmed with the Trust that there were no concerns about its children's hearing services; however, the CQC is no longer expected to publish a report of its findings as they will be incorporated into a wider government review, called the Kingdon review, that will bring together the NHS England programme and the CQC's review. The review was announced on 9 May 2025; the Trust is not expected to be included in the Kingdon review due to its positive outcomes in both the NHS England review (which we completed in 2023) and the CQC's review last year.

The CQC requires all trusts to participate in the NHS England's patient survey programme. The outcomes of the following surveys were published in 2024-25:

- 2023 Adult Inpatient survey, published August 2024
- 2023 National Cancer Patient Experience Survey (NCPES), published August 2024
- 2024 Maternity survey, published November 2024
- 2024 Urgent and Emergency Care survey, published November 2024.

We generally performed favourably in these surveys both compared to previous performance, and in relation to other trusts. No serious concerns were raised in any survey published this financial year; where improvements were needed, they were managed in line with normal Trust processes.

## Our workforce

The Trust people priorities 2024-25 set out a clear vision for our workforce. Each year, the Trust draws on these Trust annual priorities alongside national, regional and local drivers.

The national NHS People Plan and NHS People Promise, launched in 2020-21 sets an ambitious challenge to all NHS organisations; the NHS needs "more people, working differently, in a compassionate and inclusive culture". We have aligned our Trust people priorities to the national approach, which is also being adopted by the acute provider collaborative, where the people priorities are based around the four pillars in the national people plan. Progress against our strategy is monitored on a monthly basis by the people executive management board (EMB) and summarised for the people committee and collaborative people committee.

To ensure rigour around monitoring and early escalation of concerns, we reviewed monthly progress against the people priorities at the EMB people meeting, providing an update on delivery of the people priorities, performance against key milestones and associated metrics, updates on future activities and links to corporate and local risks. This report will also be summarised for EMB, people committee and collaborative people committee. This includes reporting against all equality diversity and inclusion national requirements.

We use best practice methodology in accordance with Developing Workforce Standards (NHSEI, 2018) and 'Safe, Sustainable and Productive Staffing' (National Quality Board, 2016), using evidence based tools (Safer Nursing Care Tool) to accurately assess patient acuity and dependency and apply staffing ratios and professional judgement across all adult inpatient wards, acute assessment units, emergency departments, and children's and young persons inpatient areas. We use this to review nursing establishments every six months and formally report these reviews via Trust committees. We review nursing and midwifery actual vs planned numbers on a monthly basis, and benchmark care hours per patient day as part of this review.

## Integrated performance management

Improvement for All, one of the Trust's key programmes, is refreshing the Trust's improvement approach so that it is systematically embedded into how we run our organisation, including our approach to integrated performance management.

The Trust's improvement methodology has been re-framed as a structured problem-solving approach which is applicable to all elements of our work. All directorates will have a single improvement plan bringing together all improvement requirements in a single document which is explicitly prioritised and aligned with the Trust strategy. Improvement-driven routines, including those outlined in the performance and accountability framework, will ensure that we put our improvement plans and improvement method into practice. A key enabler of this is data and insights to identify issues, inform diagnosis of root causes and monitor the impact of improvements.

The integrated performance scorecards have been designed to align more clearly with strategic objectives and priority programmes whilst continuing to maintain oversight of statutory national standards. The scorecards are balanced and contain a suite of metrics covering quality, safety, workforce, operational response and recovery and finance.

The scorecards differentiate between 'driver metrics', prioritised areas for improvement and 'watch metrics', where performance is at an acceptable level, but visibility is important. Business rules accompany the scorecard which provide guidance on appropriate response during performance meetings e.g. sharing successes, giving structured verbal updates or presentation of a countermeasure summary with trend analysis and improvement actions.

Performance data is discussed routinely through the meetings of the Trust board, board committees, executive management board, executive subgroups, divisional performance and accountability review meetings and directorate performance meetings. This framework allows detailed reviews and assurances to be given where potential issues are identified, with instigation of quality improvement plans and escalations.

## External oversight

All trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence. The single oversight framework remains the external mechanism for NHS England to oversee organisational performance and identify any support needed to deliver high quality, sustainable healthcare services.

Throughout 2024-25, the Trust has continued to have provider oversight meetings led by the integrated care board (ICB) with support from the NHS England regional team and other regulators such as CQC.

Trusts are segmented according to the level of support needed across themes of quality, finance and use of resources, operational performance, strategic change and leadership. Each Trust is segmented into one of four categories ranging from 1 (greatest autonomy) to 4 (mandated intensive support). The Trust is in segment 2.

The approach to system-based performance is set out in the NHS oversight framework.

## Review of economy, efficiency and effective use of resources

The Trust has a range of processes to ensure resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff and the presentation of finance and performance reports monthly to the executive management board and bi-monthly to the finance, investment and operations committee and the Trust board. The Trust has an agreed risk-based annual audit programme with the Trust's internal auditors.

These audit reports are aimed at evaluating the Trust's effectiveness in operating in an efficient and effective manner and are focused, in part, on reviewing operational arrangements for securing best

value and optimum use of resources in respect of the services we provide. The head of internal audit's opinion provides assurance regarding the robustness of the system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. More information about our committees, their structure and responsibilities as well as our compliance with the NHS Code of Governance is included in the corporate governance report.

To ensure that any cost improvement schemes, a key part of the Trust's focus on economy, efficiency and effectiveness, do not impact adversely on the quality of patient care, a Trust board approved quality impact process is usually used to review schemes. Schemes approved by the responsible director are then reviewed and risk assessed by the medical director and chief nurse prior to sign off; schemes rated as high risk require mitigations and controls in place before approval is granted. Post-implementation reviews occur to ensure that low risk scoring schemes did not have a higher quality impact than expected and that the controls enacted for high-risk scoring schemes were effective. If a serious quality impact begins to materialise during implementation, schemes are stopped.

As discussed above in the risk section of the report, we have identified one of our principal risks is financial sustainability. The Trust's external auditors have reported a 'significant weakness' in this area and made a recommendation to the Trust regarding implementation and timely identification of savings opportunities as set out in their audit report on page 112. However, the Trust has made progress since the year's end in identifying efficiencies with a considerable proportion of the efficiency target being identified in the early part of 2025-26 and mitigations are in place in the early part of the year to ensure that we stay on track to deliver our financial plan.

## Data security and protection shared service

The data protection office shared service was implemented in April 2023. The shared service consists of the following four services:

- Imperial College Healthcare NHS Trust data protection officer services
- NHS North West London Integrated Care Board (ICB) – corporate data protection officer services
- NHS North West London ICB – GP data protection officer services
- NHS North West London Integrated Care System – data protection officer services

The new service has been created following a transfer of the NHS North West London ICB data protection officers into the Trust to form a data protection office shared services team.

## Data protection framework

The Trust has a published data protection framework designed to deliver compliance with the General Data Protection Regulation (UK-GDPR), Data Protection Act 2018 and the NHS digital data security and protection toolkit.

## Data security and protection committee

The data security and protection committee is responsible for oversight of Trust data protection and security policies and monitoring the mitigation plans identified in the information and communications technology risks.

## Chief information officer/senior information risk officer

The chief information officer acts as the senior information risk officer, a role designed to take ownership as an advocate for information risk on the Trust board, with overall accountability for data protection and cyber security.

## Chief clinical information officer/Caldicott Guardian

The chief clinical information officer/Caldicott Guardian is the appointed senior clinician with ultimate responsibility to oversee the use and sharing of patient identifiable clinical information. This is a key advisory role in ensuring the Trust satisfies the highest practical standards for handling patient identifiable information.

## Data protection officer

The data protection officer is a role assigned in compliance with, and duties outlined in, the Data Protection Act 2018. These include to inform and advise the organisation and its employees about their obligations to comply with the UK-GDPR and other data protection laws; to monitor compliance with the UK-GDPR and other data protection laws, including managing internal data protection activities; advise on data protection impact assessments; train staff and conduct internal audits; and to be the first point of contact for the Information Commissioner's Office (ICO) and for individuals (patients/staff) whose data is processed.

## Data security and protection toolkit

The NHS digital data security and protection toolkit (DSPT) is an online self-assessment tool that enables organisations to measure and publish performance against the national data guardian's ten data security standards. It consists of three leadership obligations, 10 data security standards, and 45 contributing outcomes – all now aligned with the national Cyber Assurance Framework (CAF). Following the COVID-19 pandemic, the submission period for the data security and protection toolkit now runs from 1 July to 30 June every year. The data protection office shared service has in place data security and protection toolkit planners, action plans and metrics to ensure a successful submission of the toolkit in June 2025 accompanied by a "standards met" "low risk" audit opinion.

## Data security and protection training (DSPT)

The 2024-25 data security and protection training brings about a change in the assessment and review of data security and protection training compliance. The new requirement states staff must have an appropriate understanding of information governance and cyber security and the Trust can develop a range of approaches to ensure training and awareness. There is a new flexibility for trusts to develop and deliver their own training materials pursuant to ensuring better understanding and compliance among groups of staff. This means the new focus will be on a detailed training needs analysis (TNA) and programmes of training tailored to specific staff groups where the frequency of delivery of training can be amended based on the depth of information provided. There is a plan in place to achieve the annual mandatory training target for the 2024-25 Data Security and Protection Toolkit return by 30 June 2025.

## Data security and protection incidents – April 2024 to March 2025

The Trust is mandated to report all incidents via the data security and protection toolkit. In cases where there is a risk to the rights and freedoms of data subjects the incident reporting tool will automatically notify the Information Commissioner's Office and Department of Health and Social Care.

## Incidents reported April 2024 – March 2025

| Grade of incident | Number |
|---|---|
| Incidents reported to the ICO and Department of Health* | **9** |
| Trust-level incident | **5 (part of above figures)** |
| Incidents under investigation yet to be classified | **70** |
| **Total** | **79** |

* This is the total number of personal data breaches that we have reported to the ICO and the Department of Health via the NHS England Data Security and Protection Toolkit. Note that the UK GDPR, under Article 33 (Notification of a personal data breach to the Commissioner), mandates a data controller to report a personal data breach "without undue delay and, where feasible, not later than 72 hours after having become aware of it, notify the personal data breach to the Commissioner, unless the personal data breach is unlikely to result in a risk to the rights and freedoms of natural persons. Where the notification under this paragraph is not made within 72 hours, it shall be accompanied by reasons for the delay".

## Analysis of types of incidents (not mutually exclusive)

The following are categories of incidents. This analysis provides a high-level overview of the areas of work creating greatest concern. These figures have been used to support prioritisation of formal process reviews in order to identify service improvements and risk mitigations that may be implemented.

| Category of incident | Number |
|---|---|
| Loss / theft | **1** |
| Email | **2** |
| Abuse of authorised access | **25** |
| Counter fraud | **1** |

## Incidents reported to the Information Commissioner's Office and Department of Health and Social Care (Total = 9)

| Incident | Summary of incident | Incident details | Action taken by ICO |
|---|---|---|---|
| 1 | P2302271718<br><br>A report was sent regarding a child patient to the patient's school by a Trust paediatrician without the consent of the patient's parent/s. | Trust paediatrician sent a report to the patient's school without the consent of the parent. The letter contained information about the parent and the child (childbirth complications, breastfeeding, IVF, family history). The DPO team had a meeting with the Caldicott Guardian. It was decided that this was a high-risk level 2 incident and therefore reportable to the ICO. Since this incident, the team have already made changes to the process by ensuring no child is put on the referral pathway for autism and ADHD until the consent form is signed. | ICO confirmed no further action required. |
| 2 | P2402161221<br><br>Four patient letters were mistakenly handed to the wrong patient. | A clinic secretary erroneously handed an envelope of correspondence to a patient at St Mary's Hospital which included the letters of four other patients. The letters include identifiers such as the patient's name, date of birth, address, gender, and diagnosis. This was classed as a high-risk level 2 incident at the time of reporting due to non-containment but has since been contained. | ICO confirmed no further action required. |
| 3 | P2407291031<br><br>A global outage affecting Microsoft and CrowdStrike which affected Trust systems | A global Crowdstrike and Microsoft IT outage was reported on 16 July 2024 and this outage affected several systems within the Trust. It was identified that this loss in the availability of systems (for example those holding patient records) constitute a personal data breach. As the DPO were unable to fully predict the impact of the incident on direct care, this was automatically classed as a high-risk level 2 incident by the DSPT. | The DHSC contacted the Trust for an in-depth risk assessment, which was provided, after which there were no follow up actions required. |
| 4 | P2405011139<br><br>Alleged abuse of authorised access of a patient's record by a Trust staff member | A complaint was filed by patient against a member of staff who was suspected of abuse of unauthorised access of the patient's record. The initial investigation by P&OD failed to mention unauthorised access to the patient's medical record and therefore, the DPO deemed this incident a high-risk level 2 incident. | ICO confirmed no further action required. |
| 5 | P2408211731<br><br>Staff member adding incorrect data entries against patient's records. | The staff member who checked this patient into the Lindo Wing was being performance managed due to general poor performance and with particular note, inputting data entries incorrectly resulting in significant errors in recording information. This led to incorrect invoices being sent out. Owing to the impact on data subjects' rights, the DPO deemed this incident as a high-risk level 2 incident. | ICO confirmed no further action required. |

| Incident | Summary of incident | Incident details | Action taken by ICO |
|---|---|---|---|
| 6 | P2411251135<br>A patient's appointment information was shared with the patient's ex-partner | A staff member from the contact centre shared confidential medical information regarding a surgical termination of pregnancy of a patient under safeguarding with the patient's ex-partner over a telephone call. Due to the clinical and safety risk to the patient as a result of the incident, the DPO deemed this incident as a high-risk level 2 incident. | ICO confirmed no further action required. |
| 7 | P2412161550<br>Patient's personally identifiable data (PID) was shared with a Trust shared mailbox. | A staff member from the Care Information Exchange (CIE) sent an email to the imaging department shared inbox, which contained a patient's name, email address, and contact number. This resulted in the email being sent to 190 recipients, some of whom were no longer employed by the Trust. As it was not possible to recall all the emails, the DPO deemed this incident as a high-risk level 2 incident. | ICO confirmed no further action required |
| 8 | P2411211657<br>Taxi journey information for 89 Trust staff was shared with 63 other Trust staff members via email. | An employee of the HATS Group, a data processor, conducted a mail merge to send taxi booking confirmations to NHS staff. The employee inadvertently sent each recipient's journey information to 63 other NHS staff members. This included booking confirmations for 89 individuals. As the DPO were unable to recall all the emails that were sent, it was determined that it would not be possible to fully contain the incident. Therefore, this was determined to be a high-risk level 2 incident. | ICO confirmed no further action required. |
| 9 | P2401191540<br>A patient's letter was sent to an incorrect email address. | A patient's letter was sent to an incorrect email address as an extra letter was mistakenly added to the patient's email address, resulting in the email being sent to the wrong recipient. The email contained the patient's hospital number, NHS number, appointment date, name and address. As the DPO were unable to receive a response from the incorrect recipient to delete the email and letter, it was not possible to fully contain the incident, and therefore this was determined to be a high-risk level 2 incident. | ICO confirmed no further action required. |

## Data quality and governance

Accurate and high-quality information is essential for effective decision-making and enhancing patient care and safety. For 2024-25, the Trust successfully achieved the benchmark for the Data Quality Maturity Index, a national measure that evaluates data quality by monitoring coverage, consistency, completeness, and validity across key patient-level datasets, with results published by NHS England.

In recent years, broader operational challenges have impacted the quality of waiting list data. We actively manage these risks and prioritise improvements through our waiting list data quality and reporting framework. This framework, led by our chief operating officer, regularly reports to the executive management board. A vital element of our strategy involves implementing a quality assurance process that identifies data quality errors and promotes training, learning, and development. The performance support team oversees a rolling audit programme to ensure patient pathways are recorded and reported appropriately across key operational waiting lists and patient waiting times. Alongside these ongoing assurance reviews, we conducted 85 individual audits of waiting list data quality throughout the year, enabling us to understand and address the root causes of data inconsistencies. For example, using results to direct educational efforts as part of routine performance-oriented operational learning forums to improve waiting list management.

Throughout 2024-25, the performance support team continued to focus on improving outpatient data quality as a dedicated workstream within the Trust's outpatient improvement and transformation programme. In 2024-25, we collaborated with staff to design processes that enhance outpatient data quality and minimise waiting list errors occurring at the front end of our systems, and we implemented tools and dashboards for outpatient models of care to assist staff in managing Cerner waiting lists.

The Trust is committed to continuously transforming data quality, ensuring that it is accurate, complete, and timely. Our goal is to shift from reactive data validation to consistent business-as-usual processes supported by proactive, real-time corrections.

## Register of interests

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

The Trust is required to hold and maintain a register of details of company directorships and other significant interests held by Trust board directors which may conflict with their management responsibilities. This register is updated on the change of any directors' interests and is reported formally to the Trust board annually; the register is available to the public on the Trust website.

The Trust board considers that all its non-executive directors are independent in character and judgement. Where potential conflicts of interest are identified in relation to matters to be discussed by committees or Trust board, these are recorded and the individual excluded from the discussion.

In addition, the Trust seeks annual declarations from all staff graded band 8d and above. Returns for 854 staff, 63%, had been returned at the end of March 2025.

The Trust has published on its website an up-to-date register of interests 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.

The register can be found here: https://www.imperial.nhs.uk/about-us/foi/lists-and-registers

## Pensions and remuneration

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.

Details of directors' remuneration and further information on the wider workforce are set out in the remuneration and staff report as are exit packages and severance payments, and the Trust off-payroll engagement disclosures (which are in accordance with HMRC requirements). The Trust's external auditor and details of their remuneration and fees are also set out in the accounts.

## Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. We continue to see progress towards our goal of becoming truly fair and inclusive organisation. For example, increasing the representation of Black, Asian and minority ethnic staff at senior levels so that our workforce is representative of the communities we serve; providing adequate reasonable adjustments to our disabled staff; and launching an ambitious engagement programme to facilitate important discussions with our staff, patients and community groups to help us develop a shared understanding of what it means for us to be truly fair and inclusive. Further information can be found in our report for 2024-25 which will be published in autumn 2025.

## Sustainability

The Trust has a board approved Green Plan for the period 2024-25 to 2026-27 with a named director to lead on its implementation. The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with. The Trust recognises that the delivery of the Green Plan is a strategic risk and this has been assessed and is included on the board assurance framework.

## Emergency preparedness, resilience and response

The Trust is required and has put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS emergency preparedness, resilience and response (EPRR) framework 2022. The Trust participates in the annual EPRR assurance process carried out by NHS England and is rated as having 'substantially compliant' assurance against the national EPRR core standards.

## Annual quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

The quality report has been prepared in accordance with the requirements set out in the ***NHS foundation trust annual reporting manual 2019-20 and supporting guidance: Detailed requirements for quality reports 2019-20.***

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our quality committee held in May, and at our audit, risk and governance committee held in June, where the authority of signing the final quality account document was delegated to the chief executive and chair.

## Chief executive's review of effectiveness

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive

managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other 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, risk and governance committee and other board committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In support of this:

- the head of internal audit has provided me with reasonable assurance that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are being applied consistently. Internal audits carried out have all received ratings of 'significant assurance with minor improvement opportunities' or 'partial assurance with improvements required'. For all audits completed, management have accepted, and taken action to address recommendations made
- executive directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements also confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it
- the Trust board reviews risks to the delivery of the Trust performance
- the board assurance framework and risk registers provide me with evidence of the effectiveness of the controls used to manage the risks to the organisation achieving its strategic objectives have been regularly reviewed
- the Trust's committee structures ensure sound monitoring and review mechanisms to ensure the systems of internal control are working effectively
- the Trust has continued to engage with the CQC through regular engagement meetings
- other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports; mortality monitoring; reports from external assessments; Deanery and Royal College assessments; accreditation of clinical services; and patient led assessments of the care environment

I can confirm, having taken all appropriate steps to be aware of potential breaches or failures to comply, that arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant.

## Conclusion

The Trust board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. The board is also committed to ensuring that serious incidents, as well as the incidence of non-compliance with standards and regulatory requirements, are escalated and subject to prompt and effective remedial action. This is to ensure that patients, service users and staff and stakeholders of Imperial College Healthcare NHS Trust can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

No significant control issues have been identified in 2024-25. We recognise the risk to the Trust securing medium term financial sustainability (see the review of economy, efficiency and effective use of resources on page 80) and are developing a medium-term financial plan.

**Professor Tim Orchard, Chief executive**
**27 June 2025**

# Remuneration and staff report

The remuneration and staff report sets out the organisation's remuneration framework for directors and senior managers, and sets out the amounts awarded to directors and senior managers including performance-based remuneration where applicable.

The senior officers to be disclosed in the remuneration report comprise those executive and non-executive directors holding voting rights for board and board sub-committee meetings. Remuneration for the Trust's executive directors is determined by the remuneration committee of the board.

Remuneration consists mainly of salary and pension benefits in the form of contributions to the NHS pension fund.

Annual salary increases are ordinarily in line with increases for the wider NHS workforce but may be higher where there is a significant change to an individual's responsibilities.

In order to attract high quality candidates to senior posts and to support retention, the Trust is able to offer salaries on an individual basis (i.e. 'spot' salaries). The Trust has offered spot salaries to 31 senior managers who are not executive directors.

Spot salaries enable the Trust to make decisions in the context of the current market and take into account relevant comparator data inside and outside the Trust. Salaries are assessed against the pay ranges set out in the 2018 national guidance for very senior managers (VSM), uplifted for annual pay awards since 2018. Non-standard roles or significant changes to executive roles are evaluated externally using a structured and recognised job evaluation system. New joiner salaries, and any changes to salaries, are approved by the remuneration committee. Any salaries above £150,000 are submitted for national approval in line with the VSM pay guidance.

Salary levels typically take effect from 1 April and salary levels for those executive directors who are voting members of the board are disclosed in the following pages.

Non-executive directors are normally appointed on fixed term contracts of between two and four years. Non-executive directors are not generally members of the pension scheme. Remuneration for non-executive directors is set by NHS England based on a national framework.

The remuneration of all other members of staff is determined by national terms and conditions such as the Agenda for Change and medical consultant terms and conditions.

## Pay multiples (subject to audit)

The Trust is required to disclose the relationship between the remuneration of its highest-paid director against the 25th percentile, median and 75th percentile of remuneration of its workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

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

The banded remuneration (shown as £5k band range) of the highest paid director changed between financial years as shown in the table below:

| Highest paid director | 2024-25 | Change from prior year (%) | 2023-24 | Change from prior year (%) |
|---|---|---|---|---|
| Total remuneration (£) | £330k - £335k | 6.4% | £310k - £315k | 5.0% |
| Salary component of total remuneration (£) | £320k - £325k | 6.6% | £300k - £305k | 5.2% |
| Performance pay and bonuses component of total information | £5k - £10k | 0.0% | £5k - £10k | 0.0% |

It should be noted that whilst this disclosure is required to show pay with reference to the mid-point of the applicable £5k band, the actual increase in salary may be more or less than the increase shown, depending on whether the movement drives a change from one £5k band to another.

The following tables compare the banded remuneration of the highest paid director:

| 2024-25 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration (£) | 36,203 | 47,980 | 61,927 |
| Salary component of total remuneration (£) | 36,203 | 47,980 | 61,927 |
| Pay ratio | 9.18 | 6.93 | 5.37 |

| 2023-24 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration (£) | 34,378 | 45,225 | 58,612 |
| Salary component of total remuneration (£) | 34,378 | 45,225 | 58,612 |
| Pay ratio | 9.09 | 6.91 | 5.33 |

The year-on-year change in ratio is comparatively small, with a minor increase in the 25th and 75th percentiles. This change will be influenced by movements in the composition of staff in different bands across the year and the impact of pay awards relative to the composition of the staff in the year. The highest paid director's remuneration is uplifted in line with pay awards to other relevant staff groups.

In 2024-25, there were no employees who received remuneration in excess of the highest paid director (zero in 2023-24). Remuneration ranged from £20k to £25k to £330k to £335k in 2024-25 (£20k to £25k to £310k to £315k in 2023-24). The calculated average salary across the organisation was £55,506 in 2024-25, which was an increase of 7% from 2023-24 (£52,069, which was an increase of 3% on 2022-23).

The calculation uses standardised reports from the electronic staff record (ESR) system based on the Month 12 position. Calculations are then undertaken to reflect an annualised salary for those whose working pattern is less than full time, or who were in post for less than the whole year.

The calculation also includes assumptions for agency and other temporary employees but excludes consultancy services. Only the remuneration paid to the employee are included.

Agency fees are excluded from the calculation but are not always known so are assumed to be 20% (notional) of total cost.

In addition to pay multiples, the Trust also separately reports on the "gender pay gap" which is the aggregate difference between pay for women and men across the workforce. Information is available via the Government reporting website on gender pay: https://gender-pay-gap.service.gov.uk/employers/6538 These published gender pay gap reports are not subject to audit.

# Remuneration tables

Salary and pension disclosure tables are below; information subject to audit.

## Board arrangements – acute provider collaborative

Since 2022-23, the Trust has been part of the North West London Acute Provider Collaborative. The Collaborative is an arrangement for common governance processes across the four acute providers in the North West London Integrated Care System (Imperial College Healthcare NHS Trust, Chelsea and Westminster NHS Foundation Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust). As part of the acute provider collaborative, trust boards meet as a 'board in common'. The board in common is led by a joint chair who acts as chair for all four trusts, with each trust also having a vice-chair. The board in common comprises executive and non-executive directors from each trust.

Board in common meetings act as the board meetings for each trust within the collaborative but voting on individual trust items is restricted to board members from the relevant trust. More information on the arrangements is provided in the corporate governance section of this annual report.

As part of the collaborative arrangements, all non-executive directors are now required to serve on the boards of at least two of the acute providers in the collaborative. As noted above, the chair is a member of all four boards.

The remuneration report includes all voting directors of the Trust; the chair, non-executive directors and executive directors. Non-executive directors and the chair are paid a combined fee for all their board positions with the acute collaborative providers. The remuneration shown in this report reflects the proportion of their total remuneration relevant to their role with the Trust. Remuneration related to their roles with other members of the Collaborative is included in the annual reports of the relevant organisations. The below tables list all those directors who served during the financial year.

### Non-executive directors' remuneration 2024-25

| | (a) | (b) | (c) | (d) | (e) | (f) = (a to e) |
|---|---|---|---|---|---|---|
| **Salaries and allowances** | **Salary[5] bands of £5,000)** | **Expense payments (taxable) (total to nearest £100)** | **Performance pay and bonuses (bands of £5,000)** | **Long term perfor-mance pay and bonuses (bands of £5,000)** | **All pension related benefits (bands of £2,500)** | **Total remuneration (bands of £5,000)** |
| **Name and title** | **£000** | **£00** | **£000** | **£000** | **£000** | **£000** |
| Matthew Swindells, joint chair | 20 - 25 | - | - | - | - | 20 - 25 |
| Robert Alexander, vice chair / non-executive director | 10 - 15 | - | - | - | - | 10 - 15 |
| Sim Scavazza, non-executive director | 5 - 10 | - | - | - | - | 5 - 10 |
| Nick Gash, non-executive director | 5 - 10 | - | - | - | - | 5 - 10 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Linda Burke, non-executive director | 5 - 10 | - | - | - | - | 5 - 10 |
| Loy Lobo, non-executive director | 5 - 10 | - | - | - | - | 5 - 10 |
| Carolyn Downs, non-executive director[1] | 0 - 5 | - | - | - | - | 0 - 5 |
| Neena Modi, non-executive director[2] | 0 - 5 | - | - | - | - | 0 - 5 |
| Dame Helen Stephenson, non-executive director[3] | 0 - 5 | - | - | - | - | 0 - 5 |
| Catherine Williamson, non-executive director[4] | 0 - 5 | - | - | - | - | 0 - 5 |

## Executive directors' remuneration 2024-25

| | (a) | (b) | (c) | (d) | (e) | (f) = (a to e) |
|---|---|---|---|---|---|---|
| **Salaries and allowances** | **Salary (bands of £5,000)** | **Expense payments (taxable)[9] (total to nearest £100)** | **(bands of £5,000) Performance pay and bonuses** | **Long term (bands of £5,000) performance pay and bonuses** | **All pension related benefits[10] (bands of £2,500)** | **Total (bands of £5,000) remuneration** |
| **Name and title** | **£000** | **£** | **£000** | **£000** | **£000** | **£000** |
| Professor Tim Orchard, chief executive officer[6] | 320 - 325 | - | 5 - 10 | - | 90 - 92.5 | 420 - 425 |
| Professor Julian Redhead, medical director[7] | 295 - 300 | - | - | - | 100 - 102.5 | 395 - 400 |
| Professor Janice Sigsworth, chief nurse[8] | 205 - 210 | - | - | - | - | 205 - 210 |
| Jazz Thind, chief financial officer | 200 - 205 | 1,200 | - | - | - | 205 - 210 |
| Claire Hook, chief operating officer | 210 - 215 | - | - | - | 107.5 - 110 | 320 - 325 |

| Pension benefits | (a) Real increase in pension at pension age[11] (bands of £2,500) | (b) Real increase in lump sum at pension age[11] (bands of £2,500) | (c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000) | (d) Lump sum at pension age relating to accrued pension at 31 March 2025 (bands of £5,000) | (e) Cash equivalent transfer value at 1 April 2024 (nearest £1k) | (f) Real increase in cash equivalent transfer value[12] (nearest £1k) | (g) Cash equivalent transfer value at 31 March 2025[12] (nearest £1k) | (h) Employer's contribution to stakeholder pension (nearest £1k) |
|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| Professor Tim Orchard, chief executive officer | 5 - 7.5 | 0 - 2.5 | 160 - 165 | 195 - 200 | 2,699 | 109 | 3,028 | - |
| Professor Julian Redhead, medical director | 5 - 7.5 | 2.5 - 5 | 105 - 110 | 270 - 275 | 2,208 | 117 | 2,509 | - |
| Professor Dame Janice Sigsworth, chief nurse | - | - | - | - | - | - | - | - |
| Jazz Thind, chief financial officer | - | 92.5 - 95 | 70 - 75 | 200 - 205 | 1,507 | 195 | 1,827 | - |
| Claire Hook, chief operating officer | 5 - 7.5 | 5 - 7.5 | 65 - 70 | 165 - 170 | 1,132 | 95 | 1,330 | - |

**Notes:**

1. Carolyn Downs left the board on 30 September 2024.
2. Neena Modi left the board on 31 July 2024.
3. Dame Helen Stephenson joined the board from 1 October 2024. She is also a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust.
4. Catherine Williamson joined the board from 20 January 2025. She is also a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust.
5. All remuneration shown relates to the individuals' roles with Imperial College Healthcare NHS Trust. Non-executive directors are paid a combined fee to sit on the boards of at least two providers within the North West London Acute Provider Collaborative. Remuneration for roles in other North West London providers are shown in the remuneration reports of the respective organisations. The annual fee paid to non-executive directors is £15k-20k per annum, or £20k-25k for those with vice-chair responsibilities. The chair is paid a combined fee of £80k-85k per annum.
6. Professor Tim Orchard – the amount of £45-50k of salary relates to payment for his clinical role.
7. Professor Julian Redhead – the amount of £60-65k of salary relates to payment for his clinical role.
8. Professor Dame Janice Sigsworth elected not to be covered by the pension arrangements during the reporting year (2024-25).
9. Jazz Thind participated in our electric vehicle salary sacrifice scheme during the year and had use of an electric vehicle over the course of the period with a taxable benefit of £1,200. These benefits are open to executive directors on the same terms available to other members of staff. No additional allowance is paid to staff in respect of these benefits – the benefits arise from the tax treatment of the schemes, which are in line with HMRC rules and guidance.
10. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase in pension is the nominal value adjusted for the impact of inflation and any increase or decrease due to a transfer of pension rights to or from other schemes. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
11. The real increases in pension and lump sum represent the nominal increase adjusted for the impact of inflation.
12. The movement in column (f) illustrates the real gain in value in the cash equivalent transfer value in the year and excludes gains resulting from inflation, employee contributions or transfers of benefits. For this reason, column (g) is not intended to be the sum of columns (e) and (f).

There were no non-contractual payments made to individuals where the payment was more than 12 months' annual salary (exit packages).

In common with other members of staff, executive directors are able to buy or sell annual leave in line with Trust policy. In 2024-25, no director has exercised this option.

## Non-executive directors' remuneration 2023-24

| | (a) | (b) | (c) | (d) | (e) | (f) = (a to e) |
|---|---|---|---|---|---|---|
| **Salaries and allowances** | **Salary[8] bands of £5,000)** | **Expense payments (taxable) (total to nearest £100)** | **Performance pay and bonuses (bands of £5,000)** | **Long term performance pay and bonuses (bands of £5,000)** | **All pension related benefits[12] (bands of £2,500)** | **Total remunera-tion (bands of £5,000)** |
| **Name and title** | **£000** | **£00** | **£000** | **£000** | **£000** | **£000** |
| Matthew Swindells, joint chair | 20 - 25 | - | - | - | - | 20 – 25 |
| Robert Alexander, vice chair / non-executive director | 10 - 15 | - | - | - | - | 10 – 15 |
| Carolyn Downs, non-executive director[1] | 5 - 10 | - | - | - | - | 5 – 10 |
| Neena Modi, non-executive director[2] | 5 - 10 | - | - | - | - | 5 – 10 |
| Sim Scavazza, non-executive director | 5 - 10 | - | - | - | - | 5 – 10 |
| Nick Gash, non-executive director | 5 - 10 | - | - | - | - | 5 – 10 |
| Linda Burke, non-executive director | 5 - 10 | - | - | - | - | 5 – 10 |
| David Moss, non-executive director[3] | 5 - 10 | - | - | - | - | 5 – 10 |
| Janet Rubin, non-executive director[4] | 5 - 10 | - | - | - | - | 5 – 10 |
| Peter Goldsbrough, non-executive director[5] | 0 - 5 | - | - | - | - | 0 – 5 |
| Professor Andrew Bush, non-executive director[6] | 0 - 5 | - | - | - | - | 0 – 5 |
| Loy Lobo, non-executive director[7] | 0 - 5 | - | - | - | - | 0 – 5 |

## Executive directors' remuneration 2023-24

| | (a) | (b) | (c) | (d) | (e) | (f) = (a to e) |
|---|---|---|---|---|---|---|
| **Salaries and allowances** | **Salary (bands of £5,000)** | **Expense payments (taxable)[12] (total to nearest £100)** | **Performance pay and bonuses (bands of £5,000)** | **Long term performance pay and bonuses (bands of £5,000)** | **All pension related benefits[13] (bands of £2,500)** | **Total remunera-tion (bands of £5,000)** |
| **Name and title** | **£000** | **£** | **£000** | **£000** | **£000** | **£000** |
| Professor Tim Orchard, chief executive officer[9] | 300 - 305 | - | 5 - 10 | - | 37.5 - 40 | 350 - 355 |
| Professor Julian Redhead, medical director[10] | 275 - 280 | - | - | - | - | 275 - 280 |
| Professor Janice Sigsworth, chief nurse[11] | 195 - 200 | - | - | - | - | 195 - 200 |
| Jazz Thind, chief financial officer | 190 - 195 | 1,200 | - | - | - | 195 - 200 |
| Claire Hook, chief operating officer | 190 - 195 | - | - | - | 50 – 52.5 | 240 - 245 |

| Pension benefits | (a) Real increase in pension at pension age[14] (bands of £2,500) | (b) Real increase in lump sum at pension age[14] (bands of £2,500) | (c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000) | (d) Lump sum at pension age relating to accrued pension at 31 March 2024 (bands of £5,000) | (e) Cash equivalent transfer value at 1 April 2023 (nearest £1k) | (f) Real increase in cash equivalent transfer value[15] (nearest £1k) | (g) Cash equivalent transfer value at 31 March 2024[15] (nearest £1k) | (h) Employer's contribution to stakeholder pension (nearest £1k) |
|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| Professor Tim Orchard, chief executive officer | 2.5 - 5 | - | 145 - 150 | 180 - 185 | 2,080 | 369 | 2,699 | - |
| Professor Julian Redhead, medical director | - | 42.5 - 45 | 90 - 95 | 250 - 255 | 1,702 | 300 | 2,208 | - |
| Professor Janice Sigsworth, chief nurse | - | - | - | - | - | - | - | - |
| Jazz Thind, chief financial officer | - | - | 80 - 85 | 100 - 105 | 1,246 | 129 | 1,507 | - |
| Claire Hook, chief operating officer | 0 – 2.5 | 52.5 - 55 | 55 - 60 | 145 - 150 | 730 | 302 | 1,132 | - |

Notes:

1. Carolyn Downs joined the board from 1 September 2023. She is also a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust.
2. Neena Modi joined the board from 1 September 2023. She is also a non-executive director of Chelsea and Westminster Hospital NHS Foundation Trust.
3. David Moss became a 'designate' non-executive director from February 2024 after assuming additional responsibilities with London North West University Healthcare NHS Trust. Designate non-executive directors attend board meetings but do not carry voting rights. David Moss is included in this table in respect of his service as a voting non-executive director during the year.
4. Janet Rubin left the board on 14 February 2024.
5. Peter Goldsbrough left the board on 31 August 2023.
6. Andrew Bush left the board on 31 August 2023.
7. Loy Lobo joined the board on 15 February 2024. He is also a non-executive director of London North West University Healthcare NHS Trust.
8. All remuneration shown relates to the individuals' roles with Imperial College Healthcare NHS Trust. As noted above, non-executive directors are now paid a combined fee to sit on the boards of at least two providers within the North West London Acute Provider Collaborative. Remuneration for roles in other North West London providers are shown in the remuneration reports of the respective organisations. The annual fee paid to non-executive directors is £15k-20k per annum, or £20k-25k for those with vice-chair responsibilities. The chair is paid a combined fee of £80k-85k per annum.
9. Professor Tim Orchard – the amount of £45-50k of salary relates to payment for his clinical role.
10. Professor Julian Redhead – the amount of £60-65k of salary relates to payment for his clinical role.
11. Professor Janice Sigsworth elected not to be covered by the pension arrangements during the reporting year (2023-24).
12. Jazz Thind participated in our electric vehicle salary sacrifice scheme during the year and had use of an electric vehicle over the course of the period with a taxable benefit of £1,200. These benefits are open to executive directors on the same terms available to other members of staff. No additional allowance is paid to staff in respect of these benefits – the benefits arise from the tax treatment of the schemes, which are in line with HMRC rules and guidance.
13. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase in pension is the nominal value adjusted for the impact of inflation and any increase or decrease due to a transfer of pension rights to or from other schemes. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
14. The real increases in pension and lump sum represent the nominal increase adjusted for the impact of inflation.
15. The movement in column (f) illustrates the real gain in value in the cash equivalent transfer value in the year and excludes gains resulting from inflation, employee contributions or transfers of benefits. For this reason, column (g) is not intended to be the sum of columns (e) and (f).

There were no non-contractual payments made to individuals where the payment was more than 12 months' annual salary (exit packages).

In common with other members of staff, executive directors are able to sell annual leave in line with Trust policy. In 2023-24, one director exercised this option: Professor Tim Orchard sold leave in the value of £0–5k.

# Staff report

The staff report provides information on the people employed by the Trust, broken down by relevant characteristics. The headcount data is as of 31 March 2025 and is for clinical and corporate divisions and research and development (including hosted and contracted services).

Further information on the Trust's staff, and its approach to encouraging an equal and diverse workforce that represents the population we serve is available in its equality, Diversity and Inclusion annual report, which is available on the Trust's main website: https://www.imperial.nhs.uk/about-us/equality-diversity-and-inclusion/reporting-on-equality-diversity-and-inclusion

## Workforce composition by staff group

At the end of 2024-25 the Trust employed 16,529 staff. Approximately 81.7% are employed in clinical roles. Further information on the breakdown by staff group is shown in the table below.

| Trust staff group | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| Admin and clerical | 2,153 | 2,104 |
| Allied health professional (qualified) | 887 | 831 |
| Allied health professional (support) | 129 | 118 |
| Ancillary | 1,077 | 1,112 |
| Doctor (career grade) | 30 | 30 |
| Doctor (consultant) | 1,381 | 1,346 |
| Doctor (training grade) | 2,184 | 2,017 |
| Nursing and midwifery (qualified) | 4,842 | 4,544 |
| Nursing and midwifery (support) | 1,276 | 1,224 |
| Pharmacist | 171 | 165 |
| Physician associate | 9 | 9 |
| Scientific and technical (qualified) | 974 | 908 |
| Scientific and technical (support) | 536 | 463 |
| Senior manager | 880 | 828 |
| **Trust total** | **16,529** | **15,699** |

## Workforce composition by sex

69% of our workforce are female and 31% are male. The high proportion of female workers is typical of NHS organisations. The proportion of male employees increases in more senior roles. The gender tables below show that at the end of 2024-25 women accounted for 59% of senior managers, 28% of executive directors and 38% of board directors. There are five directors who are defined both as executive team members and as board directors.

| Gender – all | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| Female | 11,393 | 10,848 |
| Male | 5,136 | 4,851 |
| **Trust total** | **16,529** | **15,699** |

| Gender – senior managers | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| Female | 515 | 483 |
| Male | 365 | 316 |
| **Trust total** | **880** | **799** |

| Gender – board of directors | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| Female | 7 | 7 |
| Male | 9 | 9 |
| **Trust total** | **16** | **16** |

| Gender – executive team | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| Female | 7 | 7 |
| Male | 13 | 13 |
| **Trust total** | **20** | **20** |

## Workforce composition by age and ethnicity

| Age group | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| 16-19 years | 10 | 9 |
| 20-29 years | 2,981 | 2,846 |
| 30-39 years | 5,394 | 5,077 |
| 40-49 years | 3,397 | 3,233 |
| 50-59 years | 3,156 | 3,068 |
| 60 years and over | 1,591 | 1,466 |
| **Trust total** | **16,529** | **15,699** |

| Ethnic origin | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| White – British | 3,158 | 3,158 |
| White – Irish | 341 | 348 |
| White – Any other White background | 1,898 | 1,841 |
| Mixed – White and Black Caribbean | 104 | 96 |
| Mixed – White and Black African | 96 | 102 |
| Mixed – White and Asian | 155 | 139 |
| Mixed – Any other mixed background | 287 | 264 |
| Asian or Asian British – Indian | 1,758 | 1,626 |
| Asian or Asian British – Pakistani | 366 | 325 |
| Asian or Asian British – Bangladeshi | 277 | 236 |
| Asian or Asian British – Any other Asian background | 1,731 | 1,680 |
| Black or Black British – Caribbean | 639 | 605 |
| Black or Black British – African | 2,140 | 1,967 |
| Black or Black British – Any other Black background | 537 | 496 |
| Chinese | 251 | 289 |
| Any other ethnic group | 1,724 | 1,590 |
| Undefined | 661 | 521 |
| Not stated | 406 | 416 |
| **Trust total** | **16,529** | **15,699** |

## Average staff numbers (subject to audit)

This table represents the average full-time equivalent staff numbers through the year and so presents a different figure than the analysis tables above, which relate to the number of staff employed as of 31 March 2025.

| Average staff numbers | 2024-25 | | | 2023-24 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently employed | Other | Total | Permanently employed | Other |
| Medical and dental | 2,488 | 2,481 | 7 | 2,389 | 2,382 | 7 |
| Administration and estates | 4,262 | 4,251 | 11 | 4,189 | 4,173 | 16 |
| Healthcare assistants and other support staff | 2,155 | 2,138 | 17 | 2,088 | 2,071 | 16 |
| Nursing, midwifery and health visiting staff | 5,037 | 4,980 | 57 | 4,804 | 4,720 | 84 |
| Scientific, therapeutic and technical staff | 1,316 | 1,210 | 106 | 1,243 | 1,129 | 114 |
| Healthcare science staff | 720 | 720 | - | 691 | 691 | - |
| Other | 9 | 9 | - | 9 | 9 | - |
| **Total** | **15,987** | **15,789** | **198** | **15,413** | **15,175** | **238** |
| Staff engaged on capital projects (included above) | 32 | 30 | 2 | 34 | 29 | 5 |

The analysis of staff costs is shown below (subject to audit):

| | 2024-25 | | | 2023-24 | | |
|---|---|---|---|---|---|---|
| | Total | Permanent | Other | Total | Permanent | Other |
| | £000s | £000s | £000s | £000s | £000s | £000s |
| Salaries and wages | 915,935 | 822,879 | 93,056 | 829,999 | 734,941 | 95,058 |
| Social security costs | 101,005 | 89,943 | 11,062 | 92,927 | 81,966 | 10,961 |
| Apprenticeship levy | 4,377 | 3,834 | 543 | 4,057 | 3,524 | 533 |
| Employer contributions to NHS BSA | 151,538 | 140,465 | 11,073 | 119,156 | 108,918 | 10,238 |
| Other pension costs | 138 | 54 | 84 | 165 | 78 | 87 |
| **Total employee benefits** | **1,172,993** | **1,057,175** | **115,818** | **1,046,304** | **929,427** | **116,877** |
| Employee costs capitalised | 4,408 | 4,408 | - | 4,380 | 4,380 | - |
| **Gross employee benefits ex. capitalised costs** | **1,168,585** | **1,052,767** | **115,818** | **1,041,924** | **925,047** | **116,877** |

## Sickness absence

At the time of publication, validated sickness absence statistics for 2024-25 were not available. When data is released it will be available via the following link:

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

## Staff turnover

Staff turnover for 2024-25 was 7.8% compared to 10.2% in 2023-24.

## Employment of staff with disabilities

The Trust is committed to attracting and developing staff with disabilities. The Trust's commitments are described in its equal opportunities policy and its policy on maintaining the employment of people with disabilities. The Trust is a 'two ticks' employer, guaranteeing an interview for any disabled person who meets the minimum criteria for a role. Information on the proportion of staff with declared disabilities is shown in the table below. Further information on the employment of people with disabilities is available in our annual equality workforce information report which is published on the Trust website.

| Staff with disabilities | Headcount 2024-25 | Headcount 2023-24 |
|---|---|---|
| No | 13,382 | 12,699 |
| Not declared | 1,383 | 1,604 |
| Prefer not to answer | 176 | 151 |
| Unspecified | 944 | 743 |
| Yes | 644 | 502 |
| **Trust total** | **16,529** | **15,699** |

## Consultancy

In 2024-25, the Trust incurred consultancy costs of £144k (2023-24: £425k)

### Trade union facility time publication requirements report: 2024-25

The facility time data that organisations are required to collate and publish under the new regulations is shown below. We have included tables to illustrate the information required.

### Trade union (TU) facility time information required for publication

The below data refers to the relevant period which is 1 April 2024 through 31 March 2025.

**TU representatives** – the total number of employees who were TU representatives during the relevant period.

| Number of employees who were relevant union officials during the relevant period | FTE employee number |
|---|---|
| 64 | 58.09 |

**Percentage of time spent on facility time** – How many employees who were TU representatives 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% | 54 |
| 1-50% | 10 |
| 51%-99% | 0 |
| 100% | 0 |

**Percentage of pay bill spent on facility time** – The figures requested in the first column of the table below will determine the percentage of the total pay bill spent on paying employees who were TU representatives for facility time during the relevant period.

| Reporting requirement | Figures |
|---|---|
| Provide the total cost of facility time | £ 23,636.28 |
| Provide the total pay bill | £1,112,145,055 = total figure for 2024-25 including apprenticeship levy (£4,759,576)<br>£1,107,385,839 = total figure excluding apprenticeship levy |
| Provide the percentage of the total pay bill spent on facility time, calculated as:<br>(total cost of facility time ÷ total pay bill) x 100 | 0.002% |

**Paid TU activities** – As a percentage of total paid facility time hours, how many hours were spent by employees who were TU representatives during the relevant period on paid TU activities.

| | |
|---|---|
| Time spent on paid TU activities as a percentage of total paid facility time hours calculated as:<br>(total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100 | 68.03% |

# Appendix 1

Glossary of terms

| Term | Definition |
|---|---|
| Relevant public sector employer | Section 7 of the regulations defines what is a relevant public sector employer.<br>This specifies:<br>• government departments, which include executive agencies and non-ministerial departments (other than the Secret Intelligence Service, the Security Service and the Government Communications Headquarters)<br>• the Scottish Ministers<br>• public authorities described or listed in Schedule 1 of the regulations |
| TU representative | A relevant union official. An official of an independent TU recognised by the employer. |
| Relevant period | A period of 12 months beginning with 1 April, the first relevant period starts on 1 April 2017. |
| Total pay bill | Is the total amount of<br>(the total gross amount spent on wages) + (total pension contributions) + (total national insurance contributions) during the relevant period. |
| Full time equivalent (FTE) employee number | The (total number of full time employees) + (the total fractions of full time employee hours worked by all employees who are not full time). |
| TU duties | Duties where there is a statutory right to reasonable paid time off during normal working hours to undertake recognised duties and to complete training relevant to their TU role. This arises under:<br>(a) section 168, section 168A of -the 1992 Act (TULR(C)A)<br>(b) section 10(6) of the Employment Relations Act 1999;<br>(c) regulations made under section 2(4) of the Health and Safety at Work etc. Act 1974. |
| TU activities | Means time taken off under section 170 (1) (b) of the 1992 Act.<br>TU activities could include:<br>• meetings, where the purpose or principal purpose is to discuss internal union matters<br>• TU conferences<br>• internal administration of the union e.g. answering internal union correspondence, dealing with financial matters, responding to internal surveys<br>There is no statutory entitlement to paid time off to undertake activities.<br>However TU representatives are entitled to be granted reasonable unpaid time off to participate in TU activities. |
| Paid TU activities | Time taken off for TU activities under section 170 (1) (b) of the 1992 Act in respect of which a TU representative receives wages from the relevant public sector employer.<br>There is no statutory entitlement to paid time off to undertake activities.<br>It is accepted that there could be exceptional circumstances where paid time off for activities may be appropriate, however it is recommended the organisations ensure they have appropriate controls in place to monitor this. |

| Term | Definition |
|---|---|
| Total paid facility time hours | Total number of hours spent on facility time by TU representatives during a relevant period.<br><br>Does not include hours attributable to time taken off under section 170(1)(b) of the 1992 Act in respect of which a TU representative does not receive wages. |
| Hourly cost | For each employee:<br><br>(the gross amount spent on wages) + (pension contributions) + (national insurance contributions) divided by the number of hours during the relevant period. |
| Total cost of facility time | For each employee who was a TU representative during the relevant period, facility time cost is calculated by:<br><br>(Hourly cost for each employee x number of paid facility time hours)<br><br>Total facility time cost is calculated by adding together the amounts produced by the calculation of facility time cost for each employee.<br><br>In calculating this figure the wages of any employee who can be identified from the information being published must be expressed as a notional hourly cost to represent the employee's wages. |

## Off-payroll arrangements

It is Trust policy that all substantive staff should be paid through the payroll wherever possible. NHS bodies are required to disclose specific information about off-payroll engagements.

## Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2025, for more than £245 per day:

| | Number |
|---|---|
| Number of existing engagements as of 31st March 2025 | 4 |
| **Of which, the number that have existed:** | |
| for less than one year at the time of reporting | - |
| for between one and two years at the time of reporting | - |
| for between two and three years at the time of reporting | 2 |
| for between three and four years at the time of reporting | - |
| for four or more years at the time of reporting | 2 |

## Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day:

| | Number |
|---|---|
| Number of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024 | 4 |
| **Of which:** | |
| Number not subject to off-payroll legislation (see note) | - |
| Subject to off-payroll legislation and determined as in-scope of IR35 (see note) | 2 |
| Number subject to off-payroll legislation and determined as out of scope of IR35 (see note) | 2 |
| Number of engagements reassessed for compliance or assurance purpose during the year | - |
| Number of engagements that saw a change to IR35 status following review | - |

## Off-payroll board member and senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025.

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year | 0 |
| Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements | 20 |

## Exit packages (subject to audit)

In 2024-25 the Trust approved severance payments to six staff (2023-24: 13 staff).

| 2024-25 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Exit package cost band (including any special payment element) | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages | Total cost of exit packages | Number of departures where special payments have been made | Cost of special payment element included in exit packages |
| | Number | £s | Number | £s | Number | £s | Number | £ |
| Less than £10,000 | 2 | 12,107 | 1 | 6,092 | 3 | 18,199 | - | - |
| £10,000-£25,000 | - | - | 2 | 36,877 | 2 | 36,877 | - | - |
| £25,001-£50,000 | - | - | 2 | 70,874 | 2 | 70,874 | - | - |
| £50,001-£100,000 | - | - | - | - | - | - | - | - |
| £100,001 - £150,000 | - | - | - | - | - | - | - | - |
| £150,001 - £200,000 | - | - | - | - | - | - | - | - |
| **Total** | **2** | **12,107** | **5** | **113,843** | **7** | **125,950** | **-** | **-** |

| 2023-24 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Exit package cost band (including any special payment element)** | **Number of compulsory redundancies** | **Cost of compulsory redundancies** | **Number of other departures agreed** | **Cost of other departures agreed** | **Total number of exit packages** | **Total cost of exit packages** | **Number of departures where special payments have been made** | **Cost of special payment element included in exit packages** |
| | **Number** | **£s** | **Number** | **£s** | **Number** | **£s** | **Number** | **£** |
| Less than £10,000 | - | - | 6 | 40,555 | 6 | 40,555 | - | - |
| £10,000-£25,000 | - | - | 6 | 79,904 | 6 | 79,904 | 1 | 13,500 |
| £25,001-£50,000 | - | - | - | - | - | - | - | - |
| £50,001-£100,000 | - | - | 1 | 64,273 | 1 | 64,273 | - | - |
| £100,001 - £150,000 | - | - | - | - | - | - | - | - |
| £150,001 - £200,000 | - | - | - | - | - | - | - | - |
| **Total** | **-** | **-** | **13** | **184,732** | **13** | **184,732** | **1** | **13,500** |

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

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

## Exit packages – other departures analysis

This table provides a breakdown of the other departures agreed figures shown in the table above. Note:

- the expense associated with these departures may have been recognised in part or in full in a previous period
- an exit package relating to one individual may appear in more than one row of the analysis provided in this table if it comprises different elements of payment

| | 2024-25 | | 2023-24 | |
|---|---|---|---|---|
| | Agreements | Total value of agreements | Agreements | Total value of agreements |
| | Number | £000s | Number | £000s |
| Contractual payments in lieu of notice | 5 | 83 | 6 | 54 |
| Exit payments following employment tribunals or court orders | 2 | 31 | 6 | 117 |
| Non-contractual payment requiring HM Treasury approval | - | - | 1 | 14 |
| **Total** | **7** | **114** | **13** | **185** |

**Professor Tim Orchard, Chief executive**
**27 June 2025**

# Independent auditor's report

**Independent auditor's report to the directors of Imperial College Healthcare NHS Trust**

**Report on the audit of the financial statements**

**Opinion**
In our opinion the financial statements of Imperial College Healthcare NHS Trust (the 'trust'):

- give a true and fair view of the state of the trust's affairs as at 31 March 2025 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by the Secretary of State.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 39.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by the Secretary of State.

**Basis for opinion**
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General, the Local Audit and Accountability Act 2014 (the 'Act') and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the 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 opinion.

**Conclusions relating to going concern**
In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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

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

The going concern basis of accounting for the trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the

financial statements where it is anticipated that the services which they provide will continue into the future.

**Other information**
The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. 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.

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

**Responsibilities of directors**
As explained more fully in the directors' responsibilities statement, the directors are 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 directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the trust without the transfer of the trust's services to another public sector entity.

**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.

**Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud**
Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material

misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the trust and its control environment, and reviewed the trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuation and IT specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following area, and our specific procedures performed to address it are described below:

- determination of whether expenditure is capital in nature is subjective: we tested a sample of capital expenditure to assess whether it meets the relevant accounting requirements to be recognised as capital in nature.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal audit concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

**Report on other legal and regulatory requirements**

**Opinions on other matters**
In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the Accounts Direction made under the National Health Service Act 2006 in all material respects; 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.

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

***Use of resources***

Under the Code of Audit Practice and the Act, we are required to report to you if we have not been able to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 26 June 2025 we reported to the trust a significant weakness in the trust's arrangements to secure financial sustainability. The significant weakness reported was in relation to the Trust's arrangements to deliver and identify cost improvements because the financial plan for 2024/25 was met through reliance on non-recurrent measures and the delivery of the financial plan for 2025/26 is dependent on material unidentified efficiency savings. Our recommendations for improvement were that the Trust's arrangements around the identification of savings opportunities and planning for their delivery are further developed to enable timely identification of cost improvement opportunities and project planning further ahead of the start of the relevant period with a focus on recurrent savings to reduce reliance on non-recurrent measures each year.

**Respective responsibilities of the accountable officer and auditor relating to the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources**
The accountable officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the trust's resources.

We are required under the Code of Audit Practice and section 21(3)(c) of the Act, as amended, to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the trust a

significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025. Other findings from our work, including our commentary on the trust's arrangements, will be reported in our separate Auditor's Annual Report.

***Governance statement and reports in the public interest or to the regulator***

We are also required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by NHS England;
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act.

We have nothing to report in respect of these matters.

**Delay in the certification of completion of the audit**

As at the date of this audit report, we have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete. In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Imperial College Healthcare NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

**Use of our report**

This report is made solely to the Board of Directors of Imperial College Healthcare NHS Trust in accordance with Part 5 of the Act. Our audit work has been undertaken so that we might state to the trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
London, United Kingdom
27 June 2025

# Financial statements and notes

## Statement of Comprehensive Income

| | Note | 2024/25 £000 | 2023/24 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3 | 1,677,741 | 1,523,242 |
| Other operating income | 4 | 197,794 | 191,445 |
| Operating expenses | 7,10 | (1,894,972) | (1,724,684) |
| **Operating deficit from continuing operations** | | **(19,437)** | **(9,997)** |
| Finance income | 12 | 7,150 | 9,465 |
| Finance expenses | 13 | (2,732) | (1,963) |
| Public Dividend Capital (PDC) dividends payable | | (14,091) | (12,614) |
| **Net finance costs** | | **(9,673)** | **(5,112)** |
| Other gains / (losses) | 14 | (539) | 6 |
| Losses arising from transfers by absorption | 33 | - | (1,105) |
| **Deficit for the year from continuing operations** | | **(29,649)** | **(16,208)** |
| **Deficit for the year** | | **(29,649)** | **(16,208)** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 9 | (1,360) | (4,070) |
| Revaluations | 18 | 8,047 | 8,246 |
| Other reserve movements | | - | 7 |
| **Total other comprehensive income for the period** | | **6,687** | **4,183** |
| **Total comprehensive expense for the period** | | **(22,962)** | **(12,025)** |
| **Adjusted financial performance (control total basis):** | | | |
| Deficit for the period | | (29,649) | (16,208) |
| Remove net impairments not scoring to the Departmental Expenditure Limit | | 42,111 | 27,173 |
| Remove losses on transfers by absorption | | - | 1,105 |
| Remove Income & Expenditure impact of capital grants and donations | | (12,421) | (12,080) |
| Remove net impact of DHSC centrally procured inventories | | 41 | 40 |
| **Adjusted financial performance surplus** | | **82** | **30** |

An NHS Trust's financial performance is derived from its accounting surplus/(deficit) but is adjusted for impairments and reversal of prior year impairments to property, plant, equipment, elimination of income and expenditure arising from donations and donated assets, and certain other transactions that are not considered to be part of the organisation's operating position.

## Statement of Financial Position

| | Note | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 15 | 16,452 | 15,871 |
| Property, plant and equipment | 16 | 660,673 | 638,604 |
| Right of use assets | 20 | 47,317 | 49,354 |
| Receivables | 22 | 2,362 | 2,304 |
| **Total non-current assets** | | **726,804** | **706,134** |
| **Current assets** | | | |
| Inventories | 21 | 12,172 | 11,427 |
| Receivables | 22 | 169,670 | 126,711 |
| Cash and cash equivalents | 23 | 92,915 | 136,718 |
| **Total current assets** | | **274,757** | **274,856** |
| **Current liabilities** | | | |
| Trade and other payables | 24 | (295,517) | (257,501) |
| Borrowings | 26 | (9,683) | (8,318) |
| Provisions | 27 | (17,394) | (49,839) |
| Other liabilities | 25 | (31,171) | (23,726) |
| **Total current liabilities** | | **(353,765)** | **(339,384)** |
| **Total assets less current liabilities** | | **647,796** | **641,606** |
| **Non-current liabilities** | | | |
| Borrowings | 26 | (35,825) | (36,061) |
| Provisions | 27 | (4,336) | (6,040) |
| Other liabilities | 25 | (1,852) | (2,058) |
| **Total non-current liabilities** | | **(42,013)** | **(44,160)** |
| **Total assets employed** | | **605,784** | **597,446** |
| | | | |
| **Financed by** | | | |
| Public dividend capital | | 874,109 | 842,809 |
| Revaluation reserve | | 25,333 | 21,443 |
| Income and expenditure reserve | | (293,658) | (266,805) |
| **Total taxpayers' equity** | | **605,784** | **597,446** |

The notes on pages 7 to 52 form part of these accounts.

**Professor Tim Orchard, Chief executive**
**27 June 2025**

## Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

| | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2024 - brought forward** | **842,809** | **21,443** | **(266,805)** | **597,446** |
| Deficit for the year | - | - | (29,649) | **(29,649)** |
| Other transfers between reserves | - | (2,796) | 2,796 | **-** |
| Impairments | - | (1,360) | - | **(1,360)** |
| Revaluations | - | 8,047 | - | **8,047** |
| **Total comprehensive income / (expense) for the period** | **-** | **3,891** | **(26,853)** | **(22,962)** |
| Public dividend capital received | 31,300 | - | - | **31,300** |
| **Taxpayers' and others' equity at 31 March 2025** | **874,109** | **25,334** | **(293,658)** | **605,784** |

## Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

| | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2023 - brought forward** | **827,189** | **18,765** | **(252,103)** | **593,851** |
| Deficit for the year | - | - | (16,208) | **(16,208)** |
| Other transfers between reserves | - | (1,498) | 1,498 | **-** |
| Impairments | - | (4,070) | - | **(4,070)** |
| Revaluations | - | 8,246 | - | **8,246** |
| Other reserve movements | - | - | 7 | **7** |
| **Total comprehensive income / (expense) for the period** | **-** | **2,678** | **(14,703)** | **(12,025)** |
| Public dividend capital received | 15,620 | - | - | **15,620** |
| **Taxpayers' and others' equity at 31 March 2024** | **842,809** | **21,443** | **(266,805)** | **597,446** |

### 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 & Social Care as the PDC 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 & Expenditure Reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

## Statement of Cash Flows

| | Note | 2024/25 £000 | 2023/24 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating deficit | | (19,437) | (9,997) |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 7.1 | 70,498 | 63,680 |
| Net impairments | 9 | 42,166 | 31,014 |
| Income recognised in respect of capital donations | 4 | (15,200) | (14,404) |
| (Increase) in receivables and other assets | | (43,900) | (8,899) |
| (Increase) / decrease in inventories | | (744) | 6,176 |
| Increase / (decrease) in payables and other liabilities | | 47,354 | (22,313) |
| (Decrease) / increase in provisions | | (34,805) | 8,767 |
| **Net cash flows from operating activities** | | **45,932** | **54,025** |
| **Cash flows from investing activities** | | | |
| Interest received | | 7,255 | 9,488 |
| Purchase of intangible assets | | (6,231) | (3,169) |
| Purchase of PPE and investment property | | (113,705) | (101,473) |
| Sales of PPE and investment property | | - | 769 |
| Initial direct costs or up front payments in respect of new right of use assets (lessee) | | (203) | - |
| Receipt of cash donations to purchase assets | | 15,200 | 4,504 |
| **Net cash flows used in investing activities** | | **(97,684)** | **(89,881)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 31,300 | 15,620 |
| Movement on loans from DHSC | | (1,226) | (1,226) |
| Movement on other loans | | (351) | (550) |
| Capital element of lease rental payments | | (7,668) | (7,734) |
| Interest on loans | | (326) | (375) |
| Interest paid on lease liability repayments | | (465) | (435) |
| PDC dividend paid | | (13,314) | (11,941) |
| **Net cash flows from / (used in) financing activities** | | **7,950** | **(6,641)** |
| **Decrease in cash and cash equivalents** | | **(43,803)** | **(42,497)** |
| **Cash and cash equivalents at 1 April - brought forward** | | **136,718** | **179,215** |
| **Cash and cash equivalents at 31 March** | 23 | **92,915** | **136,718** |

# Notes to the Accounts

## Note 1 Accounting policies and other information

### Note 1.1 Basis of preparation

The Department of Health and Social Care 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 2024/25 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 policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

**Accounting convention**

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

### Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case, and that the Trust will continue to have access to adequate resources to service its operational activities in cash terms for the next 12 months. The directors also note that the condition of the Trust's estate continues to represent a significant risk in terms of the level of backlog maintenance commitments and the potential for failures that impact services and which would be unaffordable for the Trust to rectify within its own resources.

### Note 1.3 Interests in other entities

**Joint operations**

Joint operations are arrangements in which the Trust has joint control with one or more counterparties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its full share of the assets, liabilities, income and expenses for North West London Pathology (NWLP), of which it is a joint operator, with a corresponding debtor or creditor with the other joint operators for their share of operational performance.

NWLP provides pathology testing services to the Trust and other partners, primarily Chelsea & Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. Services are provided primarily at the sites of partner trusts. Imperial holds a 61.2% share in the arrangement.

### Note 1.4 Revenue from contracts with customers

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations

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

The Trust expects to receive income broadly in line with the satisfaction of performance obligations. Most of the Trust's funding is provided on a monthly basis from commissioners and of this, most pertains to the performance obligation of delivery of healthcare. In relation to other performance obligations, the Trust would expect to receive payment in line with the satisfaction of those obligations. Where payments are delayed, the Trust takes standard credit control actions to secure settlement.

**Revenue from NHS contracts**

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts (API) form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15.  Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with no adjustments for actual achievement being made at the end of the year. However, CQUIN and BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other NHS clinical income' in these accounts.

Elective recovery funding is additional funding provided by NHSE to integrated care boards to fund the commissioning and payment of additional elective services within their systems delivered by Provider organisations for activity above nationally prescribed baseline targets.  Trusts do not directly earn all elective recovery funding based on activity delivered, however most is earned for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners. High-cost drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

### 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. 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 given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

### Private patient income

The Trust operates a private healthcare operation - Imperial College Healthcare Private Care. Revenue is recognised in line with completion of the performance obligations - a performance obligation relating to delivery of a spell of healthcare to a private patient is generally satisfied over time, as the healthcare is received and consumed simultaneously by the private patient as the Trust performs it.

### Education & training income

NHS England (NHSE) provide funding to maintain education and training capacity, retain students on education and training programmes, and enable students to provide their skills to the NHS to support service delivery. Income is recognised in line with the requirements of IFRS 15. 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.

## Note 1.5 Other forms of income

### Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the 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 account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## Note 1.6 Expenditure on employee benefits

### Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

### Pension costs

NHS Pension Scheme

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

## Note 1.7 Expenditure on other goods and services

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

## Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

The Trust has not discontinued any operations in 2024/25 or 2023/24.

## Note 1.9 Property, plant and equipment

### Recognition

Property, plant and equipment is capitalised where:

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

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

**Subsequent expenditure**

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

**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. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

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

*Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be

depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

*Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

The valuation carried out as at 31st March 2025 is based on assumptions made by a suitably qualified professional in accordance with HM Treasury guidance and the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards. The valuer has used the BCIS index for construction cost with adaptations for locations. The valuer provided the Trust with a valuation of land and building assets - this process leads to revaluation adjustments as set out in Note 16 to the accounts. Future revaluations of the Trust's land and buildings may result in further changes to the carrying values of non-current assets.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

*Impairments*

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

**De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell.  Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

**Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has

imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

**Useful lives of property, plant and equipment**

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

| | Min life Years | Max life Years |
|---|---|---|
| Land | - | - |
| Buildings, excluding dwellings | 2 | 60 |
| Plant & machinery | 5 | 15 |
| Information technology | 5 | 8 |
| Furniture & fittings | 5 | 10 |

## Note 1.10 Intangible assets

**Recognition**

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

*Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised 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 where it meets recognition criteria. Expenditure on research into software development is not capitalised. It is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised only if all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

### Measurement

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

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

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

*Amortisation*

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

### Useful lives of intangible assets

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 |
|---|---|---|
| **Intangible assets - internally generated** | | |
| Information technology | 3 | 6 |

## Note 1.11 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 formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

## Note 1.12 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 1.13 Financial assets and financial liabilities

### Recognition

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

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

### Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.
Financial liabilities are classified as subsequently measured at amortised cost.

### Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income 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.

The Trust holds financial assets and liabilities at amortised cost unless the criteria for recognition at fair value through other comprehensive income or through profit or loss are met. For receivable and payable items, the transaction price (less impairments in respect of receivables) is determined to be a reliable measure of fair value and no discounting is

applied. The Trust also holds interest-free loans as part of its arrangement with other NHS partners for hosting the North West London Pathology service (NWLP). Repayment of these balances is conditional on arrangements around NWLP and is not timebound, therefore no discounting has been applied.

### Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses 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).

Credit loss allowances are determined according to the category of financial asset based on assessment of previous losses incurred on the relevant category.

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.

### De-recognition

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

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

## Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

### The Trust as lessee

*Initial recognition and measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is

applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT.  Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

*Subsequent measurement*

As required by an HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

**The Trust as lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

*Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

*Operating leases*

Income from operating leases is recognised on a straight-line basis or another systematic 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.

## Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

| | | Nominal rate | Prior year rate |
|---|---|---|---|
| Short-term | Up to 5 years | 4.03% | 4.26% |
| Medium-term | After 5 years up to 10 years | 4.07% | 4.03% |
| Long-term | After 10 years up to 40 years | 4.81% | 4.72% |
| Very long-term | Exceeding 40 years | 4.55% | 4.40% |

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

| | Inflation rate | Prior year rate |
|---|---|---|
| Year 1 | 2.60% | 3.60% |
| Year 2 | 2.30% | 1.80% |
| Into perpetuity | 2.00% | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

### Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 27.2 but is not recognised in the Trust's accounts.

### Non-clinical risk pooling

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

## 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 entity's control) are not recognised as assets, but are disclosed in note 24 where an inflow of economic benefits is probable.

Contingent liabilities are defined as:

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

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

### 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, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

### 1.18 Value added tax

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

### 1.19 Corporation tax

The Trust does not undertake any activities that would fall due for corporation tax. All activities are carried out directly by the Trust as an NHS body.

### 1.20 Climate change levy

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

### 1.21 Foreign exchange

The functional and presentational currency of the Trust is pounds sterling.

### 1.22 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 ***FReM***.

## 1.23 Losses and special payments

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

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

## 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

*IFRS 17 Insurance Contracts* – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. The application of this standard from 2025/26 is not expected to have a material impact on the Trust's financial statements.

*IFRS 18 Presentation and Disclosure in Financial Statements* – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

*IFRS 19 Subsidiaries without Public Accountability: Disclosures* – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

*Changes to non-investment asset valuation* – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods has not yet been assessed, but could have a material impact on the Trust's financial statements in future years both in respect of the impact of capital expenditure incurred between valuation periods, and the use of an alternative site basis to value the Trust's main land & buildings assets. Property Plant and Equipment (PPE) and Right of Use assets currently subject to revaluation have a total book value of £528.2m as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £504.7m as at 31 March 2025.

## Note 1.26 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are reviewed on an on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

In 2024/25, the Trust made the judgement to impair Asset Under Construction (AUC) balances relating to the New Hospital Programme (NHP) following the government's announcement to re-phase the programme, which as a result delayed redevelopment work until at least 2035. The Trust impaired £14.7m of AUC balances in respect of redevelopment work undertaken on our sites and judged that the expenditure (which was incurred across 2024/25 and previous years) no longer meets the requirements for capitalisation at the reporting date, given the delays in the project.

There are no other critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies that have a significant effect on the amounts recognised in the financial statements.

## Note 1.27 Sources of estimation uncertainty

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

### Note 1.27.1 Land & buildings valuations

The Trust adopts a policy of revaluing its estate on an annual basis. Valuations are based on a range of assumptions. See Note 1.9 for further details.

Land and building assets are valued using the modern equivalent asset (MEA) approach. Both physical and functional obsolescence is applied to buildings, to reflect their actual characteristics and value.

The Trust values its overall estate on an 'alternative site' valuation basis assumed to be held in one, notional North West London location broadly consistent with the Trust's Hammersmith Hospital site. This judgement has been revisited in light of the redevelopment works and the Trust is satisfied that it continues to be appropriate. The judgement is appropriate because for the purposes of deriving a suitable MEA valuation basis, it is assumed that redevelopment would be on one site which would not be based in central London. This judgement is informed by analysis of fully anonymised post-code data for the Trust's patients to demonstrate the validity of the generic location used.

The Trust works with its valuer to ensure that assumptions that underpin the valuation are appropriate. The key assumptions used in the valuation are building costs and land values which are inherently uncertain. The total value of assets subject to this estimation uncertainty at the 31st March 2025 is £528.2m, so movements in the basis for estimation can have a material impact on the financial statements (though it is less likely that they would impact on the Trust's adjusted financial performance measure). The impact of any movement will be accounted across the Statement of Comprehensive Income and Revaluation Reserves.

As part of the annual asset valuation process, the Useful Economic Lives (UEL) of building assets are estimated by the external valuer based on information supplied by the Trust and discussions between management and the valuer. The Trust has made a judgement that the UELs of building assets should not be amended to reflect the anticipated redevelopment of key Trust sites (particularly St. Mary's Hospital) as part of the national New Hospital Programme.

Whilst the Trust continues to be included in (and fully committed to) the national programme, the timing of the overall redevelopment programme, the phasing of the work and the impact on specific building assets are, in the Trust's judgement, not yet sufficiently certain to be incorporated into the asset valuation exercise, except in respect of the buildings to be incorporated into the proposed Fleming Centre at the St Mary's site, which has a much earlier proposed construction timeline.

**Sensitivity (changes to land rates and building cost)**

The valuation of land and building assets is sensitive to the cost and market-based inputs used, which may result in movements in the carrying amounts of assets and liabilities within the next financial year.

Given that the Trust's land valuation is underpinned by land rates, a 5% increase or decrease in land rates would result in a direct £5.7m increase or decrease in value.

For the Depreciated Replacement Cost valuations, the input cost rates are revisited, reflecting a combination of cost data from the RICS Building Cost Information Service (BCIS), together with Trust-specific factors, including changes due to capital expenditure. The average building cost uplift applied by the valuer across the estate was around 3% since the last valuation.

The valuation then takes into consideration age and obsolescence, reflecting building condition and relevant changes such as capital works, with the useful economic lives of assets re-assessed. After reflecting the changes in cost rate inputs and obsolescence adjustments, the overall increase in value between 2023/24 and 2024/2025 was 3%, which is consistent with the increase in building cost inputs from 2023/24 to 2024/25 - although this may not be the case year on year.

It can reasonably be assumed, therefore, that (other things being equal) a 5% increase or decrease in the average building cost uplift would result in a corresponding £19.6m (5%) increase or decrease in value.

The timing, percentage increase and other influencing variables will vary on a case by case basis, and the actual sensitivity may differ from the modelled scenario.

## Note 2 Operating Segments

From autumn 2022, the Trust Board meets as part of a 'Board in Common' covering the acute providers within the North West London Integrated Care System. However, the Trust Board retains decision making authority for the Trust and individual Trust boards at the Board in Common continue to make decisions on behalf of their organisations.

The Trust Board is the 'chief operating decision maker' within the Trust. It is the duty of the chief operating decision maker to consider classes of activities, services or locations that constitute discrete operating segments meriting separate disclosure within the accounts.

The Trust provides a range of healthcare services which are reported internally in six divisional categories: surgery and cancer; medicine and integrated care; women's cardiac and clinical support services; West London Children's Healthcare Alliance (a collaborative management arrangement for children's services with Chelsea & Westminster NHS Foundation Trust); Imperial Private Care; and, corporate services. The Trust also hosts the North West London Pathology service.

However, having considered the requirements, the Trust Board considers that for the purpose of statutory reporting the Trust's activities fall under the single heading of healthcare, given that the financial position is reported to the Trust Board on a consolidated basis during the year, along with

consolidated workforce and operational performance. Consequently, there are no additional disclosures to be made as regards the statutory accounts with regard to operating segments.

## Note 3 Income

### Note 3.1 Income from patient care activities (by nature)

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| Income from commissioners under API contracts* | 1,430,447 | 1,365,464 |
| Other NHS clinical income | 26,608 | 16,538 |
| **Community services** | | |
| Income from commissioners under API contracts* | 4,001 | 3,841 |
| Income from other sources (e.g. local authorities) | 238 | 177 |
| **All services** | | |
| Private patient income | 52,469 | 42,624 |
| National pay award central funding*** | 4,160 | 656 |
| Additional pension contribution central funding** | 59,815 | 36,252 |
| Other clinical income | 100,003 | 57,690 |
| **Total income from activities** | **1,677,741** | **1,523,242** |

*Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the NHS Payment Scheme documentation: https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

*** Additional funding was made available by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were made. In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

### Note 3.2 Income from patient care activities (by source)

| Income from patient care activities received from: | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| NHS England | 624,723 | 583,506 |
| Integrated care boards | 913,388 | 819,592 |
| Department of Health and Social Care | 177 | 118 |
| Other NHS providers | 65,241 | 58,653 |
| Local authorities | 200 | 168 |
| Non-NHS: private patients | 52,469 | 42,624 |
| Non-NHS: overseas patients (chargeable to patient) | 10,115 | 7,571 |
| Injury cost recovery scheme | 3,391 | 2,016 |
| Non-NHS: other | 8,037 | 8,994 |
| **Total income from activities** | **1,677,741** | **1,523,242** |
| **Of which:** | | |
| Related to continuing operations | 1,677,741 | 1,523,242 |
| Related to discontinued operations | - | - |

North West London ICB (formerly the NWL Clinical Commissioning Group) makes up the majority of the income received from Integrated Care Boards (ICB) (£793.5m in 2024/25 and £721.7m in 2023/24).

## Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

| | 2024/25 | 2023/24 |
|---|---|---|
| | £000 | £000 |
| Income recognised this year | 10,115 | 7,571 |
| Cash payments received in-year | 2,911 | 3,498 |
| Amounts added to provision for impairment of receivables | 3,625 | 2,854 |
| Amounts written off in-year | 1,300 | 1,283 |

## Note 4 Other operating income

| | 2024/25 | | | 2023/24 | | |
|---|---|---|---|---|---|---|
| | Contract income | Non-contract income | Total | Contract income | Non-contract income | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Research and development | 14,357 | 41,487 | **55,844** | 15,840 | 45,894 | **61,734** |
| Education and training | 59,964 | 2,585 | **62,549** | 55,458 | 1,976 | **57,434** |
| Non-patient care services to other bodies | 22,095 | | **22,095** | 18,893 | | **18,893** |
| Income in respect of employee benefits accounted on a gross basis | 13,060 | | **13,060** | 12,426 | | **12,426** |
| Receipt of capital grants and donations and peppercorn leases | | 15,200 | **15,200** | | 14,404 | **14,404** |
| Charitable and other contributions to expenditure | | 1,107 | **1,107** | | 1,856 | **1,856** |
| Revenue from finance leases (variable lease receipts) | | 256 | **256** | | 288 | **288** |
| Revenue from operating leases (minimum lease receipts) | | 1,081 | **1,081** | | 1,357 | **1,357** |
| Other income | 26,602 | - | **26,602** | 23,053 | - | **23,053** |
| **Total other operating income** | **136,078** | **61,716** | **197,794** | **125,670** | **65,775** | **191,445** |
| **Of which:** | | | | | | |
| Related to continuing operations | | | 197,794 | | | 191,445 |
| Related to discontinued operations | | | - | | | - |

All income relates to continuing operations, - the Trust has not discontinued any operations in 2024/25 or 2023/24.

Other income includes income relating to goods, services or other items which are outside of the Trust's core activity of delivery of healthcare, including funding for clinical excellence awards and other income including car parking, catering and other services.

## Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

| | 2024/25 | 2023/24 |
|---|---|---|
| | £000 | £000 |
| Revenue recognised in the reporting period that was included within contract liabilities at the previous period end | 12,062 | 14,245 |

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less, and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

## Note 6 Operating leases - Imperial College Healthcare NHS Trust as lessor

This note discloses income generated in lease agreements where Trust is the lessor.

The Trust is the lessor for a number of arrangements including the use of space in Trust sites by other parties for purposes including retail and healthcare activities, as well as the use of Trust buildings to site telecommunications equipment.

The Trust has granted a finance lease over staff accommodation to a housing association over 99 years running to 2098. The Trust has a right under a nomination agreement to nominate staff for tenancies in the properties as space becomes available.

The Trust recognised a disposal of the asset on receipt of an initial payment for the property of £5.7m in 1999 (with subsequent rent being at a peppercorn rate). Following subsequent amendment to the agreement, the Trust receives variable payments dependent upon occupancy and rental income for certain of the units in the properties. The income for the 2024/25 year was £256k.

As future lease payments are variable payments dependent on usage, no disclosure is possible of future lease payments receivable, but if this is at the same annual income for the remainder of the lease the total undiscounted value of receipts would be £18.7m. Following reassessment of the Trust's lease arrangements as part of the transition to IFRS 16, the Trust has concluded it is appropriate to disclose this as variable finance lease income, rather than operating lease income.

## Note 6.1 Lease income

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **Lease receipts recognised as income in year:** | | |
| Minimum lease receipts | 1,081 | 1,357 |
| Variable lease receipts / contingent rents | 256 | 288 |
| **Total in-year lease income** | **1,337** | **1,645** |

## Note 6.2 Future lease receipts

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| **Future minimum lease receipts due in:** | | |
| - not later than one year | 1,025 | 1,191 |
| - later than one year and not later than two years | 587 | 1,166 |
| - later than two years and not later than three years | 483 | 986 |
| - later than three years and not later than four years | 481 | 931 |
| - later than four years and not later than five years | 350 | 708 |
| - later than five years | 1,149 | 2,750 |
| **Total** | **4,075** | **7,732** |

## Note 7.1 Operating expenses

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| Purchase of healthcare from NHS and DHSC bodies | 18,445 | 15,652 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 11,635 | 11,797 |
| Staff and executive directors costs | 1,137,554 | 1,012,648 |
| Remuneration of non-executive directors | 135 | 181 |
| Supplies and services - clinical (excluding drugs costs) | 196,509 | 163,899 |
| Supplies and services - general | 21,057 | 19,300 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 170,325 | 161,470 |
| Inventories written down | 311 | 707 |
| Consultancy costs | 144 | 425 |
| Establishment | 9,244 | 9,589 |
| Premises | 80,933 | 68,007 |
| Transport (including patient travel) | 27,562 | 26,275 |
| Depreciation on property, plant and equipment and right of use assets | 64,848 | 57,450 |
| Amortisation on intangible assets | 5,650 | 6,230 |
| Net impairments | 42,166 | 31,014 |
| Movement in credit loss allowance: contract receivables / contract assets | 5,444 | 3,727 |
| (Decrease) / increase in other provisions | (31,874) | 13,200 |
| Change in provisions discount rate(s) | (100) | - |
| Fees payable to the external auditor | 678 | 714 |
| Internal audit costs | 200 | 222 |
| Clinical negligence | 43,504 | 37,559 |
| Legal fees | 2,192 | 507 |
| Insurance | 653 | 688 |
| Research and development | 58,272 | 57,971 |
| Education and training | 11,168 | 10,369 |
| Expenditure on short term leases | 58 | - |
| Redundancy | 114 | 185 |
| Hospitality | 167 | 206 |
| Other | 17,978 | 14,692 |
| **Total** | **1,894,972** | **1,724,684** |

All expenditure relates to continuing operations, the Trust has not discontinued any operations in 2024/25 or 2023/24.

## Note 8 External Audit

### Note 8.1 Auditor Remuneration

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **Other auditor remuneration paid to the external auditor:** | | |
| Statutory external audit fee | 678 | 714 |

Costs shown include VAT. The costs for 2023/24 relates to both audit fees for the financial year 2023/24 and £70k (Incl VAT) in respect of overruns on the audit of the 2022/23 accounts agreed following the end of the financial year.

### Note 8.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2023/24: £2 million).

## Note 9 Impairment of assets

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **Net impairments charged to operating deficit resulting from:** | | |
| Loss or damage from normal operations | - | 237 |
| Over specification of assets | 2,149 | - |
| Abandonment of assets in course of construction | 14,712 | 3,604 |
| Changes in market price | 25,305 | 27,173 |
| **Total net impairments charged to operating deficit** | **42,166** | **31,014** |
| Impairments charged to the revaluation reserve | 1,360 | 4,070 |
| **Total net impairments** | **43,526** | **35,084** |

## Note 10 Employee benefits

| | 2024/25 Total £000 | 2023/24 Total £000 |
|---|---|---|
| Salaries and wages | 901,556 | 813,002 |
| Social security costs | 101,005 | 92,927 |
| Apprenticeship levy | 4,377 | 4,057 |
| Employer's contributions to NHS pensions | 151,538 | 119,156 |
| Pension cost - other | 138 | 165 |
| Temporary staff (including agency) | 14,379 | 16,997 |
| **Total staff costs** | **1,172,993** | **1,046,304** |
| **Of which** | | |
| Costs capitalised as part of assets | 4,408 | 4,380 |
| Redundancy Cost | 114 | 185 |

### Note 10.1 Retirements due to ill-health

During 2024/25 there were 5 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £533k (£465k in 2023/24).

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

## Note 11 Pension costs

### Note 11.1 Defined benefit pension schemes

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 is as 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

### Note 11.2 Defined contribution pension scheme

Whilst the standard NHS pension offer remains a defined benefit scheme, the Trust meets its obligations around pensions auto-enrolment through providing access to the NEST defined contribution pension scheme for those who opt-out of the main NHS pension scheme. The Trust pays employer's contributions to this scheme at the minimum rate of 3%. Employees may also choose to opt out of this scheme if they wish.

## Note 12 Finance income

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

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| Interest on bank accounts | 7,150 | 9,465 |
| **Total finance income** | **7,150** | **9,465** |

## Note 13 Finance expenditure

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

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **Interest expense:** | | |
| Interest on loans from the Department of Health and Social Care | 324 | 373 |
| Interest on lease obligations | 464 | 434 |
| **Total interest expense** | **788** | **807** |
| Unwinding of discount on provisions | 1,825 | 1,002 |
| Other finance costs | 119 | 154 |
| **Total finance costs** | **2,732** | **1,963** |

## Note 14 Other gains / (losses)

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| Gains on disposal of assets | - | 6 |
| Losses on disposal of assets | (539) | - |
| **Total gains / (losses) on disposal of assets** | **(539)** | **6** |

## Note 15 Intangible Asset

### Note 15.1 Intangible assets - 2024/25

| | Information Technology £000 | Intangible assets under construction £000 | Total £000 |
|---|---|---|---|
| **Valuation / gross cost at 1 April 2024 - brought forward** | **31,827** | **2,978** | **34,805** |
| Additions | 4,711 | 1,520 | **6,231** |
| Reclassifications | 2,909 | (2,909) | **-** |
| Disposals / derecognition | (783) | - | **(783)** |
| **Valuation / gross cost at 31 March 2025** | **38,664** | **1,589** | **40,253** |
| | | | |
| **Amortisation at 1 April 2024 - brought forward** | **18,934** | **-** | **18,934** |
| Provided during the year | 5,650 | - | **5,650** |
| Disposals / derecognition | (783) | - | **(783)** |
| **Amortisation at 31 March 2025** | **23,801** | **-** | **23,801** |
| | | | |
| **Net book value at 31 March 2025** | **14,863** | **1,589** | **16,452** |
| **Net book value at 1 April 2024** | **12,893** | **2,978** | **15,871** |

## Note 15.2 Intangible assets - 2023/24

| | Information Technology £000 | Intangible assets under construction £000 | Total £000 |
|---|---|---|---|
| **Valuation / gross cost at 1 April 2023 - as previously stated** | **33,236** | **1,806** | **35,042** |
| Additions | 1,997 | 1,172 | **3,169** |
| Disposals / derecognition | (3,406) | - | **(3,406)** |
| **Valuation / gross cost at 31 March 2024** | **31,827** | **2,978** | **34,805** |
| | | | |
| **Amortisation at 1 April 2023 - as previously stated** | **16,110** | **-** | **16,110** |
| Provided during the year | 6,230 | - | **6,230** |
| Disposals / derecognition | (3,406) | - | **(3,406)** |
| **Amortisation at 31 March 2024** | **18,934** | **-** | **18,934** |
| | | | |
| **Net book value at 31 March 2024** | **12,893** | **2,978** | **15,871** |
| **Net book value at 1 April 2023** | **17,126** | **1,806** | **18,932** |

## Note 16 Property, plant & equipment

### Note 16.1 Property, plant and equipment - 2024/25

| | Land | Buildings excluding dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/gross cost at 1 April 2024 - brought forward** | **113,686** | **382,275** | **34,878** | **160,082** | **57,515** | **2,026** | **750,462** |
| Additions | - | 43,790 | 38,683 | 18,108 | 10,864 | 42 | **111,487** |
| Impairments | - | (338) | (14,712) | (2,149) | - | - | **(17,199)** |
| Reversals of impairments | - | 10 | - | - | - | - | **10** |
| Revaluations | 37 | (48,811) | - | - | - | - | **(48,774)** |
| Reclassifications | - | 16,568 | (18,334) | 1,766 | 5,230 | - | **5,230** |
| Disposals / derecognition | - | - | - | (16,207) | (4,094) | - | **(20,301)** |
| **Valuation/ gross cost at 31 March 2025** | **113,723** | **393,494** | **40,515** | **161,600** | **69,515** | **2,068** | **780,915** |
| **Accumulated depreciation at 1 April 2024 - brought forward** | **-** | **75** | **-** | **77,976** | **32,278** | **1,529** | **111,858** |
| Provided during the year | - | 32,223 | - | 13,451 | 11,186 | 244 | **57,104** |
| Impairments | - | 32,190 | - | - | - | - | **32,190** |
| Reversals of impairments | (37) | (7,456) | - | - | - | - | **(7,493)** |
| Revaluations | 37 | (56,850) | - | - | - | - | **(56,813)** |
| Reclassifications | - | - | - | - | 3,158 | - | **3,158** |
| Disposals / derecognition | - | - | - | (15,668) | (4,094) | - | **(19,762)** |
| **Accumulated depreciation at 31 March 2025** | **-** | **182** | **-** | **75,759** | **42,528** | **1,773** | **120,242** |
| **Net book value at 31 March 2025** | **113,723** | **393,312** | **40,515** | **85,841** | **26,987** | **295** | **660,673** |
| **Net book value at 1 April 2024** | **113,686** | **382,200** | **34,878** | **82,106** | **25,237** | **497** | **638,604** |

## Note 16.2 Property, plant and equipment - 2023/24

| | Land | Buildings excluding dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2023 - as previously stated** | **125,481** | **373,353** | **30,563** | **182,594** | **56,634** | **2,171** | **770,796** |
| Transfers by absorption | - | - | - | (1,816) | - | - | **(1,816)** |
| Additions | - | 36,340 | 31,803 | 13,559 | 5,058 | 14 | **86,774** |
| Impairments | (3,503) | (567) | (3,604) | - | - | - | **(7,674)** |
| Revaluations | (8,292) | (41,067) | - | - | - | - | **(49,359)** |
| Reclassifications | - | 14,216 | (23,883) | 4,930 | 5,283 | - | **546** |
| Disposals / derecognition | - | - | - | (39,185) | (9,460) | (159) | **(48,804)** |
| **Valuation/gross cost at 31 March 2024** | **113,686** | **382,275** | **34,878** | **160,082** | **57,515** | **2,026** | **750,462** |
| **Accumulated depreciation at 1 April 2023 - as previously stated** | **-** | **0** | **-** | **103,400** | **33,109** | **1,431** | **137,940** |
| Transfers by absorption | - | - | - | (711) | - | - | **(711)** |
| Provided during the year | - | 27,667 | - | 13,579 | 8,629 | 257 | **50,132** |
| Impairments | 8,292 | 29,702 | - | - | - | - | **37,994** |
| Reversals of impairments | - | (9,514) | - | - | - | - | **(9,514)** |
| Revaluations | (8,292) | (47,780) | - | - | - | - | **(56,072)** |
| Reclassifications | - | - | - | 129 | - | - | **129** |
| Disposals / derecognition | - | - | - | (38,421) | (9,460) | (159) | **(48,040)** |
| **Accumulated depreciation at 31 March 2024** | **-** | **75** | **-** | **77,976** | **32,278** | **1,529** | **111,858** |
| **Net book value at 31 March 2024** | **113,686** | **382,200** | **34,878** | **82,106** | **25,237** | **497** | **638,604** |
| **Net book value at 1 April 2023** | **125,481** | **373,353** | **30,563** | **79,194** | **23,525** | **740** | **632,856** |

## Note 16.3 Property, plant and equipment financing - 31 March 2025

| | Land | Buildings excluding dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned - purchased | 113,723 | 360,762 | 40,515 | 76,147 | 26,975 | 280 | **618,402** |
| Owned - donated/ granted | - | 32,550 | - | 9,694 | 12 | 15 | **42,271** |
| **Total net book value at 31 March 2025** | **113,723** | **393,312** | **40,515** | **85,841** | **26,987** | **295** | **660,673** |

## Note 16.4 Property, plant and equipment financing - 31 March 2024

| | Land | Buildings excluding dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned - purchased | 113,686 | 357,764 | 34,299 | 75,093 | 25,221 | 497 | **606,560** |
| Owned - donated/ granted | - | 24,436 | 579 | 7,013 | 16 | - | **32,044** |
| **Total net book value at 31 March 2024** | **113,686** | **382,200** | **34,878** | **82,106** | **25,237** | **497** | **638,604** |

## Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

| | Land | Buildings excluding dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Subject to an operating lease | - | 3,544 | - | - | - | - | **3,544** |
| Not subject to an operating lease | 113,723 | 389,768 | 40,515 | 85,841 | 26,987 | 295 | **657,129** |
| **Total net book value at 31 March 2025** | **113,723** | **393,312** | **40,515** | **85,841** | **26,987** | **295** | **660,673** |

## Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

| | Land | Buildings excluding dwellings | Assets under construction | Plant & machinery | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Subject to an operating lease | - | 3,315 | - | - | - | - | **3,315** |
| Not subject to an operating lease | 113,686 | 378,885 | 34,878 | 82,106 | 25,237 | 497 | **635,289** |
| **Total net book value at 31 March 2024** | **113,686** | **382,200** | **34,878** | **82,106** | **25,237** | **497** | **638,604** |

## Note 17 Donations of property, plant and equipment

The Trust has recognised £12.3m of grant funding in the year (£2.1m in 2023/24). The funding was provided by the Salix company acting on behalf of the Department for Business, Energy & Industrial Strategy and National Institute for Health and Care Research. The grants were awarded to fund decarbonisation works on the Trust's estate and the purchase of research equipment and software. The Trust also received £2.9m of donations from the Imperial Health Charity to fund capital investments in line with the Charity's objectives (£2.4m in 2023/24).

## Note 18 Revaluations of property, plant and equipment

The Trust's land and buildings assets have been valued by a suitably qualified and independent surveyor (Avison Young Ltd provide valuations, carried out by fully RICS qualified staff). The effective date of the valuation was 31st March 2025.

The valuation was carried out in accordance with International Financial Reporting Standards, The DHSC Group Accounting Manual and the RICS Global Standards ("Red Book"). Most assets are in operational use by the Trust for the delivery of healthcare services and are valued on the Depreciated Replacement Cost with Modern Equivalent Asset, as set out in the Trust's accounting policies. A small number of assets that are non-operational are valued in line with IFRS guidance on fair value using an active market-based approach.

The Trust's operational land and buildings assets are valued on the basis that a modern equivalent asset would take the form of a single site in a general North-West London location that would be suitable for delivery of the Trust's services based on analysis of the population served by the Trust. In calculating the cost of this Modern Equivalent Asset, the Trust and the valuer have had regard to both the nature and size of the facilities that would be required. The valuer has taken the present area of the Trust's land and buildings as the baseline figure but has excluded areas which are not relevant for the comparison (such as courtyards or unused spaces).

The Trust has not made any significant changes to its approach to the accounting estimates used in 2024/25 as compared to previous years. The expected Useful Economic Lives of buildings assets are assessed by the valuer annually based on information provided by the Trust and their own inspections of the estate. The Trust places reliance on these assessments unless it has awareness of information or circumstances that would supersede them. The Trust also assesses the valuation methodologies and accounting treatments being applied to land and buildings assets and advises the valuer if, in its view, there is a need to adopt alternative accounting treatments to those in place previously.

## Note 19 Disposals of fixed assets

The Trust has disposed of assets with a gross cost of £23.6m in 2024/25, with £0.5m Net Book Value impact. The Trust continues to hold assets on the Statement of Financial Position which are fully depreciated (i.e. have zero Net Book Value) with a gross cost (i.e. cost when purchased) of £57m.

## Note 20 Leases - Imperial College Healthcare NHS Trust as a lessee

The Trust leases a number of property assets from other parties (both public and private bodies) for use in the delivery of healthcare, particularly for renal services delivered at community 'satellite' locations. The Trust also leases items of medical and other equipment for use in the delivery of healthcare service

### Note 20.1 Right of use assets - 2024/25

| | Property (land and buildings) £000 | Plant & machinery £000 | Information technology £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2024 - brought forward** | **43,223** | **10,197** | **7,432** | **60,851** | **23,146** |
| Additions | 981 | 7,425 | 1,280 | **9,686** | 883 |
| Remeasurements of the lease liability | 1,113 | 3 | (222) | **894** | 185 |
| Movements in provisions for restoration / removal costs | (1,169) | - | - | **(1,169)** | (1,171) |
| Impairments | (1,034) | - | - | **(1,034)** | (1,034) |
| Reversal of impairments | 2 | - | - | **2** | - |
| Revaluations | (2,090) | - | - | **(2,090)** | (1,531) |
| Reclassifications | - | - | (5,230) | **(5,230)** | - |
| Disposals / derecognition | (1,785) | (725) | - | **(2,510)** | (2,384) |
| **Valuation/gross cost at 31 March 2025** | **39,241** | **16,900** | **3,260** | **59,400** | **18,094** |
| **Accumulated depreciation at 1 April 2024 - brought forward** | **3,964** | **4,159** | **3,374** | **11,497** | **2,355** |
| Provided during the year | 4,167 | 2,576 | 1,001 | **7,744** | 2,142 |
| Impairments | 736 | - | - | **736** | 545 |
| Reversal of impairments | (128) | - | - | **(128)** | - |
| Revaluations | (2,098) | - | - | **(2,098)** | (1,539) |
| Reclassifications | - | - | (3,158) | **(3,158)** | - |
| Disposals / derecognition | (1,785) | (725) | - | **(2,510)** | (2,384) |
| **Accumulated depreciation at 31 March 2025** | **4,856** | **6,010** | **1,217** | **12,083** | **1,119** |
| **Net book value at 31 March 2025** | **34,385** | **10,890** | **2,043** | **47,317** | **16,975** |
| **Net book value at 1 April 2024** | **39,259** | **6,038** | **4,058** | **49,354** | **20,791** |
| Net book value of right of use assets leased from other NHS providers | | | | | 1,767 |
| Net book value of right of use assets leased from other DHSC group bodies | | | | | 15,208 |

## Note 20.2 Right of use assets - 2023/24

| | Property (land and buildings) £000 | Plant & machinery £000 | Information technology £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2023 - brought forward** | **34,414** | **9,621** | **6,440** | **50,475** | **10,303** |
| Additions | 11,329 | 1,277 | 1,000 | **13,606** | 10,133 |
| Remeasurements of the lease liability | (5,541) | 285 | - | **(5,256)** | 351 |
| Movements in provisions for restoration / removal costs | 1,634 | - | - | **1,634** | 1,634 |
| Revaluations | 1,463 | - | - | **1,463** | 747 |
| Reclassifications | - | (546) | - | **(546)** | - |
| Disposals / derecognition | (76) | (440) | (8) | **(524)** | (22) |
| **Valuation/gross cost at 31 March 2024** | **43,223** | **10,197** | **7,432** | **60,851** | **23,146** |
| **Accumulated depreciation at 1 April 2023 - brought forward** | 1,734 | 2,317 | 1,921 | **5,972** | 1,173 |
| Provided during the year | 3,446 | 2,411 | 1,461 | **7,318** | 1,959 |
| Impairments | 132 | - | - | **132** | 132 |
| Reversal of impairments | (1,202) | - | - | **(1,202)** | (111) |
| Revaluations | (70) | - | - | **(70)** | (776) |
| Reclassifications | - | (129) | - | **(129)** | - |
| Disposals / derecognition | (76) | (440) | (8) | **(524)** | (22) |
| **Accumulated depreciation at 31 March 2024** | **3,964** | **4,159** | **3,374** | **11,497** | **2,355** |
| **Net book value at 31 March 2024** | **39,259** | **6,038** | **4,058** | **49,354** | **20,791** |
| **Net book value at 1 April 2023** | **32,680** | **7,304** | **4,519** | **44,503** | **9,130** |

| | |
|---|---|
| Net book value of right of use assets leased from other NHS providers | 2,139 |
| Net book value of right of use assets leased from other DHSC group bodies | 18,652 |

## Note 20.2.1 Revaluations of right of use assets

A number of the Trust's Right of Use assets under IFRS 16 were valued as at 31st March 2025 by a suitably qualified and independent surveyor (Avison Young Ltd, RICS qualified). These are critical leaseholds properties that support the provision of healthcare services for Trust. Valuations are undertaken where the lease is judged to be non-commercial or insufficiently closely tied to market value to represent a suitable proxy for fair value. The method and assumptions applied include identifying the non-cancellable lease term, determining the specialised nature of the properties and the valuation approach of market rent calculation and depreciated replacement cost. In preparing the valuation, the valuer relied on information provided by the Trust which included floor plans and lease terms.

The Trust has not made any material changes to its approach in 2024/25 as compared to previous years. The value of Right of Use assets subject to valuation is £22.8m (2023/24: £23.9m)

The Trust independently reviews the valuation methodologies and accounting treatments being applied and advises the valuer if, in its view, there is a need to adopt alternative accounting treatments to those being used.

## Note 20.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 26.1.

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **Carrying value at 1 April** | **33,324** | **42,610** |
| Lease additions | 9,483 | 3,706 |
| Lease liability remeasurements | 894 | (5,256) |
| Interest charge arising in year | 464 | 434 |
| Lease payments (cash outflows) | (8,133) | (8,169) |
| **Carrying value at 31 March** | **36,032** | **33,324** |

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in note 7.1. with cash outflows in respect of leases recognised on Statement of Financial Position disclosed in the reconciliation above.

## Note 20.4 Maturity analysis of future lease payments

| | Total 31 March 2025 £000 | Of which leased from DHSC group bodies: 31 March 2025 £000 | Total 31 March 2024 £000 | Of which leased from DHSC group bodies: 31 March 2024 £000 |
|---|---|---|---|---|
| **Undiscounted future lease payments payable in:** | | | | |
| - not later than one year; | 8,826 | 1,295 | 7,084 | 1,795 |
| - later than one year and not later than five years; | 18,454 | 3,857 | 15,811 | 3,538 |
| - later than five years. | 10,739 | 2,754 | 11,973 | 3,380 |
| **Total gross future lease payments** | **38,019** | **7,906** | **34,868** | **8,713** |
| Finance charges allocated to future periods | (1,987) | (354) | (1,544) | (317) |
| **Net lease liabilities at 31 March 2025** | **36,032** | **7,552** | **33,324** | **8,396** |
| **Of which:** | | | | |
| Leased from other NHS providers | | 2,794 | | 3,215 |
| Leased from other DHSC group bodies | | 4,758 | | 5,181 |

## Note 21 Inventories

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| Drugs | 10,132 | 9,082 |
| Consumables | 1,796 | 1,913 |
| Energy | 244 | 432 |
| **Total inventories** | **12,172** | **11,427** |

Inventories recognised in expenses for the year were £248.1m (2023/24: £230.5m). Write-down of inventories recognised as expenses for the year were £0.3m (2023/24: £0.7m).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. This distribution ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

## Note 22 Receivables & Allowance for Credit Losses

### Note 22.1 Receivables

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| **Opening Balance** | **129,015** | **120,958** |
| **Current** | | |
| Contract receivables | 165,543 | 123,154 |
| Allowance for impaired contract receivables / assets | (18,885) | (14,173) |
| Prepayments (non-PFI) | 11,808 | 3,798 |
| Interest receivable | 566 | 671 |
| PDC dividend receivable | 309 | 1,086 |
| VAT receivable | 5,601 | 6,005 |
| Other receivables | 4,729 | 6,170 |
| **Total current receivables** | **169,671** | **126,711** |
| **Non-current** | | |
| Other receivables | 2,362 | 2,304 |
| **Total non-current receivables** | **2,362** | **2,304** |
| **Closing Balance** | **172,033** | **129,015** |

## Note 22.2 Allowances for credit losses

| | 2024/25 Contract receivables and contract assets | 2023/24 Contract receivables and contract assets |
|---|---|---|
| | £000 | £000 |
| **Allowances as at 1 April - brought forward** | **14,173** | **11,197** |
| New allowances arising | 5,444 | 3,727 |
| Utilisation of allowances (write offs) | (732) | (751) |
| **Allowances as at 31 Mar 2025** | **18,885** | **14,173** |

## Note 23 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.

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **At 1 April** | **136,718** | **179,215** |
| Net change in year | (43,803) | (42,497) |
| **At 31 March** | **92,915** | **136,718** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 38 | 134 |
| Cash with the Government Banking Service | 92,877 | 136,584 |
| **Total cash and cash equivalents as in SoFP** | **92,915** | **136,718** |
| **Total cash and cash equivalents as in SoCF** | **92,915** | **136,718** |

## Note 23.1 Third party assets held by the trust

Imperial College Healthcare NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or 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 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| Monies on deposit | 89 | 82 |
| **Total third party assets** | **89** | **82** |

## Note 24 Trade and other payables

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| **Current** | | |
| Trade payables | 66,584 | 49,747 |
| Capital payables | 27,280 | 29,499 |
| Accruals | 158,921 | 120,629 |
| Social security costs | 11,777 | 11,420 |
| Other taxes payable | 14,142 | 12,514 |
| Pension contributions payable | 13,561 | 12,178 |
| Other payables | 3,252 | 21,515 |
| **Total current trade and other payables** | **295,517** | **257,501** |
| | | |
| **Of which payables from NHS and DHSC group bodies:** | | |
| Current | 17,198 | 19,195 |
| Non-current | - | - |

## Note 25 Other liabilities

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| **Opening Balance** | **25,784** | **34,759** |
| | | |
| **Current** | | |
| Deferred income: contract liabilities | 31,171 | 23,726 |
| **Total other current liabilities** | **31,171** | **23,726** |
| | | |
| **Non-current** | | |
| Other deferred income | 1,852 | 2,058 |
| **Total other non-current liabilities** | **1,852** | **2,058** |
| | | |
| **Closing Balance** | **33,023** | **25,784** |

## Note 26 Borrowings & financing activities

### Note 26.1 Borrowings

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| **Current** | | |
| Loans from DHSC | 1,239 | 1,241 |
| Other loans | 257 | 351 |
| Lease liabilities | 8,187 | 6,726 |
| **Total current borrowings** | **9,683** | **8,318** |
| | | |
| **Non-current** | | |
| Loans from DHSC | 6,110 | 7,336 |
| Other loans | 1,870 | 2,127 |
| Lease liabilities | 27,845 | 26,598 |
| **Total non-current borrowings** | **35,825** | **36,061** |

The Trust is party to four loans as follows:

Loan 1 - capital investment of £24.5m. Commencing 15 March 2011 and continuing until settlement on 15 March 2031. Fixed interest rate of 3.95%

Loan 2 - joint arrangement loan of £1.87m. Commencing 1 April 2017. Interest free loan, non-repayable subject to going concern of the arrangement

Loan 3 - energy efficiency loan of £0.95m. Commencing May 2018 and fully settled on 1 August 2024. Interest free loan

Loan 4 - energy efficiency loan of £1.28m. Commencing 16 October 2020 and continuing until settled on 1 October 2026. Interest free loan

## Note 26.2 Reconciliation of liabilities arising from financing activities

| | Loans from DHSC £000 | Other loans £000 | Lease Liabilities £000 | Total £000 |
|---|---|---|---|---|
| **Carrying value at 1 April 2024** | **8,577** | **2,478** | **33,324** | **44,379** |
| **Cash movements:** | | | | |
| Financing cash flows - payments and receipts of principal | (1,226) | (351) | (7,668) | **(9,245)** |
| Financing cash flows - payments of interest | (326) | - | (465) | **(791)** |
| **Non-cash movements:** | | | | |
| Additions | - | - | 9,483 | **9,483** |
| Lease liability remeasurements | - | - | 894 | **894** |
| Application of effective interest rate | 324 | - | 464 | **788** |
| **Carrying value at 31 March 2025** | **7,349** | **2,127** | **36,032** | **45,508** |

| | Loans from DHSC £000 | Other loans £000 | Lease Liabilities £000 | Total £000 |
|---|---|---|---|---|
| **Carrying value at 1 April 2023** | **9,805** | **3,028** | **42,610** | **55,443** |
| **Cash movements:** | | | | |
| Financing cash flows - payments and receipts of principal | (1,226) | (550) | (7,734) | **(9,510)** |
| Financing cash flows - payments of interest | (375) | - | (435) | **(810)** |
| **Non-cash movements:** | | | | |
| Additions | - | - | 3,706 | **3,706** |
| Lease liability remeasurements | - | - | (5,256) | **(5,256)** |
| Application of effective interest rate | 373 | - | 434 | **807** |
| **Carrying value at 31 March 2024** | **8,577** | **2,478** | **33,324** | **44,379** |

## Note 27 Provisions

### Note 27.1 Provisions for liabilities and charges analysis

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| **At 1 April 2024** | **55,879** | **44,476** |
| Change in the discount rate | **(122)** | **(510)** |
| Arising during the year | **8,829** | **15,626** |
| Utilised during the year | **(8,599)** | **(3,962)** |
| Reversed unused | **(36,201)** | **(907)** |
| Unwinding of discount | **1,944** | **1,156** |
| **At 31 March 2025** | **21,730** | **55,879** |
| **Expected timing of cash flows:** | | |
| - not later than one year; | **17,394** | **49,839** |
| - later than one year and not later than five years; | **1,273** | **1,794** |
| - later than five years. | **3,063** | **4,246** |
| **Total** | **21,730** | **55,879** |

Provision balances include potential liabilities in respect of legal claims, redundancy and exit costs, dilapidation liabilities on leased properties and other amounts that may be payable to employees or other third parties. The provisions have decreased materially in the year in following resolution of issues around the liability on certain leased property dilapidations.

### Note 27.2 Clinical negligence liabilities

As 31 March 2025, £444.3m was included in provision of NHS Resolution in respect of the Trust's clinical negligence liabilities (31 March 2024: £501.3m).

## Note 28 Contingent assets and liabilities

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (83) | (79) |
| **Gross value of contingent liabilities** | **(83)** | **(79)** |

## Note 29 Contractual capital commitments

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| Property, plant and equipment | 21,331 | 15,892 |
| Intangible assets | 403 | 601 |
| **Total** | **21,734** | **16,493** |

## Note 30 Financial instruments

### Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed mean the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities. The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors and within scope of 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 therefore has low exposure to currency rate fluctuations.

#### Interest Rate Risk

The Trust can borrow from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust can also borrow from government for revenue financing subject to approval by the regulator.

Interest rates on both capital and revenue loans are confirmed by the Department of Health & Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations in respect of loans. At present, the Trust does not have any loans taken out for the purpose of revenue financing and has one capital loan.

The Trust also has borrowings funded by the Department for Business, Energy & Industrial Strategy which are interest-free, and obligations under finance leases where the interest rate is implicit in the lease. The Trust therefore has no exposure to interest rate fluctuations in respect of these borrowings.

The Trust holds significant cash balances via the Government Banking Service (operated by NatWest Bank Plc) for which it receives interest income. The Trust includes this income in its financial planning based on prudent assumptions around likely cash balances and interest rates but could therefore be exposed to interest rate fluctuations in respect of this income.

#### Credit Risk

As the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31st March 2025 is in receivables from non-NHS customers, as disclosed in the trade and other receivables note, for which the Trust feels it has made adequate provision.

#### Liquidity Risk

Liquidity risk reflects the risk that the Trust will have insufficient resources to meet its financial liabilities as they fall due. Management have noted areas affecting liquidity in the going concern disclosure in note 1.2. Mitigating this, the Trust's operating costs are incurred in relation to contracts with ICBs and NHS England, and are financed from resources voted on annually by Parliament, and the Trust funds its capital expenditure primarily from internally generated resources. The Trust's strategy is to manage liquidity risk by ensuring that it has sufficient funds to meet all of its potential liabilities as they fall due. Liquidity forecasts are produced regularly to ensure the

utilisation of current facilities is optimised and liquidity is maintained. The Trust also continually assesses its loan funding.

## Note 30.2 Carrying values of financial assets

| Carrying values of financial assets as at 31 March 2025 | Held at amortised cost £000 | Total book value £000 |
|---|---|---|
| Trade and other receivables excluding non-financial assets | 154,314 | **154,314** |
| Cash and cash equivalents | 92,915 | **92,915** |
| **Total at 31 March 2025** | **247,229** | **247,229** |

| Carrying values of financial assets as at 31 March 2024 | Held at amortised cost £000 | Total book value £000 |
|---|---|---|
| Trade and other receivables excluding non-financial assets | 118,125 | **118,125** |
| Cash and cash equivalents | 136,718 | **136,718** |
| **Total at 31 March 2024** | **254,843** | **254,843** |

## Note 30.3 Carrying values of financial liabilities

| Carrying values of financial liabilities as at 31 March 2025 | Held at amortised cost £000 | Total book value £000 |
|---|---|---|
| Loans from the Department of Health and Social Care | 7,349 | **7,349** |
| Obligations under leases | 36,032 | **36,032** |
| Other borrowings | 2,127 | **2,127** |
| Trade and other payables excluding non-financial liabilities | 243,048 | **243,048** |
| **Total at 31 March 2025** | **288,556** | **288,556** |

| Carrying values of financial liabilities as at 31 March 2024 | Held at amortised cost £000 | Total book value £000 |
|---|---|---|
| Loans from the Department of Health and Social Care | 8,577 | **8,577** |
| Obligations under leases | 33,324 | **33,324** |
| Other borrowings | 2,478 | **2,478** |
| Trade and other payables excluding non-financial liabilities | 221,911 | **221,911** |
| **Total at 31 March 2024** | **266,291** | **266,291** |

## Note 30.4 Maturity of financial liabilities

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

| | 31 March 2025 £000 | 31 March 2024 £000 |
|---|---|---|
| In one year or less | 253,636 | 230,899 |
| In more than one year but not more than five years | 23,988 | 21,793 |
| In more than five years | 13,851 | 16,395 |
| **Total** | **291,475** | **269,087** |

### Note 30.5 Fair values of financial assets and liabilities

The Trust holds financial assets and liabilities at amortised cost unless the criteria for recognition at fair value through other comprehensive income or through profit or loss are met. For receivable and payable items, the transaction price (less impairments in respect of receivables) is determined to be a reliable measure of fair value and no discounting is applied. The Trust also holds interest-free loans as part of its arrangement with other NHS partners for hosting the North West London Pathology service. Repayment of these balances is conditional on arrangements around NWLP and is not timebound, therefore no discounting has been applied.

## Note 31 Losses and special payments

| | 2024/25 | | 2023/24 | |
|---|---|---|---|---|
| | Total number of cases Number | Total value of cases £000 | Total number of cases Number | Total value of cases £000 |
| **Losses** | | | | |
| Cash losses | 20 | 63 | 14 | 28 |
| Bad debts and claims abandoned | 236 | 1,319 | 187 | 1,495 |
| Stores losses and damage to property | 12 | 311 | 12 | 707 |
| **Total losses** | **268** | **1,693** | **213** | **2,230** |
| **Special payments** | | | | |
| Ex-gratia payments | 90 | 34 | 84 | 53 |
| Special severance payments | - | - | 1 | 14 |
| **Total special payments** | **90** | **34** | **85** | **67** |
| **Total losses and special payments** | **358** | **1,727** | **298** | **2,297** |

The Trust is required to report on individual losses in excess of £300k in value. No such losses were incurred in 2024/25 or 2023/24.

## Note 32 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Imperial College Healthcare NHS Trust other than receipt of employment benefits and accrual of entitlement to post employment benefits. Remuneration of board members is disclosed in the remuneration report.

During the year 2024/25 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below for the year ending 31 March 2025. This list is indicative and not exhaustive.

- Department of Health & Social Care (Parent)
- NHS England
- NHS foundation trusts including:
- Chelsea and Westminster NHS Foundation Trust
- Hillingdon Hospitals NHS Foundation Trust

ICBs including:

- North West London ICB
- NHS trusts including:
- London North West University Healthcare NHS Trust

Other NHS Bodies including:

- Health Education England
- NHS Litigation Authority
- NHS Pension Scheme
- NHS Blood & Transplant

Other non-NHS entities:

- HM Revenue and Customs

Though not required to be disclosed under IAS24, the Trust has elected to disclose three further items of information which readers of the accounts may find useful.

The Trust enjoys a collaborative relationship with the Imperial Health Charity. The Charity is independent of the Trust. The Trust nominates trustees to the board of the Charity (at present three of the Trust's executive and non-executive directors undertake this role, of which two are voting members of the Trust board) but the Charity's governing arrangements prevent these trustees from exercising control. The Charity's aim is to support public health and the work of the NHS as a whole. The Trust benefits from this through receipt of grant funding for agreed purposes in line with the Charity's aims. Grants can cover revenue items and capital expenditure.

The Trust is also closely connected to Imperial College London. The two organisations are not related parties under IAS 24 but work together in a range of areas including research activities and medical education. The College occupies space within the Trust's sites and a number of the Trust's medical staff also hold roles with the College.

Professor Julian Redhead (the Trust's Medical Director) has undertaken private medical practice during 2024/25 through Imperial College Healthcare Private Care. This is carried out on the same basis as Imperial College Healthcare Private Care's other business. This work is not included in the remuneration report because it does not pertain to Prof. Redhead's role as an employee of the Trust.

## Note 33 Transfers by absorption

For functions that have been transferred from the Trust to another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised or de-recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/ loss corresponding to the net assets/ liabilities transferred is recognised within income and expenses, but not within operating activities.

During 2024/25 there were no transfers by absorption. However, in 2023/24 medical diagnostic equipment with a net book value of £1.1m was transferred to London North West University Hospitals NHS Trust (LNWUHT) as part of the creation of the North West London Community Diagnostic Centres (CDCs) network. The transfer supports development of the network with LNWUHT assuming control of the provision of services at the relevant CDC site.

## Note 34 Events after the reporting date

There are no events after the reporting date that require disclosure in these accounts.

### Note 35 Better Payment Practice code

| Non-NHS Payables | 2024/25 Number | 2024/25 £000 | 2023/24 Number | 2023/24 £000 |
|---|---|---|---|---|
| Total non-NHS trade invoices paid in the year | 152,488 | 730,359 | 165,789 | 655,967 |
| Total non-NHS trade invoices paid within target | 148,913 | 673,035 | 161,903 | 601,883 |
| **Percentage of non-NHS trade invoices paid within target** | 97.7% | 92.2% | 97.7% | 91.8% |
| | | | | |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 5,141 | 103,825 | 5,060 | 93,887 |
| Total NHS trade invoices paid within target | 4,486 | 88,786 | 4,445 | 74,794 |
| **Percentage of NHS trade invoices paid within target** | 87.3% | 85.5% | 87.8% | 79.7% |
| | | | | |
| **Total Payables** | | | | |
| Total trade invoices paid in the year | 157,629 | 834,184 | 170,849 | 749,854 |
| Total trade invoices paid within target | 153,399 | 761,821 | 166,348 | 676,677 |
| **Percentage of NHS trade invoices paid within target** | 97.3% | 91.3% | 97.4% | 90.2% |

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 valid invoice, whichever is later.

## Note 37 Capital Resource Limit

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| Gross capital expenditure | 128,299 | 98,292 |
| Less: Disposals | (539) | (764) |
| Less: Donated and granted capital additions | (15,200) | (14,404) |
| **Charge against Capital Resource Limit** | **112,560** | **83,124** |
| | | |
| Capital Resource Limit | 118,655 | 83,124 |
| **Under / (over) spend against CRL** | **6,095** | **(0)** |

## Note 38 Breakeven duty financial performance

| | 2024/25 £000 | 2023/24 £000 |
|---|---|---|
| Adjusted financial performance surplus / (deficit) (control total basis) | 82 | 30 |
| Remove impairments scoring to Departmental Expenditure Limit | 55 | 3,841 |
| **Breakeven duty financial performance surplus** | **137** | **3,871** |

## Note 39 Breakeven duty rolling assessment

| | 1997/98 to 2008/09 £000 | 2009/10 £000 | 2010/11 £000 | 2011/12 £000 | 2012/13 £000 | 2013/14 £000 | 2014/15 £000 | 2015/16 £000 | 2016/17 £000 |
|---|---|---|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | | 9,102 | 5,146 | (8,419) | 9,025 | 15,128 | 15,405 | (47,879) | (15,330) |
| Breakeven duty cumulative position | 24,775 | 33,877 | 39,023 | 30,604 | 39,629 | 54,757 | 70,162 | 22,283 | 6,953 |
| Operating income | | 900,234 | 920,256 | 941,690 | 971,274 | 979,312 | 1,000,614 | 1,019,905 | 1,096,575 |
| **Cumulative breakeven position as a percentage of operating income** | | 3.8% | 4.2% | 3.2% | 4.1% | 5.6% | 7.0% | 2.2% | 0.6% |

| | 2017/18 £000 | 2018/19 £000 | 2019/20 £000 | 2020/21 £000 | 2021/22 £000 | 2022/23 £000 | 2023/24 £000 | 2024/25 £000 |
|---|---|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | 3,023 | 32,996 | 11,255 | 47 | 5,005 | 325 | 3,872 | 137 |
| Breakeven duty cumulative position | 9,976 | 42,972 | 54,227 | 54,274 | 59,279 | 59,604 | 63,475 | 63,612 |
| Operating income | 1,160,803 | 1,212,959 | 1,300,616 | 1,422,789 | 1,483,121 | 1,601,459 | 1,714,687 | 1,875,535 |
| **Cumulative breakeven position as a percentage of operating income** | 0.9% | 3.5% | 4.2% | 3.8% | 4.0% | 3.7% | 3.7% | 3.4% |

# Notes

# Notes

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