Annual Report

2023/24

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NHS

Imperial College Healthcare
NHS Trust

Our annual report for 2023/24 is dedicated to the commitment and expertise of all our people.

We pay special recognition to our colleagues who died last year and celebrate their lives and contribution to the NHS:

- Mohamed Aden
- Arockiamary Arputham
- Prafful Bharkhda
- Norma Campbell
- Harjinder Chaggar
- Jenny Vaughan
- Joe Kennedy
- Edwin Lumaban
- Dr Tasneem Mahmud
- Dr Peter Mason
- Dr Nicola Mitchell-Jones
- Keerthisingham Mohanadas
- Kiran Palakurthi
- Dr Stephen Quinn
- Ju-An Sagge
- Lorna Simpson
- Ousman Sonko
- Krisztina Szecsodyne Kollar
- Yuriy Ustyanyk
- Vivek Vekaria

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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

We formed the North West London Acute Provider Collaborative in September 2022 with the ambition of providing better care, for more people, more fairly across the four acute NHS trusts in our sector. We have achieved a huge amount together already and so I want to start by thanking all our staff and volunteers for their hard work. Their commitment has been especially impressive given the challenges of the past year for our trusts and the wider NHS. As can be seen in the performance report, we have faced continuing growth in demand, especially in A&E, multiple rounds of industrial action, and increasing pressure on public finances. This has taken its toll on all our people and it requires our continuing focus on improving our health and wellbeing offer to our staff as well as our local communities.

The past 12 months have seen us deliver our first major projects under our collaborative banner. On 4 December, we welcomed the first patients to the new North West London Elective Orthopaedic Centre at Central Middlesex Hospital, a centre of excellence serving surgeons and patients from all four trusts. It has allowed us to bring together routine, low complexity orthopaedic procedures on a planned care site which will improve outcomes, allow us to treat more patients more efficiently, and reduce the risk of operations being cancelled due to urgent and emergency care pressures.

Last year, we also opened two new community diagnostic centres for north west London, in Willesden and Wembley, as well as a new eye care diagnostic centre in Willesden. So far this year, we have opened another eye care diagnostic centre in Westminster and a third community diagnostic centre in Ealing. All have been located in areas that serve communities most at risk of health inequalities and, together, provide over 196,000 additional diagnostic tests annually. They will help us bring down waiting times while also ensuring fairer access to services.

A third major development was bringing London North West University Healthcare and The Hillingdon Hospitals onto the same electronic patient record system as the other two trusts, Chelsea and Westminster Hospital and Imperial College Healthcare. This is already bringing benefits for patients who receive care at more than one of our trusts and creates further, huge potential for standardising to evidence-based, best practice and expanding data-led research and development.

Collaboration is also helping us improve our day-to-day patient activities. We have peer-review programmes, including for A&E and discharge from hospital, to help us learn from one another and spread best practice and innovation more quickly. Services with more capacity at one hospital can support those with very long waiting lists at another, helping patients to get treated more quickly and making best use of our collective resources. And we have joint teams working on a range of improvements, from recruitment and inclusion to learning from safety incidents and managing complaints.

All of this has helped our trusts meet the majority of our operational and financial performance targets while also making our hospitals better places to work. The 2023 NHS staff survey showed significant improvements for all four of our trusts, especially for morale.

As we look to the year ahead, we will be focusing particularly on our longer-term infrastructure needs. The Hillingdon Hospitals and Imperial College Healthcare are both part of the New Hospitals Programme and all our trusts are committed to continuing improvement of their estate. We'll also be looking to maximise the potential of our shared electronic patient record system and the roll out of a national federated data platform to improve care planning and coordination.

Just before I close, I would like to express my gratitude to the non-executive directors who stepped down from the board in common during the past year: Nilkunj Dodhia, Professor Des Johnston, Professor Andy Bush, Peter Goldsbrough, Nick Ross, Neville Manuel and, in particular, to thank Janet Rubin who completed her term of office as vice chair at London North West University Healthcare in February – I am very pleased to welcome David Moss as her successor.

The last two years have shown us the power of collaboration, not just between our own trusts but also with our patients, communities and health and care partners. There are many challenges ahead – and much more to do – but I am more confident than ever that our collaborative approach is the key to success.

M. Swindells

Matthew

Performance report

This section provides a summary of our performance for 2023/24. 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. It also includes a report from our chief financial officer and a review of our progress with sustainability and health inequalities.

Overview

Professor Tim Orchard, Chief executive

The NHS has been in the spotlight again this past year, with long waits and delays, industrial action and, rightly, rising expectations about quality and equity. It reflects the importance of the NHS in everyone's lives, a fact that has not gone unnoticed by politicians in the run up to the 2024 general election.

Industrial action posed fundamental challenges to who we are as an organisation, alongside practical considerations of how best to keep services running. I am proud that our staff remained one team, respecting the views of those who chose to take action and those who did not, while also working together to keep everyone safe. I hope we can build on recent national progress in resolving the disputes to help us with the challenges ahead.

We will also be able to draw on our achievements of the past year, which were significant, especially in the context of industrial action. We continued to have one of the lowest mortality rates in the NHS, maintained our 'outstanding' rating for both our maternity units following a re-inspection by the CQC, met the majority of our operational targets, improved our NHS staff survey results for the third year in a row and made progress on a range of major development programmes. And we did all that within our planned £1.5 billion budget.

I want to highlight some of those achievements in a little more detail and then look ahead to our ambitions – and the risks we will need to manage – for 2024/25.

Operational performance

Beginning with the care we deliver day-in, day-out, we increased our activity overall to 111 per cent of our pre-pandemic levels. In urgent and emergency care, this helped us meet the national target to treat and discharge or admit at least 76 per cent of A&E patients within four hours and consistently have some of the fastest ambulance handover times in London.

Our waiting lists remain much bigger than before the pandemic but we essentially eliminated waits of over 90-weeks, and we are on track to do the same for waits of over 78-weeks this summer. We also have a good route to achieving our next goal of having no one waiting over 65 weeks for treatment while continuing to treat almost all patients who are clinical priorities, for example patients with cancer, within four weeks of a decision to treat. Maintenance issues with some of our aging scanners have made it more difficult to reduce general diagnostic waiting times but we performed well against the cancer faster diagnostic standard which requires at least 75 per cent of patients with suspected cancer to receive their diagnosis within 28 days of referral. We achieved the target for 83 per cent of our patients in March 2024, the eleventh consecutive month in which we met the standard.

We have achieved improvements by focusing on operational flow, investing over £2.7 million last winter to open extra beds, extend service hours and further expand same-day emergency care. We also took over management of the urgent treatment centre at St Mary's in 2023 which enabled us to improve care pathways from the moment someone arrives for urgent care. In planned care, our operating theatre efficiency programme has meant we can treat more patients within the same resources. We are now in the top ten of NHS trusts nationally for theatre productivity, with especially good performance at the Western Eye Hospital where we added a third theatre as part of wider refurbishments.

Our culture

Building an organisation that is genuinely driven by its values – to be kind, aspirational, expert and collaborative – has been my personal priority since I took over as Chief executive in 2019. Alongside the headline improvements in our NHS staff survey scores, there has been specific progress in survey scores for 'we are compassionate and inclusive' and 'we are a team' – both areas where we particularly focused our efforts in 2023/24.

We expanded development opportunities to strengthen diversity, our staff networks continued to flourish, and we began to get real traction with our inclusive recruitment policy. This requires everyone recruiting to roles at band 7 and above to have diverse interview panels and to share their rationale for appointment decisions directly with me. This focus has helped us increase the proportion of staff at band 7 and above who are from Black, Asian and minority ethnic backgrounds from 35 per cent in 2021 to 44 per cent in 2024. Our 'engaging for equity and inclusion' programme, launched last year, involved almost 1,200 staff and ten community groups in structured discussions to help us develop a shared understanding of what it would mean for us to become a truly anti-discriminatory and anti-racist organisation.

We're driving organisational culture change through our development programmes too. For example, with our green plan and volunteering into employment initiative helping us become a better partner to our communities, and the new national patient safety incident response framework ensuring patients and families are at the centre of our response to safety issues.

Collaboration

We have continued to work much more collaboratively with a wide range of partners as well as with our patients and local communities. We expanded our lay partner network with dedicated safety partners to help ensure the new patient safety framework reflects the needs and views of all our users, as well as other safety initiatives – such as a new, 24/7 telephone safety net for inpatients whose condition may be deteriorating.

We are working closely with Imperial College London, Imperial Health Charity, our local authority partners and others on a range of initiatives, including the establishment of Paddington Life Sciences Partners in 2023. This brings together clinicians, researchers, industry, patients and local communities around St Mary's Hospital, helping to generate economic as well as health and healthcare benefits.

Our partnership with the other three acute NHS trusts in our sector, North West London Acute Provider Collaborative, delivered its first major developments in 2023/24 – a new elective orthopaedic centre at Central Middlesex Hospital, allowing routine hip and knee replacements to be consolidated in one specialist unit to help improve quality and productivity, and our first two community diagnostic centres, to expand capacity and make access fairer.

Research and innovation

Last year was the first of a new, five-year programme for Imperial Biomedical Research Centre (BRC), a partnership between the Trust and Imperial College London. The latest award of £95.3 million from the National Institute for Health and Care Research (NIHR) made us the largest BRC in the country.

We ran 1,010 clinical trials across our hospitals last year, involving more than 24,000 patients – more than ever before. This enables us to translate research breakthroughs into more new treatments and better ways of working. For example, one of our trials found that patients with chest pain may benefit from having a stent implanted rather than starting chest pain medication. The trial is influencing guidelines for the treatment of coronary artery disease worldwide and allowing immediate improvements for our patients. In November, an international trial we led in the UK resulted in the world-first approval of a novel gene-editing treatment for sickle cell disease and beta thalassaemia developed by Vertex Pharmaceuticals and CRISPR Therapeutics.

And the innovation of our teams has not been limited to clinical trials. In August 2023, a joint Imperial College Healthcare and Oxford University Hospitals team performed the UK's first womb transplant, giving a woman who was born without a functioning womb the possibility of carrying her own baby.

Looking ahead

Our external environment remains as pressured as last year, if not more so. And it is unlikely that there will be any major changes in the near term – finances will still be constrained, and the needs of our local communities will continue to grow and change.

The four organisational objectives we set ourselves for 2023-25 remain entirely relevant:

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

We will continue to prioritise developments that allow us to deliver against all of our objectives, reflecting the continuing relevance of the NHS's quadruple aim – better health for our communities, better care for our patients, better wellbeing for our staff and better value for money.

As such, I expect us to make significant progress with our outpatient improvement programme, overhauling our appointment booking system and developing new models of care that respond to the needs of patients and make the best use of everyone's time. We will also use this programme to help achieve a step-change in data quality – which has been affected by the increase in demand – by co-designing more intuitive processes that make it easier for everyone to capture and maintain accurate information.

We will continue to work with partners to ensure we are using the latest evidence to guide clinical practice and drive-up outcomes. And we will also continue to develop better ways of gathering feedback and insights and involving patients, local communities, staff and other partners in improvement – in particular to make progress on equity and inclusion and to implement the recommendations from our ongoing cancer pathways review. I am hopeful that this year will see a breakthrough in the redevelopment of our ageing estate across all our sites. We have clearly evidenced the risks that having some of the worst estate in the NHS poses to healthcare across the capital, and I would expect to be able to move on from our planning work to the beginning of practical design and delivery for our new hospitals.

Whatever the year ahead holds, I know that our nearly 16,000 staff remain committed to ensuring the very best health and healthcare for our patients and local communities. I am, as always, hugely grateful for all their efforts and expertise. Working with our communities and partners, I remain confident that we will be able to fulfil our commitment.

Tim

About the Trust

At Imperial College Healthcare NHS Trust we provide acute and specialist healthcare to over 1.3 million people a year. Formed in 2007, we are one of the largest NHS trusts in the country, with almost 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 offer private healthcare in dedicated facilities on all our sites.

We are a member of the North West London Acute Provider Collaborative, a partnership established in 2022 with the other acute NHS trusts in the 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 33,000 staff and serve a local population of over 2.2 million. We remain independent organisations with a chair in common and a board in common.

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 will enable us to achieve our vision of 'better health, for life':

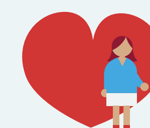
- To help create a high-quality integrated care system (ICS) with the population of north west London.
- To develop a sustainable portfolio of outstanding services.
- To build learning, improvement and innovation into everything we do.

We set four objectives for 2023-25, measurable steps towards our strategic goals that reflect our current challenges and opportunities:

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

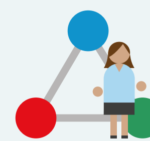
Our values

Everything we do is underpinned by our values, 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, a 24/7 A&E department and hosts the hyper acute stroke unit for the region. It is also a growing hub for integrated care in partnership with local GPs and community providers.

Hammersmith Hospital, Acton: is a specialist hospital renowned for its strong research focus. It offers a range of services, including renal, haematology, cancer and cardiology care, and provides the regional specialist heart assessment centre.

Queen Charlotte's and Chelsea Hospital, Acton: is a maternity, women's and neonatal care hospital, also with a strong research focus. It has a midwife-led birth centre as well as specialist services for complicated pregnancies, foetal and neonatal care.

St Mary's Hospital, Paddington: is the major acute hospital for north west London as well as a maternity centre with consultant and midwife-led services. The hospital provides care across a wide range of specialties and runs one of four major trauma centres in London in addition to its 24/7 A&E department.

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

We run eight renal satellite units and, as of 2023/24, two community diagnostic centres.

Private care

Our private care division offers a wide 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 and the Sainsbury Wing at Hammersmith Hospital. Our private care division allows us to extend our offer to those who are not eligible for NHS servces or who choose to have private care. The income from private care is reinvested into all our services.

Our academic partners

Imperial College London is our core academic partner – we help provide education and training for undergraduate medical students and postgraduate trainees. With Imperial College, we run one of the 20 National Institute for Health and Care Research biomedical research centres and, with additional partners – The Institute of Cancer Research, London, The Royal Marsden NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust – we are one of eight academic health science centres in England. We also work in partnership with a range of other universities, including Buckinghamshire New University, Brunel University and Kings 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, which helps our five hospitals do more through grants, arts, volunteering and fundraising. In 2023/24, the charity invested approximately £4.54m 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 as well as awarding emergency hardship grants for patients and their families at times of financial crisis.

Supporting the arts in healthcare, the Charity manages a museum-accredited hospital art collection and runs an arts engagement programme, providing creative activities for patients, NHS staff and the wider community. The Charity also manages a community of over 950 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, and from 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 2024. 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.

Our lay partners

We are committed to increasing and deepening the involvement of patients and the public in every aspect of our work. One important element of our involvement approach is our community of lay partners – local people and/or patients who provide independent insight and oversight to help ensure we understand and respond to the needs of our patients and local communities.

The strategic lay forum was established in 2015 to ensure we put patients at the centre of everything we do and to guide and oversee our patient and public involvement strategy. It brings 12 lay partners together with senior staff from across the Trust and representatives from Imperial College London and Imperial Health Charity, meeting formally every two months.

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.

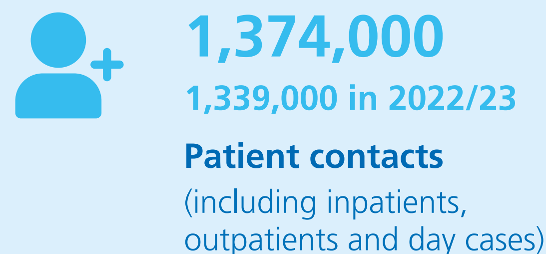
The North West London ICS has four key objectives, to:

- 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.

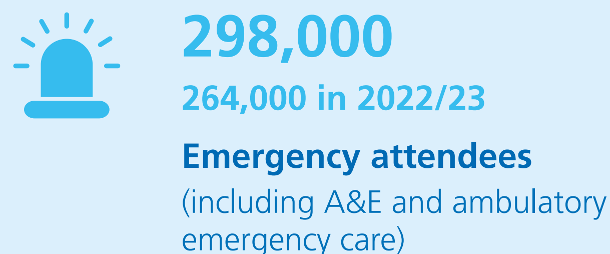
The Integrated Care Board in North West London is called NHS North West London. It is the statutory NHS organisation responsible for developing a plan that meets the health needs of the local population, managing the NHS budget and arranging for the provision of health services in north west London. Around 47 per cent of our income is from services commissioned by NHS North West London, around 38 per cent is from specialist services commissioned by NHS England, and the remainder is earned from other sources including other NHS bodies, local authorities, research and private healthcare.

Trust in numbers 2023/24

Our services



1,374,000
1,339,000 in 2022/23
Patient contacts
(including inpatients, outpatients and day cases)



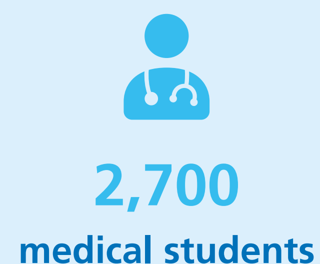
298,000
264,000 in 2022/23
Emergency attendees
(including A&E and ambulatory emergency care)

9,500
9,400 in 2022/23
Babies born

33,400
32,600 in 2022/23
Operations

96%
Same in 2022/23
Positive overall rating of care for inpatients
(Response to our friends and family test inpatient survey)

Our students



2,700
medical students

641
nurses in education

Our research

1,010
active clinical research studies

24,000
patients involved in research studies

Our finances

£1.5B
budget

£30,000
surplus
(adjusted)*

£1.7B
£1.6B in 2022/23
turnover

£53.4M
£15.8M in 2022/23
efficiencies

£98.3M
£141.7M in 2022/23
capital investments, including buildings, infrastructure and IT

Our staff

2,104
Admin and clerical

831
Allied health professional (qualified)

118
Allied health professional (support)

1,112
Ancillary

30
Doctor (career grade)

1,346
Doctor (consultant)

2,017
Doctor (training grade)

4,544
Nursing and midwifery (qualified)

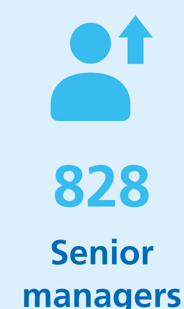
1,224
Nursing and midwifery (support)

165
Pharmacist

9
Physician associate

908
Scientific and technical (qualified)

463
Scientific and technical (support)



828
Senior managers

15,699
Trust total

*NHS England monitors NHS trust financial performance using an adjusted measure, which is derived from its surplus/(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

This section outlines our performance, achievements and challenges against our objectives and business plan for 2023/24.

How we're doing against our organisational objectives

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.

We set four objectives for 2023-25, measurable steps towards our strategic goals that reflect our current challenges and opportunities:
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 business plan which incorporates financial and operational performance targets agreed with NHS England and NHS North West London. Our annual quality account provides a more detail report on progress against our quality metrics and objectives – it is available on our website.

We measure performance in operational areas against key national indicators. Performance indicators are reported monthly to highlight risks and uncertainty in specific areas of service. Our analysis of these key national indicators on **page 21.**

Risks and challenges in achieving our strategic goals

Risks to our strategic goals are included in our board assurance framework.

Key risks to the achievement of our strategic goals are:

- Inequalities in our population's access to, experience of and outcomes from the care we provide.
- Failure to transfer medically optimised patients to mental health inpatient settings due to lack of available beds impacting on patient safety and experience.
- Failure to provide appropriate condition of buildings and infrastructure impacting on patient, visitor and staff safety and effective clinical delivery.
- Failure to follow infection prevention and control policies and guidelines resulting in healthcare acquired infections.
- Poor data quality across people, process, systems and reporting causing delays to the booking of patients.
- Not achieving the required underlying deficit improvements to deliver a sustainable financial position.
- Failure to gain funding and approvals from key stakeholders for the redevelopment programme resulting in continuing to deliver services from suboptimal estates and clinical configuration.
- Failure to maintain critical services following an emergency event or pandemic due to inadequate business continuity planning.

Further detail on risk is explored in the annual governance statement on **page 58**.

1. Building a values-led culture

We have made significant progress in developing an organisational culture that genuinely reflects our values – to be kind, collaborative, aspirational and expert. This was despite the challenges of continuing industrial action and the significant financial and operational pressures faced by the whole NHS.

We are becoming a fairer and more inclusive organisation, focused on understanding and responding to the needs of all our users – patients, local communities and staff as well as our wider health and care partners.

We saw real evidence of this progress in the 2023 NHS staff survey with our third consecutive year of improved results. We are now above the acute trust average in seven out of nine survey themes and we maintained particularly high scores for 'engagement' and 'opportunities to learn'. Our scores improved on the previous year for all four questions under the theme 'we are compassionate and inclusive', rising above the average for acute trusts for the first time. However, our scores for the themes 'flexible working' and 'reward and recognition' still sit at or just below the acute trust average.

Here are last year's major developments:

Improving equality, diversity and inclusion

Our work draws on feedback from staff, patients, and local communities with our staff networks and patient and public involvement activities playing increasingly important roles.

In 2023, we asked each division and directorate to create their own action plans for equality, diversity and inclusion, identifying and addressing their local priorities for improvement. Progress is monitored by our equality, diversity and inclusion committee, chaired by the chief executive.

We expanded training and development opportunities, including introducing the targeted Healthcare Leaders' Fellowship and participating in the national White Allies programme. We also maintained a strong focus on our inclusive recruitment programme which ensures diverse interview panels and requires recruiting managers to share their rationale for appointment decisions. This has helped us increase the proportion of staff at band 7 and above who are from Black, Asian and minority ethnic backgrounds from 35 per cent in 2021 to 44 per cent in 2024.

In September, we launched a major new initiative – engaging for equity and inclusion. Just under 1,200 staff and 76 patients and patient representatives joined discussions in the six months to the end of February 2024 to help us develop a shared understanding of what it would mean for us to become a truly anti-discriminatory and anti-racist organisation. We're now using the insights to shape our first inclusion pledges and guide our equality, diversity and inclusion priorities for 2024 and beyond.

Building our management, leadership and engagement capabilities

We have been building our leadership and line management capabilities, especially to ensure all staff feel they are part of a team, working towards common goals, valued for their contribution and empowered to speak up and be heard.

Over 2,000 of our managers took part in our bespoke 'improvement through people management' training scheme last year. And, at Charing Cross Hospital, we have been working towards the international Pathway to Excellence accreditation which is helping us to create and demonstrate a positive practice environment for all nurses.

We have also overhauled our staff intranet to make it as easy as possible for staff to access the information and resources they need and get involved in key programmes. This has been particularly important in facilitating wider engagement in the development of a more patient-focused organisational culture, such as the introduction of the new patient safety framework.

Ensuring improvement is for everyone

In November 2023, we launched our new 'Improvement for all' programme with a series of virtual 'big rooms' open to all staff and lay partners. The sessions focused on how we can enable each ward, service and department to drive and prioritise change through one integrated improvement plan owned by the whole team. Key elements include ensuring we gather and respond to insights and views that help us understand the views and needs of patients, local communities and staff.

Being a good community partner

We serve some of the poorest communities in London and have an important role to play in helping to improve health and tackle health inequalities outside, as well as within, our hospital walls. Paddington Life Sciences Partners – the network of life sciences organisations that we established last year, based around St Mary's Hospital – has a core objective to deliver social value as well as better healthcare. We teamed up with Bloomberg Associates and Westminster City Council to undertake a skills mapping initiative to encourage and support education and training providers to develop programmes that will help local people gain work in health and life sciences.

We joined forces with the Chelsea FC Foundation to create 'Bridging the Blues', community rehabilitation for patients with a variety of health conditions. These 12-week programmes combine exercise, physical activity and peer support to improve physical and mental wellbeing.

As one of the largest contributors to climate change and air pollution in the UK, the NHS has a particular responsibility to reduce its carbon emissions. Our refreshed green plan commits us to reducing our carbon footprint by at least 34 per cent against 2019/20 levels. Last year, we launched a green community network for staff who want to learn more as well as a green champions programme to support staff who want to make their own work areas more environmentally friendly.

Looking ahead

We will continue our focus on improving equality, diversity and inclusion, with the launch of our refreshed strategy incorporating the feedback from last year's engagement programme. The NHS staff survey results also showed us that we need to improve our offer on 'flexible working' and 'reward and recognition'. And, with the full roll out of the new patient safety framework, we will be working hard to become more patient-focused in everything we do, including through the development of our user insights and design capabilities and compassionate engagement with patients and families on learning from incidents, complaints and concerns.

2. Improving outcomes for patients and local communities

We continued to have one of the lowest mortality rates of all acute NHS trusts and our clinical leadership structure helps ensure that quality of care is always at the heart of our governance processes. Our patients, lay partners and local communities are increasingly involved in identifying and shaping improvements, through developments to improve our use of insights and feedback and to expand co-design and community engagement.

But we need to do more to improve how we respond to incidents and feedback, especially to ensure we involve patients and their families fully and compassionately and ensure our care offer is inclusive for all members of our communities.

One of the biggest quality challenges we face is our aging estate, especially at St Mary's, parts of which are almost 180 years old. As well as continuing to make progress on longer-term redevelopment schemes for all three of our main sites (despite a set-back on government funding plans), we have been able to make targeted capital investments in the last year of over £18m.

This is how we focused our efforts to improve outcomes last year:

Patient centred safety

The NHS introduced a new national patient safety incident response framework (PSIRF) last year. PSIRF encourages us to understand how incidents occur, leading to better learning and ultimately safer care for patients. It will help us to prioritise efforts on areas where improvements will make the most difference. Instead of having multiple separate action plans in response to incidents, we will connect insights to inform existing improvement programmes and spot when we need to add new ones.

We have also been focusing on delivering our safety improvement programme, with workstreams to improve patient care, experience and outcomes in our key areas of clinical risk. Our patient safety partners are now actively involved in each workstream and have been instrumental in developing our local strategy for 'involving patients in patient safety' which will help ensure patients are designing safer healthcare from the outset and that they know how to stay safe when they visit hospital.

Call for concern

In January 2024, we introduced Call for concern, a 24/7 service that gives patients, relatives and carers direct access to a clinical response team if they are concerned ward staff are not recognising that a patient's condition may be deteriorating. The response team, who already work closely with colleagues across our hospitals when a patient is very unwell, assess the situation and take any action that is needed. This service, based on one developed by the Royal Berkshire NHS Foundation Trust, also meets many requirements of Martha's Rule, a national initiative to help identify and respond quickly to patients whose condition deteriorates while in hospital, named after 13-year-old Martha Mills who died from sepsis.

Improving end-of-life care

We conducted a comprehensive service evaluation to improve end-of-life care with support from the Helix Centre, funded by Imperial Health Charity. We identified opportunities for improved care such as a discrete system to let staff know patients are at the end of their lives, so staff can better support patients and carers. We're also improving patient and carer information and end-of-life care feedback surveys.

Redevelopment

St Mary's, Charing Cross and Hammersmith hospitals are part of the New Hospital Programme, and we plan to incorporate a new Western Eye into one of these developments. We submitted a first-stage business case for a full redevelopment of St Mary's in 2021. Following the government's decision in May 2023 to delay the main capital funding for the Trust's schemes, we have been working with the New Hospital Programme to explore ways to keep our redevelopments on track, particularly St Mary's where the need is most urgent. We ran an engagement programme with patients and local communities through January 2024 to get early input to our plans for St Mary's.

Tackling health inequalities

Patients from Black, Asian, and minority ethnic backgrounds, as well as those in living areas with high levels of deprivation, have a poorer experience waiting for treatment and are more likely to miss their initial outpatient appointments. Together with the Helix Centre and community partners, we have been testing improved digital reminders and information to reduce missed appointments among our target population. This work is part of an ongoing study, with results expected by the end of 2024.

We are also currently testing a predictive system to identify patients at high risk of missing appointments. Staff or volunteers are then able to contact these patients, reminding them of their upcoming appointments and offering assistance. This approach has been effective in reducing missed appointments at other NHS organisations.

A review conducted in winter 2022/23 highlighted that our interpreting services were in need of major improvement and were contributing to health inequities. We have appointed a dedicated lead to improve patient interpreting services, implementing immediate improvements and working with partners to agree a new approach for the longer term.

Maintaining 'outstanding' maternity care

We are really proud that our maternity services continue to be rated as outstanding overall, following Care Quality Commission inspections of Queen Charlotte's & Chelsea and St Mary's hospitals in March 2023. The ratings cover both our NHS and private maternity services, with the reports published in July 2023.

The inspectors highlighted how staff work well together, the importance we place on engaging with our community and, most of all, how we are focused on the needs of patients.

Looking ahead

Embedding the new patient safety framework is a key focus for the year ahead, as is the further development of our user insight, design and involvement capabilities. We have begun a user-insight driven review of our cancer care pathways to ensure they meet the needs and expectations of our patients and their families. We also expect our outpatient improvement programme to make significant progress this year, tackling longstanding issues with appointment processes and administration and co-designing new care pathways that work for our patients and staff and make better use of digital technologies.

In terms of redevelopment, we are hopeful that we will be able to begin detailed design work and planning for a new St Mary's Hospital in the coming year and progress our business case for Charing Cross and Hammersmith hospitals. And we will continue to make targeted investments in our estates in the meantime.

3. Reducing waits and delays for our patients

We met the majority of our operational performance targets for 2023/24, despite significant challenges with waiting lists that built up during the pandemic, industrial action and pressure across the wider health and care system. We have also had to put significant additional effort into validating operational data to ensure it is accurate.

Here is a summary of our performance against our key operational targets and the major developments of the past year that have enabled us to make improvements. There is more detail on our operational performance metrics in our annual quality account, available on our website.

Urgent and emergency care

We saw just under 275,500 patients in our A&E departments in 2023/24 and there were 54,000 emergency admissions, compared with around 263,600 attendances and 45,600 emergency admissions the previous year.

We are regularly one of the best-performing trusts in London for ambulance handover times, consistently achieving the national target to complete at least 95 per cent of handovers within 30 minutes.

We met the national target to admit, transfer or treat and discharge at least 76 per cent of A&E patients within four hours of their arrival in July 2023 but, like most other NHS trusts, our performance dropped below the target at the start of winter 2023. We steadily recovered and reached 77.8 per cent in March 2024.

Planned care

There were just under 99,400 people waiting for planned care in our hospitals at the end of March 2024, broadly the same as March 2023. However, we did make progress during the year in reducing the number of patients waiting for the longest times while continuing to treat those with the most urgent clinical needs as quickly as possible (see cancer care below). There were no patients waiting longer than 104 weeks at the end of March 2024. We came close to eliminating waits of over 90 weeks, with four patients waiting. We are on track to eliminate waits of 78 weeks this summer. In March 2024, just over 750 patients had been waiting over 65 weeks. Eliminating these waits is one of our top priorities.

Diagnostics

In March 2024, 12.7 per cent of patients waiting for a diagnostic test had been waiting longer than six weeks, against the national target of no more than five per cent. We did make progress in reducing waiting times for diagnostics during the first half of last year, with 6.8 per cent of patients waiting over six weeks as of October 2023. However, performance has dropped in more recent months, partly due to maintenance issues with our aging imaging equipment. Our MRI and CT scanners replacement programme is now underway and the opening of our community diagnostic centres (see page 22) will help us get back on track with our operational performance in diagnostics.

Cancer care

In March 2024, 78.5 per cent of patients with cancer received their first treatment within 62 days of referral, up from 73 per cent in March 2023 and ahead of the current national operating target of at least 70 per cent. Our performance against the faster diagnostic standard – which requires at least 75 per cent of patients with suspected cancer to receive their diagnosis within 28 days of referral – was 83.1 per cent in March 2024, the eleventh consecutive month in which we met the standard. We have found it more challenging to speed up the time between decision

to treat and treatment starting – the national target is to do that within 31 days for at least 96 per cent of patients. Our performance in March 2024 was 87.3 per cent.

Reducing waits and delays has required a consistent focus from teams across all our services throughout the year but we have also established larger, cross-cutting improvement initiatives, including:

Keeping care flowing

We were allocated an additional £2.7million last winter to help us care for more patients in our hospitals. Measures to prepare for extra demand included opening an additional 24 beds across St Mary's and Charing Cross hospitals; extra focus on avoiding unnecessary emergency admission for frail, older people; expanding our same-day emergency care services; and extending our discharge lounge operating hours. In October 2023, responsibility for the management of the urgent treatment centre at St Mary's Hospital transferred to us from a private provider. Having worked through some challenges with staffing levels, we were then able to make improvements across the whole A&E pathway.

Improving theatre efficiency

We have focused on improving our operating theatre productivity – aiming to treat more patients with the same resources and make positive steps to tackle long waits that built up in the wake of the Covid-19 pandemic.

We now consistently use 95 per cent of our planned theatre sessions each week, with over 85 per cent of each session spent in active patient treatment. This puts us in the top ten of NHS trusts nationally for theatre productivity. Performance is especially high at the Western Eye Hospital where we added a third theatre last year as part of wider refurbishments. This is enabling us to treat an additional 2,200 patients each year. While making a very positive and important contribution to reducing backlogs, these improvements do not represent an increase in absolute capacity, and the challenge is now to sustain performance in the context of ongoing challenges in a number of areas, including our estates and chronic shortages in some key staff groups.

Introducing community diagnostic centres

In June 2023, we opened the first of three community diagnostic centres for north west London. This first centre, in Willesden, was followed in January 2024 by a centre in Wembley, both managed by our Trust. The third centre, in Ealing, is due to open later in 2024 and will be managed by London North West University Healthcare NHS Trust.

The centres are part of a national initiative to reduce waiting times, with their location carefully chosen to also help tackle health inequalities by improving access in areas impacted by higher levels of deprivation. The two sites run by our Trust will offer 90,000 diagnostic tests for cancer and other serious illnesses each year and support hospitals across the sector in making best use of their capacity.

North West London Elective Orthopaedic Centre

In December 2023, orthopaedic surgeons from the Trust operated on the first patient at the new North West London Elective Orthopaedic Centre at Central Middlesex Hospital. The centre is benefitting patients of all four acute trusts in the sector, allowing us to bring together most routine bone and joint procedures, such as knee and hip replacements, in one specialist unit. Patients' pre-operative and post-operative care remains in their local hospitals, with their surgeons moving with them to carry out their procedures in the new centre. This approach has been shown to improve quality and efficiency, enabling better care for more patients. It also frees up surgical capacity in other hospitals, such as our Charing Cross Hospital, to focus on more complex procedures where patients need more specialist care.

Looking ahead

The challenges ahead are clear – not least the likelihood of even more pressured NHS finances alongside the urgent need to make more impact on reducing waits and delays. Potentially ongoing industrial action and the 2024 general election is likely to create more instability in the wider, political environment. But we will maintain our focus on improving flow, addressing inequalities,completing our review of cancer pathways from a patient-focused perspective and ensuring delivery of our outpatient improvement programme. In addition, while we have made significant progress in improving the quality of our operational data – key to managing performance and risk – there is much more to do. Improving data quality by making sustainable changes in our outpatient processes is a key aspect of our outpatient programme, alongside additional, immediate measures such as additional training and support for our frontline teams.

4. Achieving sustainable financial balance

Last year, we achieved our plan for a break-even income and expenditure position on a budget of just over £1.5 billion. Our initial plan was underpinned by a £53 million cash-releasing, efficiency target which included reducing our use of bank and agency staff by filling more of our vacancies.

We made capital investments of £98.3m (funded through our own cash, national funding and donations and charity funding), of which, just under £19 million had to be used to address the most urgent estate maintenance needs.

While we delivered our financial plan in 2023/24, we still relied on a significant element of one-off income and we know that, to be financially sustainable, we must clear our underlying financial deficit (which is forecast to be £106.8m in 2024/25). Over time, we need to move to delivering an annual 3.5 per cent 'surplus' on adjusted financial performance so that we can invest more in new developments and build our financial resilience.

Some of the key ways in which we looked to increase our financial sustainability last year included:

Private care

Our private care services make an important contribution to our finances as well as enabling us to extend our offer to people who cannot – or choose not – to use NHS services. All private care income is reinvested back into the Trust. Full-year revenue from private care services totalled £43 million in 2023/24, an increase of £6 million on the previous year but still some way from our income before the Covid-19 pandemic.

In 2023, we launched a new name and identity for our private care services, adopting Imperial College Healthcare, Private Care. This recognises the close and mutually beneficial relationship between our private and NHS services. The launch of a new website and an updated suite of patient information has helped to raise awareness and understanding amongst staff as well as patients as we seek to expand our offer.

Other developments last year included welcoming two more members to our international affiliate network – Novacare Hospital in Islamabad, Pakistan, and the Athens Medical Group in Greece.

Efficiency through innovation

We held a 'breaking new ground' workshop in March 2024 to generate new ideas for a more financially sustainable and efficient approach to the delivery of our services, against the backdrop of increasingly complex patient needs and pressured finances. The session, supported by Imperial College Health Partners and the Health Foundation, brought together a range of clinicians and managers from across the organisation, as well as lay partners and patient representatives. Several ideas were selected for further exploration, including team-based rostering, more streamlined reporting, artificial intelligence to improve outpatient pathways, predictive analytics and wearable devices and a walk-through health assessment scanner. Feedback from the session has been positive and we plan to run this format with more staff groups to generate further ideas.

Looking ahead

We will increase our focus on how we can transform our services and models of care to be more efficient as well as deliver higher quality and better outcomes. We know that our processes could be much more streamlined and that we need to work with patients, local communities and staff to create processes that make better use of everyone's time. For example, a major focus for next year and beyond is our outpatient improvement programme. We know that we have too many missed and cancelled appointments and we will be working to co-design new booking processes and making the most of digital technology. This will allow us to better meet the needs of patients and staff and release time and money to be reinvested elsewhere.

The redevelopment of our three main sites will also have a big impact on reducing waste and improving efficiency and, increasingly, we are looking to make nearer term investments in our estates to support improvements in the way we work.

Research and innovation

Patients at Imperial College Healthcare benefit from care at the leading edge of scientific and clinical discovery. The National Institute for Health and Care Research (NIHR) Imperial Biomedical Research Centre (BRC) was re-designated with a £95m award in December 2022. This year, the total award was updated with an inflationary uplift to £97.6m. An additional £3.79m of capital funding has been contracted. This translational research partnership with Imperial College London – as well as growing partnerships with our local communities, industry and other health and care partners – has enabled us to expand to over 1,010 active clinical studies last year, involving over 24,000 patients.

In June 2023, we launched Paddington Life Sciences, a new life sciences cluster centred around St Mary's Hospital. There are now 15 full and four associate members of Paddington Life Sciences Partners – organisations from across life sciences and data industries, land owners, our local communities, the NHS and academia who all share a commitment to delivering healthcare innovation, alongside wider health, economic and social value.

Paddington Life Sciences, along with the White City Innovation District that includes our Hammersmith Hospital campus – forms part of Imperial College's WestTech Corridor and both Paddington Life Sciences and White City are included in MedCity's map of London's innovation district.

A fundraising appeal was launched last year for the development of a new research, policy and public engagement centre at St Mary's Hospital. The Fleming Centre is intended to help drive a global movement to tackle antimicrobial resistance. The UK government has committed £5 million in seed funding to support the initiative.

The Imperial Health Knowledge Bank was successfully piloted last year and is now being rolled out across the Trust. The Knowledge Bank is a secure database of our patients willing to be contacted about relevant clinical trials and to share their health information and blood samples for research purposes. Following the pilot in oncology, hepatology and cardiology services, all outpatients are now receiving a text inviting them to join in advance of their next appointment.

Building on the work of our Digital Collaboration Space, part of Paddington Life Sciences, we have begun to develop a strategic approach to harnessing artificial intelligence (AI) to benefit all aspects of our work. We have already seen a wide range of practical applications across our hospitals – including a new virtual biopsy tool which uses AI to analyse CT scans and support more personalised treatment and AI stethoscopes that analyse heart sounds for signs of cardiac abnormalities. Last year, we established a multi-disciplinary team to review our use of AI and they have highlighted the need for a more focused approach that puts the needs and views of patients and staff at its core.

Research and innovation highlights from last year include:

World's first gene-editing treatment for sickle cell disease and beta thalassaemia

In November, the UK became the first country in the world to approve gene editing as a potential cure for two inherited blood disorders following global clinical trials, with the UK arm led at St Mary's. This treatment was developed by Vertex Pharmaceuticals with CRISPR Therapeutics. The revolutionary new treatment for sickle-cell disease and transfusion-dependent beta thalassaemia represents the potential for a new landscape of treatment options for patients living with these blood disorders.

World's first womb transplant

In August, after more than 25 years of research, a team co-led by surgeons from Imperial College Healthcare and Oxford University Hospitals, performed the first womb transplant in the UK, giving a woman who was born without a functioning womb the possibility of getting pregnant and carrying her own baby. The transplant was undertaken as part of the UK living donor programme, which is sponsored and funded by the charity Womb Transplant UK, following approval from the Human Tissue Authority. This remarkable achievement was only possible thanks to the recipient's sister who came forward and was willing to donate.

New evidence for stents as an alternative to chest pain medication

In November, a team of researchers funded by the NIHR Imperial BRC published new evidence supporting the use of stents as an alternative to medication for patients suffering from chest pain, known as angina. Patients were enrolled across 14 sites in the UK, led at Hammersmith Hospital. Stents are currently offered only after patients have exhausted chest pain medication options, yet the trial found that stenting had the most benefit for patients who have not yet started medication. This finding is a potential paradigm shift in the management of angina globally.

First UK patients receive mRNA cancer therapy

In February, patients at Imperial College Healthcare became the first in the UK to receive an experimental mRNA cancer therapy. An 81-year-old man from Surrey with treatment-resistant malignant melanoma was the first person to receive the therapy, administered as part of a global trial to evaluate its safety and potential effectiveness in treating melanoma, lung cancer, and other solid tumor cancers. This technology represents a promising avenue in cancer treatment, leveraging the body's own mechanisms to target and destroy cancerous cells.

Chief financial officer's report

Introduction and overview

The Trust set an ambitious financial plan for 2023/24 which relied upon no ongoing industrial action, delivery of a stretching efficiency target, dealing with inflationary pressures over and above funded levels, and the challenge of reducing the average length of stay prior to winter given the level of patient acuity. The Trust also needed to take account of the level of NHS funding it would expect to receive for the activity it would provide, the cost base it needs to incur to deliver on this, and the actions it had to take to deal with a range of significant new pressures.

The Trust was significantly impacted by the industrial action undertaken by junior doctors, consultants and nurses during the financial year. Addressing the operational, workforce and financial challenges this presented became a key area of focus. The impact of more than 40 days of industrial action led to both a materially lower than planned level of elective work and therefore income, and the need to incur additional unavoidable costs, with the greater reliance on temporary staffing compounding the pressure to live within national agency spend limits. In recognition of the fact that plans were set on the basis that there would not be significant ongoing industrial action, a package of national financial support was made available to offset the financial impact. This included funding for the additional unavoidable costs incurred and a 4 per cent reduction in the elective activity target in recognition of the disruption to services and activity levels and the ability to deliver underlying recurrent savings initially envisaged.

Our financial performance 2023/24

Performance against Income and Expenditure plan

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

Despite the extremely difficult operational and financial environment across the NHS, once the technical adjustments (which form part of the adjusted financial performance calculation) are excluded, the Trust reported an adjusted surplus of £30k which is marginally favourable to the breakeven plan.

The table on the next page sets out the actual income and expenditure performance as at the 31 March 2024, including comparative information for 2022/23 and tracks this against the Trust agreed plan.

Statement of comprehensive income	2023/24 £'m	2022/23 £'m
Income	1,714.7	1,601.5
Expenditure	(1724.7)	(1,623.4)
Net financing income	7.5	4.2
Loss on disposal of assets	(1.1)	(2.8)
Public dividend capital payable	(12.6)	(11.5)
Surplus before revaluations and impairments	**(16.2)**	**(32.2)**
Other comprehensive income*	4.1	(2.8)
Surplus/(deficit) for the financial year as per annual accounts	**4.6**	**(34.9)**

Performance against plan	2023/24 £'m	2022/23 £'m
Surplus/(deficit) for the financial year as per annual accounts	**4.6**	**(34.9)**
Donated asset adjustment	(12.0)	(29.0)
Adjust for revaluation and impairment**	23.0	64.2
Adjustment for (gains) / losses on transfer by absorption	1.1	-
Adjusted surplus	**0.0**	**0.2**
Planned position	0.0	0.0
Performance against plan	**0.0**	**0.2**

*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

At the start of the year, we set a £53.4 million efficiency target reflecting the level of savings required to deliver our financial plan, achieve national efficiency targets and treat an increased number of patients within the funding available from our commissioners. This requirement was allocated out across our clinical and corporate divisions with divisions required to develop and mobilise sustainable recurrent savings schemes that improve the efficiency of services being provided. The combination of extremely high demand for services and the need to focus on managing industrial action safely while also preparing for winter, limited management's capacity to make as much progress as it envisaged in identifying and delivering recurrent cash releasing savings. We put in place a financial recovery plan that relied upon one off (non-recurrent) measures to achieve our planned financial position. At the end of the year we reported that we have delivered 100 per cent of our target, recognising that a significant proportion, £34.9 million, of this was non-recurrent.

Performance against external financing limit and capital resource limit

We successfully remained within our expected external financing limit and capital resource limit targets. Further information on the capital programme is included below.

Income

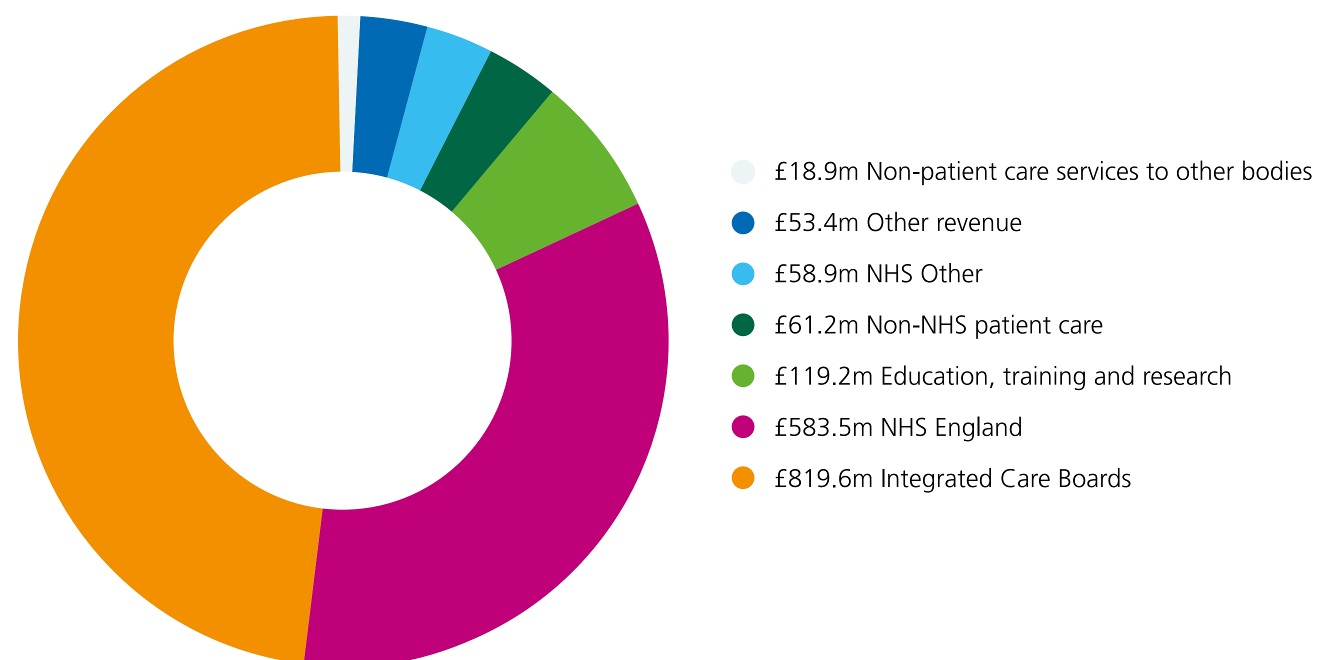
Health service income from the provision of healthcare in England exceeded income from the provision of other services, which forms only a small part of our total income. Income from other services is used to support delivery of healthcare services. Further detail is provided in notes 3 and 4 of the accounts.

Our total income amounted to £1,714.7m for 2023/24 (2022/23 £1,601.5m). The majority of this funding comes from Integrated Care Boards (previously Clinical Commissioning Groups) and NHS England for the delivery of NHS patient care clinical services. The contractual form includes a significant variable element related to elective activity and so incentivises trusts to tackle the backlog waiting lists as quickly as possible.

The chart below provides a breakdown of our key sources of income. Of this, education and training income (£57.4m) is primarily provided by Health Education England to support the costs of training doctors, nurses and other healthcare professionals and supports the quality of care provided at the Trust.

Research and development income (£61.7m) relates to both government and commercially funded research carried out by the Trust, with non-NHS care income (£61.2m) primarily earned through the provision of healthcare to private patients and overseas visitors.

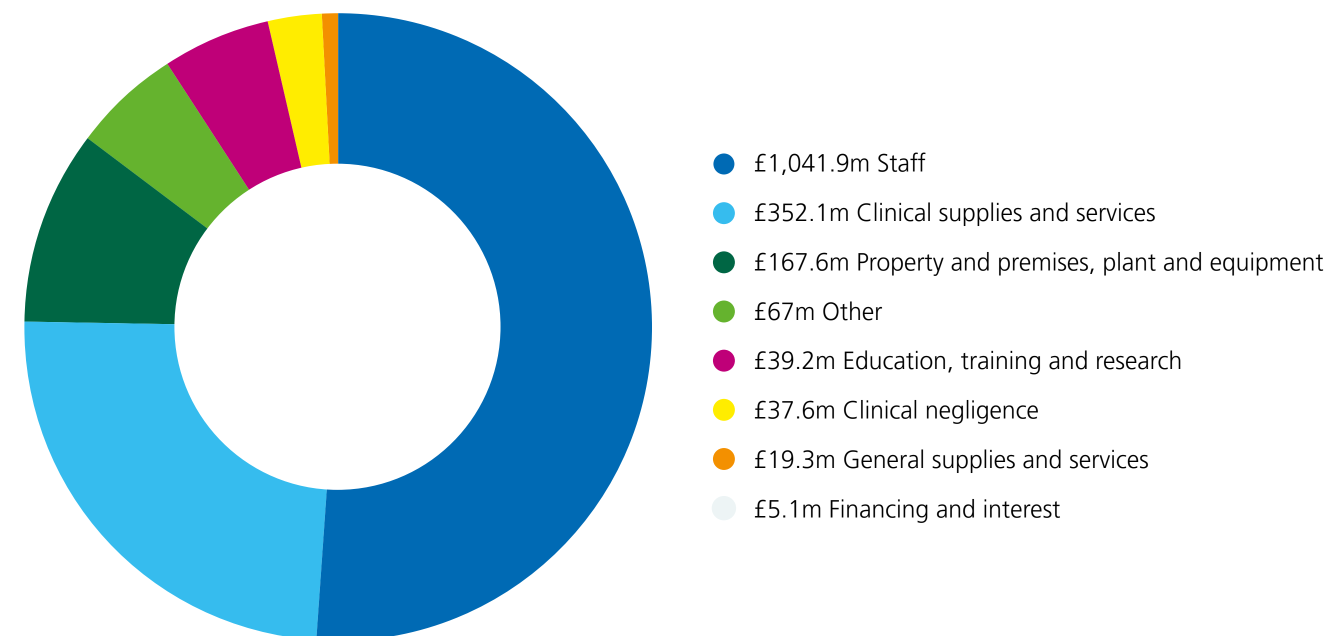
Breakdown of our income by source – 2023/24



Expenditure

Excluding financing and interest costs, our expenditure for 2023/24 was £1,724.7m (2022/23 £1,623.4m). Staff costs account for 60 per cent of this spend which includes the cost 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 e.g. legal fees; consultancy; operating leases and bad debts.

Breakdown of our expenditure by type – 2023/24



Although the Trust has a track record of delivering its annual financial plan, achieving an improvement in the underlying deficit that results in a sustainable financial position remains a key risk for the organisation. Not making the necessary improvements could lead to the Trust not achieving its year-on-year financial plans and thereby adversely impacting our ability to deliver our investment priorities and improve the quality of services for our patients in the future.

The Trust aspires to identify sufficient opportunities to enable on-going financial stability, but where this falls short the Trust is able to put in place risk-assessed actions that help mitigate this, recognising that the reliance on non-recurrent measures will not be sustainable in the long term. During 2023/24, the challenging financial position on the back of the industrial action significantly impacted the Trust's ability to focus on driving recurrent financial improvement. To mitigate a deterioration in the Trust's financial position a number of actions/decisions were put in place, including:

- a vacancy freeze during June 2023;
- resetting the Trusts Performance and Accountability framework;
- reviewing and strengthening (where needed) the key lines of enquiry set out in the NHS England Grip and Control Framework; and
- delivering greater levels of elective activity during the months where there was no industrial action.

Building on the short-term measures outlined above, the Trust has created the Productivity through Transformation Oversight Board refocussing and strengthening the Trust's framework for directing and overseeing large-scale transformational change initiatives that deliver sustainable financial improvements. It now oversees the plans and the activity of programmes; uses relevant pan-Trust expertise and leadership to provide support and challenge to programmes in order to improve the productivity and efficiency of services provided by the Trust; and oversees the enabling projects and infrastructure that will support long-term structural change.

The above efforts alongside earlier planning discussions regarding 2024/25, have all resulted in a significant improvement in the Trust's processes to identify efficiency plans that support both in-year delivery and underpin medium to longer-term planning.

Capital expenditure

By 31 March 2024 the Trust made capital investments worth £98.3m (this includes £4.5m of grant and charity funding, and other donated assets) of which £83.1m scores against the notified Capital Resource Limit.

The Trust's capital allocation (as was the case for all NHS organisations) was subject to significant changes in relation to how the budgetary treatment of leased 'Right of Use' assets were to be transacted on a 'business as usual' basis under International Financial Reporting Standard 16 (IFRS 16) for 2023/24. This resulted in the budget allocation provided to deal with the impact of leases that were brought 'on-balance sheet' under IFRS 16 no longer being held in a ring-fenced pot at national level, but being added to the Trust's core capital budget.

The Trust was able to manage this transition effectively, and through close collaboration with the North West London ICS was able to release £3m of budget cover back to support sector priority investments. In addition, the Trust had to codify a number of legacy lease arrangements with other public bodies for which estimates had been used in the 2022/23 accounts. Where it was not possible to achieve signed agreements, and the use of estimates remains the only basis to assess the financial impact, these have been refreshed in 2023/24 to reflect the latest information. This resulted in a £7.0m downward re-measurement of leases in the year, with a corresponding adjustment to the Capital Resource Limit.

Notable capital projects in-year include:

- the opening of two Community Diagnostic Centres (CDCs) at Willesden and Wembley, which will provide enhanced capacity for diagnostic testing in conjunction with the development of other CDCs across the sector;
- significant investment in imaging and diagnostic capacity in Oncology and other services across the main sites;
- refurbishment of a further cardiac catheterisation laboratory;
- significant works to manage critical estates infrastructure across the three main sites (including roofing & plumbing works, ward refurbishment and structural works) including resolving structural and safety issues at the Samaritans building; and
- enhancements to our food and retail offer to patients and staff at the St Mary's site (work in progress at year end) part funded by the Imperial Health Charity.

We remain grateful to Imperial Health Charity for its continued fundraising efforts and the financial support it provides in respect of the capital programme which supports the delivery of patient care; and investment in staff wellbeing initiatives. In addition to supporting the food and retail offer noted above, the Charity has also supported the refurbishment of paediatric therapy facilities, investment in medical equipment (including low-frequency ultrasound treatments for brain tumours) and other investments in staff facilities.

Redevelopment remains a top priority and we continued to receive some NHS England funding to support the work streams associated with the redevelopment of our sites. Although we had confirmation that funding levels will continue (and increase) in 2024/25 to allow work on the redevelopment project to move forward (including commencing enabling works to support the detailed planning at St Mary's), however confirmation of the overall level of funding required to redevelop our sites is yet to be confirmed.

Cash

The Trust continued to successfully manage its cash balance throughout the year and ended the year with a balance of £136.7m, This position represents a £42.5m reduction from the start of the year and is £6.6m higher than the cash plan set at the beginning of the year. The cash position remains high by historic standards.

The cash balance was expected to deteriorate across the year due to a combination of additional use of cash for capital investment and expected movements on working capital, including settlement of liabilities from previous years (including capital payables, which 33 were particularly high in 2022/23). Cash outflows resulting from delays to achievement of efficiencies (as outlined above) were offset by income above planned levels from activity delivered in 2023/24 and previous years, though delays to delivery of efficiencies remains a key risk in respect of the cash position going forward.

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 2023/24, 97.4 per cent of invoices by volume and 90.2 per cent of invoices by value were paid within this target. Therefore the Trust met its 95 per cent volume target but did not meet its 95 per cent value target. The performance against the value target is a small improvement on 2022/23 when 88.8 per cent of invoices by value were paid within target (more detail is included in Note 36 to the Financial Statements). The Trust continues to take steps to help improve its performance back to previous levels when it was consistently above target for both elements.

Declarations

We are committed to providing and maintaining an absolute standard of honesty and integrity in dealing with our 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 2023/24 to provide 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.

We have complied with the cost allocation and charging guidance issued by HM Treasury, have met the income disclosures as required by section 43(2A) of the NHS Act 2006 and did not make any political donations during 2023/24.

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.

We have reasonable expectation that we will continue to have access to adequate resources to service our operational activities in cash terms for at least the next 12 months, and continue 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 our activities.

2024/25 looking ahead

Although the revenue and capital position as at 31 March 2024 represents a significant achievement in 2024/25 we continue to face a number of financial challenges. These include:

- Delivering a £63.3m efficiency target – there is a risk that the schemes identified to meet this target cannot be fully delivered by 31 March 2025. A failure to mitigate any in-year slippage and not deliver a breakeven position could potentially lead to regulatory intervention.
- Clinical income risk – we need to ensure that where the activity levels fall below the fixed funding levels that this does not result in a 'claw back' of income and we achieve our elective recovery targets
- Although we developed our previous capital investment programme to live within its capital allocation there is now a greater risk that a lack of affordability on both capital budgetary cover and cash could result in operational and quality / safety risks not being sufficiently mitigated.
- Managing backlog maintenance – our capital plan allows for a level of backlog maintenance being undertaken however due to the ongoing deterioration of the aged estate there remains the risk that new issues will emerge in-year that will require us to reprioritise our capital programme to ensure we continue to deliver safe care.
- Redevelopment programme – the estate continues to pose a significant risk in terms of the level of backlog improvements required and the need to manage potential unaffordable failures. Our redevelopment schemes remain on the national 40 New Hospital Programme and funding to develop the business cases for these schemes is expected to continue into 2024/25. However, no commitment to cover any unexpected estates failures has been provided at the point of writing this report.
- Continuing to play a leadership role in the strategic direction of travel for the Acute Provider Collaborative and how together we deliver the best quality healthcare to the population we service within the financial envelope.

North West London Acute Provider Collaborative review

The four acute NHS trusts in north west London approved the appropriate delegation of authority to establish the North West London Acute Provider Collaborative (APC) in July 2022 and came into being, with a chair and board in common, 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 that have collective value. However, each trust board remains responsible for the delivery of their respective trust duties.

This approach means the trusts remain independent organisations, working closely with their local authorities, patient groups and other partners, while also being able to make more effective use of their collective resources to provide better care, for more people, more fairly.

Over the past year, our collaborative approach has helped us 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, by moving to a hospital managed by one of the other trusts where there is more capacity for that service.
- Expand a single electronic patient record system to cover all 12 hospitals of the four acute trusts, bringing immediate benefits for patients who receive care at more than one of our trusts and creating huge potential for evidence-based, best practice and data-led research and development.
- Improve inpatient orthopaedic care across the sector with the opening of the North West London Elective Orthopaedic Centre. This has allowed us to bring together routine, low complexity orthopaedic procedures in a single centre of excellence which will improve outcomes, allow us to treat more patients more efficiently, and reduce the risk of operations being cancelled due to urgent and emergency care pressures.
- Further develop our peer-review programmes, including for A&E and discharge from hospital, helping us learn from one another and spread best practice and innovation more quickly.
- Open two new community diagnostic centres for north west London, in Willesden and Wembley, as well as a new eye care diagnostic centre, in Willesden. So far this year, we have opened another eye care diagnostic centre in Westminster and a third community diagnostic centre in Ealing. All have been located in areas that serve communities most at risk of health inequalities and, together, provide approximately 196,000 additional diagnostic tests annually. They will help us bring down waiting times while also ensuring fairer access to services.
- Bring six urgent treatment centres in-house from independent sector management, meaning all seven urgent treatment centres located in our hospitals are now managed as part of integrated urgent and emergency care pathways, improving operational flow and enabling us to provide a better experience for patients and staff.
- Work together systematically on five key work streams: quality; people; finance and operational performance; digital and data, and estates and sustainability. With each work stream led by one of the trust chief executives and one of the vice chairs, we are increasingly aligning our approach on measuring performance and impact and identifying shared

learning and priorities for improvement.

We have also embarked on the development of a three-year APC strategy, engaging with staff and a range of stakeholders. The strategy, which will set out our strategic aims and implementation approach, will be shared in summer 2024.

Meanwhile, we have agreed the following joint work projects within our existing work streams (plus an additional one – equality, diversity and inclusion) for the year ahead:

- Quality: Improving care for deteriorating patients and end of life care; standardising our approach to clinical harm and mortality reviews; aligning our approach to gathering and analysing user insights; implementing the new national patient safety incident response framework, including a new incident and risk management system; implementing a maternity and neonatal delivery plan; aligning and improving infection prevention and control.
- People: Creating a careers hub and staff transfer scheme; creating a recruitment hub for hard to fill vacancies; increasing the apprenticeship levy uptake; reducing violence, aggression, bullying and discrimination; reducing the premium rate staffing expenditure.
- Digital and data: Finalising our collaborative digital and data strategy; optimising our electronic patient record system to better support frontline staff; developing a strategic reporting solution and improving patient flow and capacity with our care co-ordination solution that uses the national federated data platform.
- Finance and operational performance: Delivering our activity targets in the operational plan; supporting corporate services consolidation where appropriate; improving discharge planning and operational flow; establishing a programme of efficiency and productivity that improves our financial sustainability; outpatient transformation.
- Estates and sustainability: Developing an estates strategy to improve facilities across all sites; maximising our engagement with the national New Hospitals Programme; moving towards net zero carbon emissions.
- Equity, diversity and inclusion: Improving data to enable us to monitor, manage and improve equity across all of our services; eliminating inequalities that exist in our workforce, including by empowering staff to advance their careers and creating environments that are safe and free from discrimination and promote staff wellbeing.

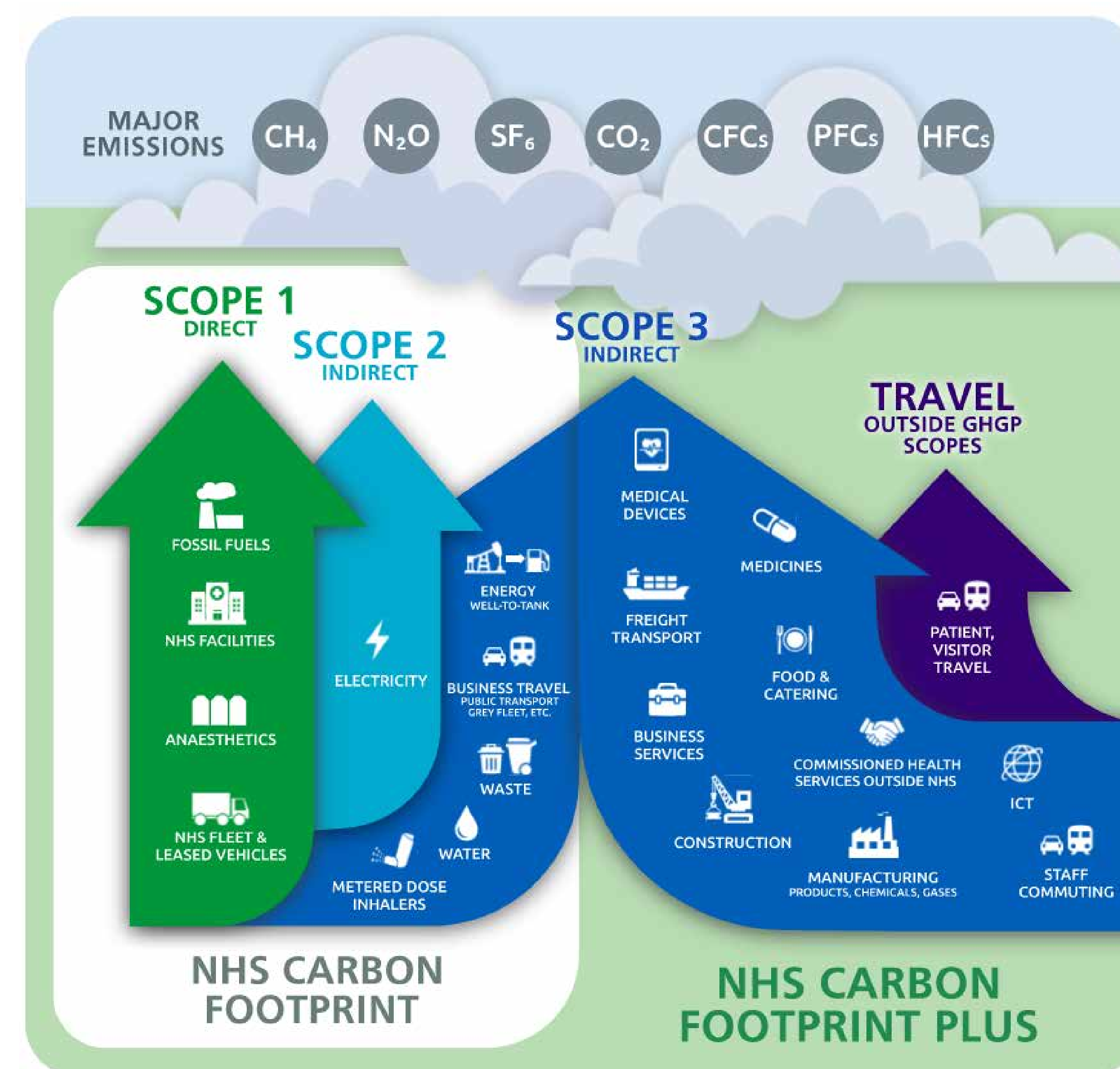
Sustainability

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

Figure 1 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.

Figure 1: Greenhouse Gas Protocol (GHGP) scopes in the context of the NHS



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

We launched our first ever Green Plan in May 2021. In 2023 delivery of this Green Plan was publicly recognised when the Trust was shortlisted as a finalists for the HSJ 'Towards Net Zero' Award in 2023.

In the last year one of our key priorities has been to learn from and build on our progress and successes and refresh and update our Green Plan to cover another three-year period. This refreshed Green Plan will move us significantly closer to delivering two nationally set targets, against a baseline of 2019/20, these being:

- Emissions we control directly (the NHS Carbon Footprint), to reach net zero emissions by 2040, reducing emissions by at least 47 per cent by 2028-2032
- Emissions we can influence (the NHS Carbon Footprint Plus), to reach net zero emissions by 2045, reducing emissions by at least 73 per cent by 2036-2038

We continue to work in close partnership with colleagues across London, the North West London ICB and the acute collaborative to mutually support one another and to ensure that evidence-based net zero solutions and best practice are rapidly adopted across the NHS.

Our NHS Carbon Footprint

In 2023/24, our NHS Carbon Footprint stood at 46,700 tonnes of carbon dioxide equivalent (tCO_2e). This is 17.3 per cent down on 2019/20 – see Figure 2 below. In absolute terms our NHS Carbon Footprint has now come down by 9,759 tCO_2e since 2019/20.

Figure 2: Our NHS Carbon Footprint 2019/20 to 2023/24

NHS Carbon Footprint emissions source	Emissions source as a per cent of NHS carbon footprint in 2023/24	Percentage change in emissions by emissions source between 2019/20 and 2023/24
Gas	39.0%	-13.8%
Electricity	49.5%	-14.4%
Oil	0.7%	-2.5%
Waste disposal	1.3%	-9.6%
Water and sewage	1.0%	-58.9%
Anaesthetic gases – volatile agents	2.4%	-75.2%
Anaesthetic gases – nitrous oxide	2.7%	-73.4%
Anaesthetic gases – Entonox (gas and air)	3.1%	-25.1%
Inhalers (propellant only)	0.3%	4.0%
NHS carbon footprint	**100.0%**	**-17.3%**

Source: Imperial College Healthcare analysis; Notes: (1) our NHS carbon footprint analysis currently excludes fleet and business travel and f-gas emissions (2) the carbon footprint for inhalers is for the propellant only (3) the gas, oil and electricity data historically covered our five main hospitals and our Hayes Dialysis Unit, however, from 2023/24 this now also includes our Wembley Community Diagnostic Centre and (4) over the last year we have continued to improve the quality of the data used to calculate our NHS carbon footprint and this included alignment of conversion factors to those being used by NHS England.

Our analysis of progress is focused on our NHS carbon footprint only – i.e. all scope 1 and 2 emissions plus a small number of scope 3 emissions. Our larger NHS Carbon Footprint Plus which includes further scope 3 and travel emissions has been estimated by Greener NHS to have been 274,888 tCO_2e in 2019/20.

Our refreshed Green Plan and its impact

Our refreshed three-year Green Plan covers the period 2024/25 to 2026/27 and is divided into nine areas of focus that span almost every part of our Trust's operations. These are:

- Workforce and system leadership
- Estates and facilities
- Travel and transport
- Medicines
- Sustainable models of care
- Digital transformation
- Food and nutrition
- Supply chain and procurement
- Adaptation

Each of these nine areas of focus have a range of underpinning work streams and success measures. In total, there are 26 success measures and 96 work streams – see figure 3 – and we will work on and initiate many workstreams in year one. It is, however, important to recognise that some work streams will be perpetual, some will need to be repeated regularly once completed and some will take more than three years for outcomes to materialise.

Figure 3: Where we want to get to by 2026/27 – our success measures

Workforce and system leadership

- Triple our Green Community Network from 250 staff in early 2023 to 750 staff by 31 March 2025
- Recruit at least 75 Green Champions by 31 March 2027
- Have a comprehensive time-series of our NHS carbon footprint from 2019/20

Estates and facilities

- Reduce our carbon emissions from our combined consumption of gas, oil and electricity by at least a third by 31 March 2027 on our 2019/20 baseline
- Reduce our water consumption across the Trust by 20 per cent by 31 March 2027 compared to 2022/23
- Transform at least one outdoor green space each year at our Trust
- Increase our coverage of LED lighting at the Trust
- Deliver net zero training and education to estates, facilities and capital projects leadership teams
- Achieve a clinical waste segregation ratio of 20:20:60 by 31 March 2027
- Reduce total waste disposal emissions by 50 per cent by 31 March 2027
- Achieve a 25 per cent recycling rate by 31 March 2027

Travel and transport

- Reduce our fleet and business travel emissions
- Increase the uptake of our cycle to work scheme

Medicines

- Reduce our carbon NHS footprint of medicines that have a high global warming potential (GWP) at the point of use (inhaler propellant, nitrous oxide, Entonox and volatile agents) by at least 40 per cent by 31 March 2027 against our 2019/20 baseline

Food and nutrition

- Increase the proportion of lower carbon / plant-based inpatient meals ordered
- Reduce inpatient food waste

Sustainable models of care

- Implementation of evidence-based good practice with at least two clinical teams to reduce carbon
- Increase the adoption of reusable gowns at the Trust
- Increase the number of walking aids returned

Digital transformation

- Reduce our reliance on paper
- Increase the uptake of the Care information Exchange
- Deliver at least 25 per cent of all first outpatient appointments and 60 per cent of all follow up appointments virtually
- Improve our IT asset disposal
- 3 per cent of patients discharged to a PIFU pathway by 2027

Supply chain and procurement

- Ensure all staff are supported to meaningfully apply a social value weighting (including net zero) of at least 10 per cent to all new procurement and to work collaboratively with partners and suppliers to drive down our NHS carbon footprint plus

Adaption

- Ensure our organisation is preparing to deal with the impacts of climate change by developing, embedding and monitoring actions from a Climate Change Adaptation Plan

Source: Imperial College Healthcare

We estimate that delivery of our refreshed Green Plan will result in our NHS carbon footprint falling by 18 per cent over the next three years. And, in terms of progress against NHS targets, implementing this Green Plan will have reduced our NHS carbon footprint by an estimated 34 per cent in 2026/27 against the NHS baseline year of 2019/20, which then places us in a strong position to go on and deliver the nationally set NHS interim target to reduce our NHS carbon footprint by at least 47 per cent by 2032.

More information about our refreshed Green Plan is available on our website. imperial.nhs.uk/about-us/our-strategy/green-plan

Task force on climate related financial disclosures (TCFD)

NHS England's Group Accounting Manual (GAM) has adopted a phased approach to incorporating the 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 pillar for 2023/24. These disclosures are provided below.

Our Trust's refreshed Green Plan goals for 2024-27 are aligned to deliver the NHS Net Zero targets. Our progress reporting is informed through our Green Plan Advisory and Operational structure that comprises themed delivery leads and our senior leadership team. The Trust's Executive Management Board and Redevelopment committee receive progress updates on our Green Plan twice a year, and these are presented by our Net Zero Board lead. In 2023 we had our sustainability reporting processes independently reviewed by internal auditors KPMG, who assessed processes and controls in place for sustainability reporting as 'providing significant assurance with minor improvement opportunities'. The improvement recommendations from this audit have now been implemented.

Our Trust's Board Assurance Framework has a risk scored area on sustainability that relates to the delivery of the sustainability outcomes within our refreshed Green Plan for 2024-27, and this is reviewed as part of our existing Board Assurance Framework governance. Our Trust's Green Plan progress is also reported to the Board via regular updates to the APC Estates and Sustainability Committee. The APC Estates and Sustainability Committee monitors individual and the overall APC performance towards delivering the NHS net zero targets.

The age and condition of our estate makes estates-related response to climate change more challenging but the Board redevelopment committee considers climate-related issues and

sustainability in all aspects of redevelopment, including the design of buildings, and oversees initiatives with the aim of reducing the carbon footprint of the existing estate.

This year our Trust will establish a Climate Change Adaption working group responsible for developing, and then monitoring actions from a Climate Change Adaptation Plan (CCAP). This CCAP will provide the Trust with a better process for adjusting our services, systems and infrastructure to continue to operate effectively while the climate changes, and managing associated risks.

Reducing health inequalities

North west London has a diverse population of 2.4 million people, with more than 200 ethnicities represented across the eight boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and City of Westminster. There are significant inequalities in health and wellbeing within these populations.

On average, marginalised groups and people living in areas of high deprivation spend more years living with ill health and die earlier than people living in more affluent areas. For example, life expectancy for males born in the most deprived area of Kensington and Chelsea is 20 years lower than for those born in the least deprived area of Westminster.

Health inequalities in access, outcomes and experience, are also directly related to wider social, economic and environmental factors that influence how different communities live. To achieve our vision of 'better health, for life', for all the communities we serve, we need to play an active role in improving health for disadvantaged populations.

Our approach

We work with patients, staff, communities and partners to understand and address health inequity across our services.

To help us navigate these complex issues and maximise our impact, we have developed a Trust-wide **health and equity framework** with the aim of improving health, wealth, wellbeing, and equity for the communities who live around our hospitals. This includes achieving equity of access, experience and outcomes for all the patients we serve, across all of our services.

Understanding our local population and their needs

We are committed to using data to monitor health inequalities and engaging with local community groups to use this data to drive change. We have made significant progress over the past 12 months to improve our data quality on the ethnicity of our patient population and our understanding of where deprivation may be an issue for our patients. We have updated our existing operational dashboards to present data that allows staff to identify inequity by ethnicity and deprivation within services. We also work closely with our local public health teams and local community groups to identify needs, gather insights and listen to what matters most to our communities, supported by our new user insight and community engagement functions.

We will report on the health inequalities metrics set out in NHS England's statement on information on health inequalities during 2024/25. We are part of a working group of providers across north west London who are co-ordinating how we report on and develop action plans to address inequities in service delivery.

Our priorities

Improving equity of our core activities

Using data, user-insights, and improvement methodologies, we have collaborated with patients and communities to identify issues and co-create solutions in the following areas:

- **Improving access to outpatients** – We have identified a notable difference in Did Not Attend (DNA) rates linked to deprivation where the DNA rate stands at 13 per cent compared to the average of 8 per cent. This presents a chance to improve health and equity as missing the initial outpatient appointment can lead to later diagnosis and treatment, leading to poorer outcomes. We are collaborating with academic partners and patients to test approaches that can support increased attendance for patients from deprived communities or minority ethnic backgrounds. These include testing different text messages to find the most effective content and piloting an artificial intelligence algorithm to identify patients at high risk of missing their appointment. This is feeding into our wider outpatient improvement programme, so the redesign of the service will be more equitable from the outset.
- **Taking care and diagnostics into the community** – Last year, we opened two of three new community diagnostic centres planned for north west London, in Willesden and Wembley. Since the end of the 2023/24 financial year an eye care diagnostic centre has opened in Westminster, supporting patients in north Paddington. All have been located in areas that serve communities with significant health inequalities and will help us bring down waiting times and ensure fairer access to services.
- **Supporting patients to 'wait well'** – Data shows that patients from the most deprived populations have a poorer experience and potentially wait longer for treatment. We are investing in ways to understand and improve the waiting experience, with an emphasis on patients from the 20 per cent most deprived populations. Working with our public partners and Imperial College London, we have completed a user-insights study to co-design initiatives to improve the waiting experience to pilot across the Trust.
- **Evolve services to address causes of ill health and prevention** – Smoking is a leading cause of health inequity and poor health outcomes for our staff, patients and their families. We are working to create a sustainable smokefree environment to empower our patients who smoke to have their best opportunity to quit smoking. This includes providing an on-site tobacco dependence treatment service, timely nicotine replacement therapy and community referral pathways.
- **Interpreting improvement programme** – Patient interpreting, including sign language, plays a vital role in promoting equity, safety and quality in healthcare delivery. A review carried out in December 2022 showed our communities had concerns about the quality of patient interpreting and translation in our hospitals. That's why in 2024 we began a programme of work, led by a newly appointed Interpreting improvement manager which aims to standardise and make improvements to our patient interpreting service. We're

trialling a new on-demand interpreting option available through our existing external service. We encourage and empower staff to make patient interpreting more accessible for patients through better information, education and training. And we are working with patients, staff and partners to co-design our interpreting services for the future.

Building partnerships to improve population health and wellbeing of our local communities

The vast majority of health outcomes are driven by factors beyond health care delivery – including secure employment, access to high-quality education and living in a healthy, connected and safe place. Many of these determinants are directly impacted by services and infrastructure delivered by our collaborators and local partners. Imperial College Healthcare NHS Trust leads work with partners to improve health and reduce inequalities by connecting communities, researchers, industry, public sector and voluntary organisations.

- **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. We invest in community recruitment, conduct local skills mapping for the health and life sciences sector, and organise community walks for staff and partners to deepen their understanding of local health needs and inequalities. Our Trust Green Plan and the redevelopment of our hospital sites also remain important contributors to this work. You can read more about those on pages 20 and 37.
- **Paddington Life Sciences Partners** – We brought together community, government, health provider and industry partners across Westminster to improve digital inclusion for Paddington residents. Our team is helping to streamline referral pathways for those residents who have more difficulty accessing or benefiting from technology. We are also focused on working with partners to provide opportunities for local residents to build skills and find high-quality work within this emerging life sciences eco-system in Paddington.
- **Westminster #2035** – Our partnership work with local communities is aiming to achieve the collective ambition of a healthier and fairer Westminster together by 2035. The collaboration aims to change futures and reduce inequalities through listening to our residents more effectively and proactively connecting with other organisations. Together with partners, we are focused on improving equity in access, experience and outcomes of services across Westminster, alongside joined-up work to support healthier, safer and cleaner environments, quality housing and giving children the best start in life.
- **Investing in community based interventions** – Our collaboration with the Chelsea FC Foundation leverages the interplay between sport, health and wellbeing. We are developing community-based programmes combining exercise, physical activity and peer support to improve participants' physical and mental wellbeing. Recently expanded to Harrow, this programme addresses local gaps in community rehabilitation.

We recognise the dual role we have to play in delivering high quality, equitable care, while also using our resources in imaginative ways to address health inequalities and improve the overall health and wellbeing of the communities we serve. This work will continue to be a major focus in the year ahead.

Professor Tim Orchard, Chief executive
28 June 2024

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 & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Hospitals NHS Trust. The four acute trusts remain as statutory bodies who also continue to work with other partners in the north west London ICS 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.

During the year we commissioned an internal audit review across the Collaborative which demonstrated that the governance model is operating appropriately overall to enable the individual trust boards to fulfil their duties, but highlighted some areas for improvement. These included the need for a collaborative strategy, the development of a collaborative risk management approach and improved engagement and oversight of local trust issues as unitary boards. Actions in response to these recommendations are all in progress and will be addressed as part of ongoing development of the governance model, either through reinforcement of existing structures and mechanisms or through the board development programmes at trust and collaborative level.

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.

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) delegate 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 directly to the board in common.

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. For example, we anticipate developing governance arrangements further around risk and assurance in the next financial year, to enable the Collaborative to identify common risk areas where collaborative action can most effectively add value in the management of risks being 'owned' by trusts.

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 the outcome of their committees, including matters for escalation, including risks, to the respective collaborative committee.

The board in common receives summary reports from the Collaborative committees and trust audit and risk 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

Our 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 at 31 March 2024 consisted of the chair, vice chair, six non-executive directors, chief executive, medical director, chief nurse, chief financial officer and chief operating officer, as outlined below. In addition, we have one associate (non-voting) non-executive director who provides additional expertise to the board.

The membership of the 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

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.

Our 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 on page 45.

The Trust board during 2023/24 was as follows:

Board member	role	Attendance at board meetings
Matthew Swindells	Chair in common	4/4
Bob Alexander	Vice chair	4/4
Nick Gash	Non-executive director	4/4
Sim Scavazza	Non-executive director	0/4*
Linda Burke	Non-executive director	4/4
David Moss	Non-executive director (designate from 15 February 2024)	4/4
Janet Rubin	Non-executive director (until 14 February 2024)	4/4
Carolyn Downs (from 1 September 2023)	Non-executive director	2/2
Neena Modi (from 1 September 2023)**	Non-executive director**	1/2
Loy Lobo	Non-executive director (from February 2024)	0/0
Aman Dalvi	Non-executive director (designate)	4/4
Peter Goldsbrough	Non-executive director (until 31 August 2023)	2/2
Andrew Bush	Non-executive director (until 31 August 2023)	1/2
Nick Ross	Associate non-executive director (until 31 December 2023)	2/2
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

Associate non-executive directors are not voting members of the Trust board, and therefore do not attend the board in common meetings but provide specialist skills and experience to the Trust in a non-executive capacity and attend Trust committees.

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.

* Sim Scavazza has been chair of the Berkshire, Oxfordshire and Buckinghamshire ICB and it was agreed with the chair that she prioritise chairing the Imperial College Healthcare People Committee and the EDI task force
**This non-executive director is the appointed representative of Imperial College London.

Trust board meetings: 1 April 2023 – 31 March 2024

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 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 board 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 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 on page 48.

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 assesses 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 2023/24)
- 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.

The Committee also reviews key areas of judgement in both financial and non-financial reports including the significant risks identified by the external auditors.

Deloitte LLP acted as the Trust's external auditors in 2023/24, 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
David Moss, non-executive director (until February 2024)	4/5
Loy Lobo, non-executive director (started February 2024)	1/1
Linda Burke, non-executive director	6/6
Jazz Thind, chief financial officer	6/6
Professor Julian Redhead, medical director	5/6
Professor Janice Sigsworth, director of nursing	5/6

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 has 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 EDI strategy, the Acute Provider Collaborative has established an EDI improvement steering group, comprising non-executive director, executive and EDI expert membership from across the APC, 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.

Remuneration and appointments committee member	Attendance (actual/possible)
Bob Alexander, vice chair (committee chair)	2/2
Nick Ross, associate non-executive director	2/2
Sim Scavazza, non-executive director (from November 2022)	2/2

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 our 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)
Peter Goldsbrough, non-executive director (committee chair until July 2023)	2/2
Professor Andrew Bush, non-executive director (member until July 2023)	0/2
Carolyn Downs (committee chair from September 2023)	4/4
Neena Modi (member from September 2023)	3/4
Aman Dalvi, non-executive director (member from September 2022)	6/6
Professor Tim Orchard, chief executive officer	6/6
Professor Janice Sigsworth, chief nurse	6/6
Professor Julian Redhead, medical director	4/6

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 for ensuring our 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)
Bob Alexander, vice chair (committee chair)	6/6
Janet Rubin, non-executive director (member of the committee until January 2024)	5/5
Aman Dalvi, non-executive director	6/6
David Moss, non-executive director (member of the committee from March 2024)	1/1
Professor Tim Orchard, chief executive officer	4/6
Jazz Thind, chief financial officer	6/6
Claire Hook, chief operating officer	6/6

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)
Bob Alexander, vice chair (committee chair)	3/3
Carolyn Downs, non-executive director (from September 2023)	2/2
Sim Scavazza, non-executive director	2/3
Nick Ross, associate non-executive director (term of office ended on 31 December 2023)	2/2
Professor Tim Orchard, chief executive officer	3/3
Jazz Thind, chief financial officer	3/3
Matthew Tulley, director of redevelopment	3/3

Trust people committee

The committee monitors, reviews and provides assurance to the board on our cultural and organisational development. 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. It identifies the strategic people and workforce priorities as a significant employer and as a partner in training, education, and development of health and care capacity in the locality, and assurance in relation to strategic issues relating to ethics and duty of care in the conduct of our affairs (including whistleblowing) and to our 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 include 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)	6/6
Linda Burke, non-executive director	6/6
David Moss non-executive director (left February 2024)	5/5
Loy Lobo, non-executive director (member from February 2024)	1/1
Professor Tim Orchard, chief executive officer	5/6
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 detailed on the previous pages, there are some collaborative meetings that have decision-making authority delegated by our board, through 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 new code covers both foundation trusts and NHS trusts and is based on the principles of the UK Corporate Governance Code. Imperial College Healthcare NHS 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.

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 online at: https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/.

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

Code reference	Assurance
Section A, 2.1	How the board works collaboratively can be found in the director's report (pg. 47).
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 NWL are disclosed in the director's report which describes how interests of system based partners are considered in discussion and decision making.
Section B, 2.6	NED disclosures are included within the accountability report.
Section B, 2.13	Board frequency and attendance has been disclosed within the director's report.
Section C, 4.2	Link to biographies which detail skills, expertise and experience of directors is included in the director's report.
Section C, 4.7	Detail of the well led self-assessment is included in the code of governance partial compliance table 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 analysis and annual governance statement.
Section D, 2.8	The board of directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. This is disclosed in the annual governance statement.
Section D, 2.9	Going concern disclosure included in annual accounts and CFO report within the performance report. (page 27).
Section E, 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings. This has not occurred this year so not applicable.

During the year, we have completed a 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 our Trust covered a total of 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.

Our Trust was assessed as being compliant with 56 points of inquiry and partial compliance with eight areas. Six areas remain partially compliant and updates on progress against these is provided to the Audit, Risk and Governance on a quarterly basis.

Provision	Reason and action required to be compliant
Provision A, 2.5 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, eg from the internal audit function, to provide an adequate and reliable level of assurance.	We do not currently disaggregate data by ethnicity and deprivation. This is being developed and will be presented within the collaborative performance report once available.
Provision B, 2.13 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 the summaries of purpose of committees and the board on our website.
Provision A, 2.7 Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners.	We identified that we had good engagement with stakeholders but we did not have non-executive walkarounds in place which would support engagement between board members and the workforce. These have now been implemented.
Provision C, 1.1 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.

Provision	Reason and action required to be compliant
Provision C, 1.3 Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.	Whilst we undertake annual effectiveness reviews of our board committees and we had a review into collaborative governance arrangements undertaken by our internal auditors, we need to undertake an effectiveness review of the board in common in order to be fully compliant with the code.
Provision C, 4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in both the provider licence and CQC regulations. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	We weree working to meet the refreshed requirements of the Fit and Proper Person checks which were to be in place in a phased approach by September 2023 and June 2024. We are now fully compliant and our submission to NHS England was made in June 2024.
Provision C, 4.7 All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances.	Whilst we had commissioned an audit of collaborative governance across the Acute Provider Collaborative, it was agreed that as the CQC framework had been under review and the new methodology and approach had not been published at the time, that it would not be value for money to commission an external review at this stage. We are currently completing self-assessments for well-led and a collaborative peer review process will be established as this provides a level of independence and opportunities for shared learning at nil cost.
Provision C, 5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	There was not an agreed programme of board development for board members. This has now been developed and statutory and mandatory training of all directors is overseen as part of the appraisal and Fit and Proper Person Checks.

Compliance with cost allocation and charging guidance

We have complied with the cost allocation and charging guidance issued by HM Treasury.

Political donations

We did not make any political donations during 2023/24.

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 Note 36 to the Financial Statements.

Well-led framework

As part of the CQC's new regulatory framework, launched for NHS trusts in January 2024, it has indicated that trust-level, well-led inspections will continue to be undertaken. However, the format will shift from being focused on the functioning of the executive and board to a more iterative process whereby the executive and board are evaluated in relation to findings from the CQC's inspections of our services. This means that while we must assure the ward to board links are robust, and enable effective and timely oversight of services at executive and board level, it must also ensure the robustness and effectiveness of the systems and processes by which decisions impacting clinical services are made at executive and board level.

Achievement of the CQC's well-led standards within services is independently evaluated through our ward accreditation programme, internal and external peer reviews, national audit, staff and patient surveys, etc. The outcomes of these are used to inform directorate 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 CEO. A self-assessment of the Trust against the CQC's well-led standards, using its new regulatory methodology, was undertaken during the first quarter (Q1) of 2023/24. The self-assessment was updated following a review of adherence to the NHS Code of Governance for trusts, which was carried out during Q2, and a final report encompassed all of the findings and made recommendations for improvement accordingly. The outcomes from the self-assessment were reviewed at the board development session in February 2024.

An overview of service governance is included in our annual governance statement and Quality Accounts, 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. Our Quality Committee is the board's assurance forum for systems, processes and outcomes relating to safety, clinical effectiveness and patient experience. Representatives from the CQC continue to join the quarterly system oversight meetings with the Trust and north west London sector colleagues. Regular informal meetings between the Trust and the CQC continued during 2023/24, as well as regular contact in relation to queries (concerns and complaints raised directly with the CQC by others, which we are asked to respond to).

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 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

We 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
28 June 2024

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 judgments 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
28 June 2024

Jazz Thind, Chief financial officer
28 June 2024

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
28 June 2024

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 our policies, aims and objectives, 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 2024 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 our 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.

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

Our 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

We have 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.

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

- risk appetite statement which sets the amount of risk that we are 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 follows:

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 2023/24 self-certification processes concluded that the organisation had taken the necessary precautions 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 in the following table. Further detail regarding the highest-rated risks relating to data quality, business continuity and financial sustainability are included within the performance report.

Description (impact)	Score	Trust committee	Controls in place
Strategic goal 1: To help create a high quality integrated care system with the population of north west London			
Health inequalities in our population Risk of inequalities in our population's access to, experience of and outcomes from the care we provide	16	Quality	• Health equity team in place. • Health equity framework developed to guide and focus work in this area. • Digital and data strategy focusing on the availability of data to enable areas of inequality to be identified. • 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 Failure to transfer medically optimised patients to mental health inpatient settings due to lack of available beds impacting on patient safety and experience.	16	Quality	• Mental health performance dashboard. • Escalation to the emergency department delivery board, ICS CEOs meetings and at system oversight meetings. • Regular surveillance at mental health steering group and between teams. • Increased registered mental health nurse workforce with enhanced security presence and dedicated consultant lead. • Escalation of delays in real time with partners within the ICS. • Development of the Trust Lighthouse facility.
Poor condition of estates Failure to provide appropriate condition of buildings and infrastructure impacting on patient, visitor and staff safety and effective clinical delivery	20	Redevelopment	• Planned preventative maintenance programme. • Hard facilities management (FM) contract. • Water safety and ventilation group and medical gases committee overseeing compliance with safety standards. • Touch point for proactive management of emerging issues. • Backlog maintenance programme informed by 6 facet survey. • Urgent jobs prioritised as P1. • Business continuity plans and estates contingency planning.
Infection prevention and control (IPC) Failure to follow infection prevention and control policies and guidelines resulting in healthcare acquired infections	16	Quality	• Safety improvement priorities. • IPC quality review meetings supporting trust-wide improvement work. • Divisional IPC action plans. • IPC policies and guidelines. • Testing and screening programmes e.g. MRSA. • Decontamination and vascular access services. • Water safety and ventilation system plans. • Antimicrobial stewardship programme. • IPC core skills training. • Improvements led via the APC, IPC and AMS working group.
Data quality Poor data quality across people, process, systems and reporting causing delays to the booking of patients	20	Audit, risk and governance	• Audit, validation and key data quality indicators reported to executive management board. • Patient safety concerns escalated to the medical director's office via the clinical harm assurance Group. • Data quality improvement programme focusing on outpatient data quality, supported by the Trust transformation team. • 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 Risk to not achieving the required underlying deficit improvements to deliver a sustainable financial position	20	Finance, investment and operations	• Tracking of underlying position. • Productivity through transformation board overseeing identification and delivery of organisational cost improvement plans. • 'Breaking new ground' sessions. • Provider collaborative working to establish recurrent and non-recurrent funding and review of income funding.

Funding Failure to gain funding and approvals from key stakeholders for the redevelopment programme resulting in continuing to deliver services from suboptimal estates and clinical configuration.	16	Redevelopment	• Regular meetings with NHSE, NHP, cvouncil planners and Greater London Authority. • Regular engagement with clinicians through models of care work. • Active internal communications and stakeholder engagement plans. • Business cases for funding approval.
Strategic goal 3: To build learning, improvement and innovation into everything we do			
Business continuity Failure to maintain critical services following an emergency event or pandemic due to inadequate business continuity planning	20	Audit, risk and governance	• Trust emergency, preparedness, resilience and response (EPRR) framework with business continuity plans at service level. • National and international horizon scanning. • FFP3 mask fit testing programme. • Imperial College Healthcare communication arrangements. • Pandemic plan assessed and approved by NHSE. • Robust command and control plan. • Capability of virtual clinics and meetings. • Staff redeployment plan. • 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 our estate and the need to redevelop our hospital sites has also been identified as a significant risk facing the Trust through 2023/2024 and as it enters 2024/25.

Estates and redevelopment

Our capital plan for 2023/24 was once again extremely challenging due to the level of backlog maintenance, information communications and technology infrastructure, and medical equipment replacements required to mitigate Trust-level risks. This is in addition to divisional capital projects which are essential for the development and improvement of our services, and reflect into quality and safety of clinical services.

We have the largest backlog maintenance liabilities of all NHS or foundation trusts, principally due to the age of our estate. Estates return information collection (ERIC) data published in 2016 showed we had nearly 25 per cent of all NHS risk adjusted backlog maintenance costs, with a fully built-up backlog liability of £1.3 billion. As a result of this data, our board approved a plan to spend a minimum of £131 million over eight years on the highest priority backlog items. The amount in the 2023/24 plan was consistent with this approach.

We follow a comprehensive approach to capital planning, collating all potential capital projects and prioritising based on factors including risk, timing and underlying drivers. This is fully peer-reviewed and challenged before being approved by the executive.

The core capital programme is £65.8 million for 2024/25 and deals with regulatory and safety issues, which includes business as usual:

- backlog maintenance
- information and communications technology
- equipment
- minor works.

The St Mary's Hospital campus hosts one of London's major trauma centres and comprises a number of unconnected buildings intersected by public roads resulting in complex and inefficient logistics for both materials and equipment. There are multiple entrances, making wayfinding a major challenge for patients, staff and visitors. The environment is often not conducive to modern day healthcare, and failures of the estate and its infrastructure can lead to unplanned closures of beds and other facilities at short notice.

While the capital programme is primarily focused on essential quality and safety-related projects, prioritisation of capital projects is also informed by the specialty review programme and our organisational strategy, and how that shapes our redevelopment work.

In addition to the immediate challenges of maintaining our infrastructure and estate, it is widely accepted that we need to fully redevelop our sites in the long term. A redevelopment programme is ongoing and in the autumn of 2019 we were included in the Department of Health and Social Care's health infrastructure plan. We submitted a strategic outline case to Department of Health and Social Care in August 2020. The health infrastructure plan has been succeeded by the New Hospital Programme, which was announced in autumn 2020. St Mary's, Charing Cross and Hammersmith hospitals were part of this announcement. The New Hospital Programme has confirmed that the "case for change for St Mary's has been made. The highest priority is to deliver a new hospital on the St Mary's site."

The redevelopment plans for the new hospitals have continued to progress in year. Working with the central New Hospital Programme the Trust has contributed to the production of the business case which was approved in early 2023. The New Hospital Programme funding announcement in May 2023 confirmed that all our schemes are supported within funding plans. Funding will now be provided to continue development of business cases.

The continuing deterioration in the condition of the estate, while addressed in part by an eight-year essential backlog maintenance programme, gives cause for material concern in that estate failures can cause significant delays to service provision and significant loss of income. There can also be very significant costs to rectify such estate failings.

Care Quality Commission regulatory framework

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. We were compliant with the requirements of its CQC registration and were not subject to any enforcement action during 2023/24.

The CQC did not carry out any routine inspections until January 2024; however, we were not subject to any routine inspection between January and March 2024. Athough the CQC will always carry out urgent inspections where it has serious concerns, no urgent inspections took place during 2023/2024. We participated in routine engagement meetings with the CQC during 2023/24, responded to routine incident requests (as part of the CQC's learning from deaths mandate), and responded to general enquiries from the CQC (complaints or concerns are raised either directly by the CQC in response to their intelligence or by others such as patients, families, members of the public, etc.).

We participated in a special review carried out by the CQC during 2022/23, which was a national maternity inspection programme that involved inspection of the safe and well-led domains for all maternity services that were last inspected prior to April 2021. The final report and updated ratings from the inspection of the Trust's maternity services in March 2023, showing we maintained all of its existing ratings:

- Maternity services at both sites remain rated 'good', safe and well-led, 'outstanding' overall.
- Because only two domains in one service were inspected, our overall ratings were not impacted by the outcomes of this inspection.

We did not participate in any special reviews or investigations by the CQC this year, nor were we captured in any reports published this year following special reviews or investigations undertaken in a previous year.

The CQC requires all trusts to participate in the NHS England patient survey programme.

- The outcomes of the 2022 urgent and emergency care survey were published July 2023. Although we performed about the same when compared to other trusts, there was a reduction in performance for the majority of questions compared to our own performance in previous surveys.
- The outcomes of the 2022 adult inpatient survey were published September 2023, and the 2023 maternity survey were published February 2024. We performed favourably in both surveys, both compared to previous performance and in relation to other trusts.

No serious concerns were raised in any survey published this year; where improvements were needed, they were managed in line with normal processes, we participated in the 2023 national cancer patient experience survey and 2023 adult inpatient survey, with outcomes to be published during 2024/25.

Our workforce

The Trust people strategy 2024/25 sets out a clear vision for our workforce. Each year, the Trust draws on this strategy and with 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". In 2024/25, it has been agreed we align our people priority framework 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, a similar approach adopted in 2023/24 will be replicated in 2024/25. Monthly reports to the people EMB are completed, providing an update on progress 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.

We use best practice methodology in accordance with developing workforce standards, 'safe, sustainable and productive staffing', (safer nursing care tool), adult inpatient wards, acute assessment units, emergency departments, and children's and young person's 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

In 2020, we introduced the new Imperial management and improvement system (IMIS) to help deliver organisational goals and objectives. This includes the performance routines within the organisation, use of integrated performance scorecards and our approach to using improvement methods towards achieving our goals.

The integrated performance scorecards have been designed to align more clearly with strategic objectives and priority programmes while 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 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.

Over the last year we have continued to have provider oversight meetings led by the integrated care board with support from the NHS England regional team and other regulators such as the Care Quality Commission.

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 and our compliance with the code of governance is included in the accountability report.

To ensure that any cost improvement schemes, a key part of our 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.

Data security and protection shared service

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

- Imperial College Healthcare NHS Trust data protection officer services
- NHS North West London ICB – corporate data protection officer services
- NHS North West London ICB – GP data protection officer services
- NHS North West London ICS – 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

We published a 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 our 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 board, with overall accountability for data protection and cyber security. A senior information risk officer's action plan has been generated to manage and mitigate information threats and risks.

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 we satisfy 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 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, 32 mandatory (and two non-mandatory) assertions and requires 108 mandatory evidence items. Mandatory standards may be either 'met' or 'not met' in a data security and protection toolkit return. Following the Covid-19 pandemic, the submission period for the data security and protection toolkit for 2023/24 now runs from 1 July 2023 to 30 June 2024. 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 2024 accompanied by a 'standards met' 'low risk' audit opinion.

Data security and protection training

The 2023/24 DSPT brings about a change in the assessment and review of DSP Training compliance. The new requirement states staff must have an appropriate understanding of information governance and cyber security and we 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 2023/24 data security and protection toolkit return by 30 June 2024.

Data security and protection incidents July 2023 to March 2024

We are mandated to report all incidents through 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. Due to the pre-set reporting interval of the toolkit 1 July 2023 through 30 June 2024 – there are only partial in-year metrics available.

Table 1: Incidents reported 1 July 2023 – 7 March 2024

Grade of incident	Number
Incident reported to the ICO and Department of Health*	1
Trust-level incident	16
Incidents under investigation yet to be classified	35
Total *+	52

***Late reporting:** There are instances where incidents may have previously occurred and were not reported to the data protection officer. This final total figure may increase should there be any such cases of late or previously unreported data protection breaches.

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	8
Abuse of authorised access	11
Paperwork	0

Incidents reported to Information Commissioner's Office and Department of Health and Social Care (Total = 1)

Incident	Summary of incident	Incident details	Action taken by ICO
1	P2305020958: Alleged abuse of authorised access regarding an employee who accessed other staff members and patients' health records.	A staff member had accessed other staff members and patients' health records. Reports were conducted to track the activity of the staff member. The first report highlighted that the staff member had accessed the colleague's health records 21 times during the scope of 12 months. The second report highlighted that the staff member had accessed a colleague's records 31 times within 21 days. The reports also highlighted that the staff member had accessed a variety of other staff members and patients records. A disciplinary hearing was undertaken with human resources and the staff member stated that she had health conditions and memory loss. Human Resources deemed that the staff member had no legitimate reason to access any of the staff members or patients' health records. Therefore, appropriate action has been undertaken to revoke all access of the individual concerned to any system that may hold personal identifiable information pertaining to staff members or patients. The DPO team had a meeting with the Caldicott Guardian. It was decided that this was a level 2 incident and therefore reportable to the ICO.	The ICO did not take action.

Data quality and governance

High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct and up to date. For 2023/24 as a whole, the Trust achieved the benchmark for the Data Quality Maturity Index, a national measure of data quality that monitors coverage, consistency, completeness and validity across a number of datasets, and is published by NHS England. However, we recognise that the pandemic, industrial action, our growing waiting list for planned care, and some of our wider operational challenges have had an impact on our waiting list data quality and we continue to prioritise improvement in this area. Progress is managed through our waiting list data quality and reporting framework, which is led by our chief operating officer and reports regularly to the executive management board. An important component of this is a quality assurance and sample audit process to inform training, learning and development. The performance support team carries out routine audits of referral to treatment (RTT), emergency care metrics, diagnostics (DM01) and cancer waiting time data.

In January 2023 the output of a Trust-wide review into data quality for waiting lists, waiting times and performance was presented to the Trust executives with a transformation session in April 2023. It was acknowledged that, whilst significant work had been completed to monitor, track and report data quality as well as mitigate risk, a sustainable improvement in real-time data quality has not yet been delivered, and it was identified that there was a higher level of risk around outpatient pathways. As a result, the performance support team are leading a multiyear programme dedicated to outpatient data quality which commenced in Q2 2023/24. This work is aligned to the wider outpatient improvement Trust-wide programme. The long-term desired goal is to improve data quality at source, to reduce layering of errors within patients' pathways by improving data capture ensuring it is accurate, complete and timely. Through this we will ensure that we are using high-quality data to assure ourselves that we are meeting our obligations.

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 1353 staff, 65 per cent, had been returned at the end of March 2024.

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 on our website at: imperial.nhs.uk/about-us/foi/lists-and-registers

Pensions and remuneration

We have control measures in place to ensure we comply with all employer obligations contained within the NHS pension scheme regulations. 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 our off-payroll engagement disclosures (which are in accordance with HMRC requirements). Our 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 a 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 2023/24 will be published in autumn 2024.

Sustainability

We have a board-approved green plan for the period 2024/25 to 2026/27 with a named director to lead on its implementation. We ensure that its obligations and reporting requirements will be complied with.

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 accounts 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 opinion of 'Significant assurance with minor improvement opportunities' has been given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control' 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 generally being applied consistently.
- 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. Internal audit has rated the framework as providing 'Significant assurance with minor improvements' on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control
- the audit, risk and governance committee oversee the effectiveness of the Trust's overall risk management and internal control arrangements. On behalf of the Trust board, it reviews the effectiveness of risk management systems in ensuring all significant risks are identified, assessed, recorded and escalated as appropriate
- 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 2023/24.

Professor Tim Orchard, Chief executive
28 June 2024

Remuneration report

Remuneration 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 we:

- make decisions in the context of the current market
- take into account independently sourced benchmark data and analysis of pay within relevant NHS, private health and non-healthcare markets
- compare pay with other staff on nationally agreed Agenda for Change and medical consultant terms and conditions.

Salaries are awarded on an individual basis (i.e. they are paid 'spot salaries') taking into account the skills and experience of the post holder and are performance based. 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.

The Trust has taken advantage of flexibilities offered in the Agenda for Change to offer spot salaries to 29 senior managers who are not executive directors. These salaries are set by the relevant executive director with approval from the director of people and organisation development.

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	2023/24	Change from prior year	2022/23	Change from prior year
Total remuneration (£)	£310k - £315k	5.0%	£295k - £300k	1.7%
Salary component of total remuneration (£)	£300k - £305k	5.2%	£285k - £290k	1.8%
Performance pay and bonuses component of total information	£5k - £10k	0.0%	£5k - £10k	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:

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 information	9.09	6.91	5.33

2022/23	25th percentile	Median	75th percentile
Total remuneration (£)	33,884	45,091	57,915
Salary component of total remuneration (£)	33,884	45,091	57,915
Pay ratio information	8.78	6.60	5.14

The year-on-year percentage change in ratio is comparatively small. It is influenced by movements in the composition of staff by different bands across the year and the impact of pay awards. The highest paid director received pay increases in 2023/24 that were in line with those received by other cohorts of staff.

In 2023/24, there were no employees who received remuneration in excess of the highest paid director (zero in 2022/23). Remuneration ranged from £20k–£25k to £310k-315k in 2023/24 (£15k–£20k to £295k–£300k in 2022/23). The calculated average salary across the organisation was £52,069 in 2023/24, which was an increase of 3% from 2022/23 (£50,754, which was an increase of 8% on 2021/22). 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 employees are included. Agency fees are excluded from the calculation but are not always known so are assumed to be 20 per cent of total cost.

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 (APC). 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 & Westminster NHS Foundation Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust). As part of the APC, 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 2023/24

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits[12]	Total remunera-tion
	bands of £5,000)	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title	£000	£00	£000	£000	£000	£000
Matthew Swindells, joint chair	20 - 25	-	-	-	-	20 - 25
Bob 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	Expense payments (taxable)[12]	Perfor-mance pay and bonuses	Long term perfor-mance pay and bonuses	All pension related benefits[13]	Total remunera-tion
	(bands of £5,000)	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(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]	(b) Real increase in lump sum at pension age[14]	(c) Total accrued pension at pension age at 31 March 2024	(d) Lump sum at pension age relating to accrued pension at 31 March 2024	(e) Cash equivalent transfer value at 1 April 2023	(f) Real increase in cash equivalent transfer value[15]	(g) Cash equivalent transfer value at 31 March 2024[15]	(h) Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(nearest £1k)	(nearest £1k)	(nearest £1k)	(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: Prof. Tim Orchard sold leave in the value of £0–5k.

Non-executive directors' remuneration 2022/23

Salaries and allowances	(a) Salary[12]	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long term performance pay and bonuses	(e) All pension related benefits[16]	(f) = (a to e) Total remuneration
	bands of £5,000)	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title	£000	£00	£000	£000	£000	£000
Matthew Swindells, joint chair[1]	20 - 25	-	-	-	-	20 - 25
Bob Alexander, vice chair / non-executive director[2]	15 - 20	-	-	-	-	15 - 20
Professor Andrew Bush, non-executive director[3]	10 - 15	-	-	-	-	10 - 15
Peter Goldsbrough, non-executive director[4]	10 - 15	-	-	-	-	10 - 15
Sim Scavazza, non-executive director[5]	10 - 15	-	-	-	-	10 -15
Nick Gash, non-executive director[6]	0 - 5	-	-	-	-	0 - 5
Linda Burke non-executive director[7]	5 - 10	-	-	-	-	5 - 10
David Moss, non-executive director[8]	5 - 10	-	-	-	-	5 - 10
Andreas Raffel, non-executive director[9]	5 - 10	-	-	-	-	5 - 10
Kay Boycott, non-executive director[10]	5 - 10	-	-	-	-	5 - 10
Nick Ross, non-executive director[11]	5 - 10	-	-	-	-	5 - 10

Executive directors' remuneration 2022/23 – Restated

	(a)	(b)	(c)	(d)	(e)	(f) = (a to e)
Salaries and allowances	Salary	Expense payments (taxable)[18]	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits[16]	Total remuneration
	(bands of £5,000)	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
Name and title	£000	£	£000	£000	£000	£000
Professor Tim Orchard, chief executive officer[13]	285 - 290	-	5 - 10	-	75 - 77.5	370 - 375
Professor Julian Redhead, medical director[14]	260 - 265	-	-	-	50 – 52.5	315 - 320
Professor Janice Sigsworth, chief nurse[15]	170 - 175	-	-	-	-	170 - 175
Jazz Thind, chief financial officer	185 - 190	4,800	-	-	32.5 - 35	220 - 225
Claire Hook, chief operating officer	165 - 170	-	-	-	57.5 - 60	225 - 230

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Pension benefits	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age at 31 March 2023	Lump sum at pension age relating to accrued pension at 31 March 2023	Cash equivalent transfer value at 1 April 2022	Real increase in cash equivalent transfer value[17]	Cash equivalent transfer value at 31 March 2023[7]	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(nearest £1k)	(nearest £1k)	(nearest £1k)	(nearest £1k)
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Professor Tim Orchard, chief executive officer[13]	5 - 7.5	0.0 - 2.5	125 - 130	170 - 175	1,897	84	2,080	-
Professor Julian Redhead, medical director[14]	2.5 - 5	-	85 - 90	185 - 190	1,567	51	1,702	-
Professor Janice Sigsworth, chief nurse[15]	-	-	-	-	-	-	-	-
Jazz Thind, chief financial officer	0.0 - 2.5	-	75 - 80	95 - 100	1,154	44	1,246	-
Claire Hook, chief operating officer	2.5 - 5	0 - 2.5	50 - 55	85 - 90	648	39	730	-

Notes:

1. Matthew Swindells joined the board as joint chair of the North West London Acute Provider Collaborative on 1 April 2022.
2. Bob Alexander assumed the role of vice-chair of Imperial College Healthcare NHS Trust from 1 September 2022. He is also a non-executive director of London North West University Healthcare NHS Trust.
3. Professor Andrew Bush became a non-executive director of Chelsea & Westminster NHS Foundation Trust from 1 September 2022.
4. Peter Goldsborough became a non-executive director of Chelsea & Westminster NHS Foundation Trust from 1 September 2022.
5. Sim Scavazza became a non-executive director of London North West University Healthcare NHS Trust from 1 September 2022.
6. Nick Gash joined the board from 14 October 2022. He is also a non-executive director of The Hillingdon Hospitals NHS Foundation Trust.
7. Linda Burke joined the board from 1 September 2022. She is also a non-executive director of The Hillingdon Hospitals NHS Foundation Trust.
8. David Moss joined the board from 1 September 2022. He is also a non-executive director of London North West University Healthcare NHS Trust.
9. Andreas Raffel left the board on 30 September 2022.
10. Kay Boycott left the board on 31 August 2022.
11. Nick Ross served as a non-executive director to 31 August 2022. He continues to serve as a non-voting associate non-executive director. Remuneration shown relates to his role as a voting non-executive director.
12. All remuneration shown relates to the individuals' roles with Imperial College Healthcare NHS Trust. Remuneration for roles in other north west London providers are shown in the remuneration reports of the respective organisations.
13. Professor Tim Orchard – the amount of £45 - 50k of salary relates to payment for his clinical role.
14. Professor Julian Redhead – the amount of £55 - 60k of salary relates to payment for his clinical role.
15. Professor Janice Sigsworth chose not to be covered by the pension arrangements during the reporting year (2022/23).
16. 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.
17. 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).
18. Taxable benefits relate to approved salary sacrifice schemes, including leased cars and home electronics. 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. This value has been restated as in the 2022/23 annual report, salary sacrifice schemes were reflected as a reduction in salary. The revised presentation shows the full salary payable to the director and in addition shows the taxable benefit in kind received, which is a value determined by HM Revenue & Customs. The restatement impacts Jazz Thind (chief financial officer) and has the effect of increasing her salary band from £175 - 180k to £185 - 190k, with a benefit in kind of £4,800. The total remuneration is restated
as £220 - 225k from £210 - 215k.

The table above reflects the proportion of the remuneration of non-executive directors that relates to their role 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. This annual fee is £18k per annum, or £23k for those with vice-chair responsibilities. The Chair is paid a combined fee of £85k per annum. Actual remuneration for the year as shown in the table above may vary as these arrangements came into effect during the year.

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 2022/23, three directors exercised this option: Professor Tim Orchard and Jazz Thind sold leave in the value of £0–5k and Professor Julian Redhead sold leave to the value of £0–5k.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

Staff report

The headcount data is as of 31 March 2024 and is for clinical and corporate divisions and research and development (including hosted and contracted services).

Workforce composition by staff group

At the end of 2023/24 the Trust employed 15,699 staff. Approximately 81.3 per cent are employed in clinical roles. Further information on the breakdown by staff group is shown in the table below.

Trust staff group	Headcount 2023/24	Headcount 2022/23
Admin and clerical	2,104	2,108
Allied health professional (qualified)	831	777
Allied health professional (support)	118	123
Ancillary	1,112	1,090
Doctor (career grade)	30	48
Doctor (consultant)	1,346	1,294
Doctor (training grade)	2,017	1,913
Nursing and midwifery (qualified)	4,544	4,325
Nursing and midwifery (support)	1,224	1,260
Pharmacist	165	159
Physician associate	9	9
Scientific and technical (qualified)	908	888
Scientific and technical (support)	463	437
Senior manager	828	782
Total	**15,699**	**15,213**

Workforce composition by sex

Sixty-nine per cent of our workforce are female and 31 per cent 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 2023/24 women accounted for 60 per cent of senior managers, 28 per cent of executive directors and 44 per cent of board directors. There are five directors who are defined both as executive team members and as board directors.

Gender – all	Headcount 2023/24	Headcount 2022/23
Female	10,848	10,502
Male	4,851	4,711
Total	**15,699**	**15,213**

Gender – senior managers	Headcount 2023/24	Headcount 2022/23
Female	483	454
Male	316	328
Total	**799**	**752**

Gender – board of directors	Headcount 2023/24	Headcount 2022/23
Female	7	6
Male	9	11
Total	**16**	**17**

Gender – executive team	Headcount 2023/24	Headcount 2022/23
Female	7	7
Male	13	13
Total	**20**	**20**

Workforce composition by age and ethnicity

Age Group	Headcount 2023/24	Headcount 2022/23
16-19 years	9	7
20-29 years	2,846	2,557
30-39 years	5,077	4,882
40-49 years	3,233	3,229
50-59 years	3,068	3,079
60 years and over	1,466	1,459
Total	**15,699**	**15,213**

Ethnic origin	Headcount 2023/24	Headcount 2022/23
White – British	3,158	3,203
White – Irish	348	361
White – Any other White background	1,841	1,763
Mixed – White and Black Caribbean	96	96
Mixed – White and Black African	102	98
Mixed – White and Asian	139	137
Mixed – Any other mixed background	264	241
Asian or Asian British – Indian	1,626	1,585
Asian or Asian British – Pakistani	325	328
Asian or Asian British – Bangladeshi	236	206
Asian or Asian British – Any other Asian background	1,680	1,444
Black or Black British – Caribbean	605	557
Black or Black British – African	1,967	1,866
Black or Black British – Any other Black background	496	410
Chinese	289	267
Any other ethnic group	1,590	1,469
Undefined	521	754
Not Stated	416	428
Trust Total	**15,699**	**15,213**

Average staff numbers (subject to audit)

This table represents the average whole 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 2024.

	2023/24			2022/23		
Average staff numbers	Total	Perma-nently employed	Other	Total	Perma-nently employed	Other
Medical and dental	2,389	2,382	7	2,367	2,352	15
Ambulance staff	-	-	-	-	-	-
Administration and estates	4,189	4,173	16	3,854	3,782	72
Healthcare assistants and other support staff	2,088	2,071	16	2,049	1,980	69
Nursing, midwifery and health visiting staff	4,804	4,720	84	4,603	4,422	181
Nursing, midwifery and health visiting learners	-	-	-	-	-	-
Scientific, therapeutic and technical staff	1,243	1,129	114	1,145	1,063	82
Social care staff	-	-	-	-	-	-
Healthcare science staff	691	691	-	655	655	-
Other	9	9	-	8	8	-
TOTAL	**15,413**	**15,175**	**238**	**14,681**	**14,262**	**419**
Staff engaged on capital projects (included above)	34	29	5	26	26	-

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

	2023/24			2022/23		
	Total	Permanent	Other	Total	Permanent	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	829,999	734,941	95,058	784,255	700,787	83,468
Social security costs	92,927	81,966	10,961	84,057	74,655	9,402
Apprenticeship levy	4,057	3,524	533	3,549	3,095	454
Employer contributions to NHS BSA	119,156	108,918	10,238	112,654	104,157	8,497
Other pension costs	165	78	87	151	81	70
Total employee benefits	**1,046,304**	**929,427**	**116,877**	**984,666**	**882,776**	**101,890**
Employee costs capitalised	4,380	4,380	-	3,780	3,780	-
Gross employee benefits ex. capitalised costs	**1,041,924**	**925,047**	**116,877**	**980,886**	**878,995**	**101,891**

Note that staff costs presented for 2022/23 included (in line with national guidance) estimated amounts payable in respect of 2022/23 as part of the 2023/24 pay settlement proposed at the reporting date and subsequently implemented following agreement with the NHS Staff Council.

Sickness absence

At the time of publication, validated sickness absence statistics for 2023/24 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 2023/24 was 10.2 per cent compared to 12.2 per cent in 2022/23.

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 2023/24	Headcount 2022/23
No	12,699	12,268
Not declared	1,604	1,802
Prefer not to answer	151	138
Unspecified	743	581
Yes	502	424
Trust Total	**15,699**	**15,213**

Consultancy

In 2023/24, the Trust incurred consultancy costs of £425k (2022/23: £258k).

Trade union facility time publication requirements report: 2023/2024

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 2023 – 31 March 2024.

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
53	51.01

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%	43
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	£ 23,530.25
Provide the total pay bill	£1,004,131,055 = total figure for 2023/2024 including apprenticeship levy (£4,397,055) £999,734,000 = total figure excluding apprenticeship levy
Provide the percentage of the total pay bill spent on facility time, calculated as: (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: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	73.08%

Appendix 1

Glossary of terms

Term	Definition
Relevant public sector employer	Section 7 of the regulations defines what is a relevant public sector employer. This specifies: • Government departments, which include executive agencies and non-ministerial departments (other than the Secret Intelligence Service, the Security Service and the Government Communications Headquarters) • the Scottish Ministers and • 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 (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: (a) section 168, section 168A of the 1992 Act (TULR(C)A) (b) section 10(6) of the Employment Relations Act 1999; (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. TU activities could include: • meetings where the purpose or principal purpose is to discuss internal union matters • TU conferences • internal administration of the union e.g. answering internal union correspondence, dealing with financial matters, responding to internal surveys. There is no statutory entitlement to paid time off to undertake activities. 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. There is no statutory entitlement to paid time off to undertake activities. 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.

Total paid facility time hours	Total number of hours spent on facility time by TU representatives during a relevant period. 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: (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: (Hourly cost for each employee x number of paid facility time hours) Total facility time cost is calculated by adding together the amounts produced by the calculation of facility time cost for each employee. 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 2024, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2024	5
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	3
for between two and three years at the time of reporting	-
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 2023 and 31 March 2024, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	5
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)	1
Number subject to off-payroll legislation and determined as out of scope of IR35 (see note)	4
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/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

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 2023/24 the Trust approved severance payments to 13 staff (2022/23: 14 staff).

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**

2022/23								
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	-	-	4	27,086	4	27,086		
£10,000 - £25,000	-	-	5	89,818	5	89,818		
£25,001 - £50,000	-	-	4	143,883	4	143,883	1	14,300
£50,001 - £100,000	-	-	1	53,005	1	53,005		
£100,001 - £150,000	-	-	-	-	-	-		
£150,001 - £200,000	-	-	-	-	-	-		
Total	-	-	14	313,792	14	313,792	1	14,300

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's scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. 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

	2023/24		2022/23	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	-	-	11	219
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Contractual payments in lieu of notice	6	54	1	10
Exit payments following employment tribunals or court orders	6	117	2	71
Non-contractual payment requiring HM Treasury approval	1	14	1	14
Total	**13**	**185**	**15**	**314**

Professor Tim Orchard, Chief executive
28 June 2024

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 financial position of the trust as at 31 March 2024 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

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, 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 non-compliance with laws and regulations.

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 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 areas, and our specific procedures performed to address are described below:

- determination of whether expenditure is capital in nature is subjective: we tested the expenditure on a sample basis to assess whether they meet 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 legal counsel 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.

We have nothing to report in respect of this matter.

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 2024. 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.

Certificate of completion of the audit

We certify that we have completed the audit of Imperial College Healthcare NHS Trust in accordance with requirements of the Act and the Code of Audit Practice.

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
28 June 2024

Financial statements and notes

Statement of Comprehensive Income

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	3	1,523,242	1,390,118
Other operating income	4	191,445	211,341
Operating expenses	7, 10	(1,724,684)	(1,623,419)
Operating deficit from continuing operations		**(9,997)**	**(21,960)**
Finance income	12	9,465	4,992
Finance expenses	13	(1,963)	(840)
Public Dividend Capital (PDC) dividends payable		(12,614)	(11,541)
Net finance costs		**(5,112)**	**(7,389)**
Other gains / (losses)	14	6	(2,808)
Losses due to transfer by absorption	33	(1,105)	-
Deficit for the year from continuing operations		**(16,208)**	**(32,158)**
Deficit for the year		**(16,208)**	**(32,158)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	9	(4,070)	(13,787)
Revaluations	18	8,246	11,020
Other reserve movements		7	-
Total other comprehensive income/ (expense)		**4,183**	**(2,767)**
Total comprehensive expense for the period		**(12,025)**	**(34,925)**
Adjusted financial performance (control total basis):			
Deficit for the period		(16,208)	(32,158)
Remove net impairments not scoring to the Departmental expenditure limit		27,173	61,391
Remove losses on transfers by absorption		1,105	-
Remove I&E impact of capital grants and donations		(12,080)	(32,437)
Remove net impact of inventories received from DHSC group bodies for COVID response		40	212
Remove loss recognised on return of donated COVID assets to DHSC		-	3,190
Adjusted financial performance surplus		**30**	**199**

An NHS trust's financial performance is derived from its accounting surplus/(deficit). This 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 2024 £000	31 March 2023 £000
Non-current assets			
Intangible assets	15	15,871	18,932
Property, plant and equipment	16	638,604	632,856
Right of use assets	20	49,354	44,503
Receivables	22	2,304	2,818
Total non-current assets		**706,134**	**699,109**
Current assets			
Inventories	21	11,427	17,604
Receivables	22	126,711	118,140
Cash and cash equivalents	23	136,718	179,215
Total current assets		**274,856**	**314,958**
Current liabilities			
Trade and other payables	24	(257,501)	(285,537)
Borrowings	26	(8,318)	(8,984)
Provisions	27	(49,839)	(36,762)
Other liabilities	25	(23,726)	(32,701)
Total current liabilities		**(339,384)**	**(363,985)**
Total assets less current liabilities		**641,606**	**650,082**
Non-current liabilities			
Borrowings	26	(36,061)	(46,459)
Provisions	27	(6,040)	(7,714)
Other liabilities	25	(2,058)	(2,058)
Total non-current liabilities		**(44,160)**	**(56,231)**
Total assets employed		**597,446**	**593,851**
Financed by			
Public dividend capital		842,809	827,189
Revaluation reserve		21,443	18,765
Income and expenditure reserve		(266,805)	(252,103)
Total taxpayers' equity		**597,446**	**593,851**

The notes on pages 118 to 163 form part of these accounts.

Professor Tim Orchard, Chief executive
28 June 2024

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £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 other 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**

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**797,116**	**20,914**	**(223,810)**	**594,220**
Implementation of IFRS 16 on 1 April 2022	-	-	4,483	**4,483**
Deficit for the year	-	-	(32,158)	**(32,158)**
Other transfers between reserves	-	(589)	589	**-**
Impairments	-	(13,787)	-	**(13,787)**
Revaluations	-	11,020	-	**11,020**
Other reserve movements	-	1,207	(1,207)	**-**
Total other comprehensive income / (expense) for the period	**-**	**(2,149)**	**(28,293)**	**(30,442)**
Public dividend capital received	30,073	-	-	**30,073**
Taxpayers' and others' equity at 31 March 2023	**827,189**	**18,765**	**(252,103)**	**593,851**

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 and 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	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating deficit		(9,997)	(21,960)
Non-cash income and expense			
Depreciation and amortisation	7.1	63,680	58,658
Net impairments	9	31,014	61,517
Income recognised in respect of capital donations	4	(14,404)	(34,261)
(Increase) in receivables and other assets		(8,899)	(51,750)
Decrease / (increase) in inventories		6,176	(203)
(Decrease) / increase in payables and other liabilities		(22,313)	3,954
Increase / (decrease) in provisions		8,767	(75)
Net cash flows from operating activities		**54,025**	**15,880**
Cash flows from investing activities			
Interest received		9,488	4,298
Purchase of intangible assets		(3,169)	(5,686)
Purchase of PPE and investment property		(101,473)	(114,812)
Sales of PPE and investment property		769	382
Receipt of cash donations to purchase assets		4,504	34,261
Net cash flows used in investing activities		**(89,881)**	**(81,557)**
Cash flows from financing activities			
Public dividend capital received		15,620	30,073
Movement on loans from DHSC		(1,226)	(1,226)
Movement on other loans		(550)	(655)
Capital element of lease rental payments		(7,734)	(6,559)
Interest on loans		(375)	(423)
Interest paid on lease liabilities		(435)	(426)
PDC dividend paid		(11,941)	(13,361)
Net cash flows (used in) / from financing activities		**(6,641)**	**7,423**
Decrease in cash and cash equivalents		**(42,497)**	**(58,254)**
Cash and cash equivalents at 1 April - brought forward		**179,215**	**237,469**
Cash and cash equivalents at 31 March	23	**136,718**	**179,215**

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 2023/24 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 National Health Service, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment 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 service to the Trust and other joint operators (Chelsea and Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust) and others. Services are provided primarily at the sites of joint operator trusts. The Trust 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 healthcare services. Funding envelopes are set at an Integrated Care System (ICS) level via the Integrated Care Board (ICB). The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. In 2023/24 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.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts.

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 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 adjustments for actual achievement being made at the end of the year. 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 ICB 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 clinical income' in these accounts.

Elective recovery funding provides additional funding to ICBs to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by trusts contributes to system performance and therefore the availability of funding to the commissioners. In 2022/23 elective recovery funding for providers was separately identified within the API contracts.

High costs 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 – i.e. when treatment has been given, notification from the Department of Work and Pension's Compensation Recovery Unit has been received, the NHS2 form completed and confirmation received that 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 Trust Private Healthcare. 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

Health Education England (HEE) 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 Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 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 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 Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

The Trust has not discontinued any operations in 2023/24 or 2022/23.

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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

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 DRC 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. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

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

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 2024 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 Building Cost Information Service (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 18 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.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

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 and 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 which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised 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. 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 DRC 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		
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.

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 of Health and Social Care.

During the year, the Trust has entered into a managed service agreement for the supply of certain lines of consumable items that were previously recognised as Inventory held within the Trust. These items are now recognised as expenditure at the point of consumption as responsibility remains with the service provider prior to this.

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 classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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 includes 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 3.51% is applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

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 a 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.

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16.

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 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

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 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
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 2.45% in real terms (prior year: 1.70%).

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 (none disclosed in 2023/24 and 2022/23).

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 27, unless the probability of 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.

Note 1.18 Value added tax

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

Note 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.

Note 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.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

Note 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 *Financial Reporting Manual (FreM)*.

Note 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.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early (i.e. in advance of the required implementation date) during 2023/24.

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

The accounting standard IFRS 17 Insurance Contracts has been issued but not yet adopted in the NHS. The standard is not expected to have a significant impact on the Trust as it does not relate closely to any activities undertaken in the course of the Trust's business.

The accounting standard IFRS 18 Presentation and Disclosure in Financial Statements has been issued but not yet adopted in the NHS. The standard will supersede IAS 1 Presentation of Financial Statements. The Standard sets out requirements for the presentation and disclosure of information in financial statements to help ensure they provide relevant information that faithfully represents an entity's assets, liabilities, equity, income and expenses.

Note 1.26 Critical judgements and key sources of estimation uncertainty

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.

There are no 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 and 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 Hammersmith 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 judgements are appropriate, but these judgements are inherently based on estimates of the application of market conditions, building costs and land values that are uncertain. The total value of assets subject to this estimation uncertainty at the 31 March 2024 is £496m, 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.

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 & cancer services; medicine and integrated care; women's, cardiovascular & clinical support services; West London Children's Healthcare Alliance (a collaborative management arrangement for children's services with Chelsea and Westminster NHS FT); private healthcare; and, corporate services. The Trust also hosts the North West London Pathology service.

However, having considered the requirements, the board considers that for the purpose of statutory reporting the Trust's activities fall under the single heading of healthcare. 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)

	2023/24	2022/23
	£000	£000
Income from commissioners under API contracts*	1,365,464	1,222,437
Other NHS clinical income	16,538	19,502
Community services		
Income from commissioners under API contracts*	3,841	3,705
Income from other sources (e.g. local authorities)	177	197
All services		
Private patient income	42,624	37,146
National pay award central funding***	656	24,650
Additional pension contribution central funding**	36,252	33,857
Other clinical income	57,690	48,624
Total income from activities	**1,523,242**	**1,390,118**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/
**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS trusts have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on trusts' behalf. The full cost and related funding have been recognised in these accounts.
*** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: 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. 2022/23: in March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

	2023/24	2022/23
Income from patient care activities received from:	**£000**	**£000**
NHS England	583,506	558,440
Clinical commissioning groups	-	173,558
Integrated care boards	819,592	562,059
Department of Health and Social Care	118	120
Other NHS providers	58,653	45,548
NHS other	-	551
Local authorities	168	191
Non-NHS: private patients	42,624	37,146
Non-NHS: overseas patients (chargeable to patient)	7,571	4,878
Injury cost recovery scheme	2,016	1,988
Non NHS: other	8,994	5,639
Total income from activities	**1,523,242**	**1,390,118**
Of which:		
Related to continuing operations	1,523,242	1,390,118
Related to discontinued operations	-	-

Of funding from Integrated Care Boards (ICB), the North West London ICB (formerly the NWL CCG)) provides a material level of funding. Total income recognised from the NWL ICB in 2023/24 is £721.7m and in 2022/23 is £644.8m.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2023/24 £000	2022/23 £000
Income recognised this year	7,571	4,878
Cash payments received in-year	3,498	3,618
Amounts added to provision for impairment of receivables	2,854	1,647
Amounts written off in-year	1,283	1,197

Note 4 Other operating income

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	15,840	45,894	**61,734**	14,131	48,000	**62,131**
Education and training	55,458	1,976	**57,434**	53,384	1,613	**54,997**
Non-patient care services to other bodies	18,893	-	**18,893**	15,361	-	**15,361**
Reimbursement and top up funding	-	-	**-**	8,182	-	**8,182**
Income in respect of employee benefits accounted on a gross basis	12,426	-	**12,426**	12,544	-	**12,544**
Receipt of capital grants and donations and peppercorn leases	-	14,404	**14,404**	-	34,261	**34,261**
Charitable and other contributions to expenditure	-	1,856	**1,856**	-	4,408	**4,408**
Revenue from operating leases (variable lease receipts)	-	288	**288**	-	227	**227**
Revenue from operating leases (minimum lease receipts)	-	1,357	**1,357**	-	1,907	**1,907**
Other income	23,053	-	**23,053**	17,323	-	**17,323**
Total other operating income	**125,670**	**65,775**	**191,445**	**120,925**	**90,416**	**211,341**
Of which:						

Related to continuing operations	191,445	211,341
Related to discontinued operations	-	-

All income relates to continuing operations - the Trust has not discontinued any operations in 2023/24 or 2022/23.

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

	2023/24	2022/23
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	14,245	19,763

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 the 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 2023/24 year was £288k.

As future lease payments are variable payments dependent on usage, no disclosure is possible of future lease payments receivable, but if at the same annual income for the remainder of the lease the total undiscounted value of receipts would be £21.4m. 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 Operating lease income

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,357	1,907
Variable lease receipts / contingent rents	288	227
Total in-year operating lease income	**1,645**	**2,134**

Note 6.2 Future lease receipts

	31 March 2024	31 March 2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	1,191	1,898
- later than one year and not later than two years	1,166	1,655
- later than two years and not later than three years	986	1,597
- later than three years and not later than four years	931	1,142
- later than four years and not later than five years	708	945
- later than five years	2,750	3,120
Total	**7,732**	**10,357**

Note 7.1 Operating expenses

	2023/24	2022/23
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	15,652	13,451
Purchase of healthcare from non-NHS and non-DHSC bodies	11,797	12,731
Staff and executive directors costs	1,012,648	953,808
Remuneration of non-executive directors	181	172
Supplies and services - clinical (excluding drugs costs)	163,899	143,627
Supplies and services - general	19,300	20,626
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	161,470	146,931
Inventories written down	707	601
Consultancy costs	425	258
Establishment	9,589	10,101
Premises	68,007	58,206
Transport (including patient travel)	26,275	22,876
Depreciation on property, plant and equipment and right of use assets	57,450	52,920
Amortisation on intangible assets	6,230	5,738
Net impairments	31,014	61,517
Movement in credit loss allowance: contract receivables / contract assets	3,727	3,276
Increase/(decrease) in other provisions	13,200	(49)
Change in provisions discount rate(s)	-	593
Fees payable to the external auditor	714	771
Internal audit costs	222	288

Clinical negligence	37,559	35,225
Legal fees	507	1,029
Insurance	688	524
Research and development	57,971	52,564
Education and training	10,369	8,784
Redundancy	185	313
Hospitality	206	85
Other	14,692	16,453
Total	**1,724,684**	**1,623,419**

All expenditure relates to continuing operations - the Trust has not discontinued any operations in 2023/24 or 2022/23.

Note 8 External Audit

Note 8.1 Auditor Remuneration

	2023/24	2022/23
	£000	£000
Other auditor remuneration paid to the external auditor:		
Statutory external audit fee	714	771

Costs shown include VAT. The audit remuneration paid for 2023/24 relates to both audit fees for the year and £70k (Incl VAT) in respect of cost 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 (2022/23: £2 million).

Note 9 Impairment of assets

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	237	-
Abandonment of assets in course of construction	3,604	126
Changes in market price	27,173	61,391
Total net impairments charged to operating surplus / deficit	**31,014**	**61,517**
Impairments charged to the revaluation reserve	4,070	13,787
Total net impairments	**35,084**	**75,304**

Note 10 Employee benefits

	2023/24	2022/23
	Total	Total
	£000	£000
Salaries and wages	813,002	757,435
Social security costs	92,927	84,057
Apprenticeship levy	4,057	3,549
Employer's contributions to NHS pensions	119,156	112,654
Pension cost - other	165	151
Temporary staff (including agency)	16,997	26,820
Total staff costs	**1,046,304**	**984,666**
Of which		
Costs capitalised as part of assets	4,380	3,780
Redundancy cost	185	313

The comparative salaries & wages figure for 2022/23 includes - in line with national guidance - an accrual of £24.7m relating to the Agenda for Change pay award for 2023/24 which included a payment in respect of 2022/23. This pay award was under discussion at the reporting date but was subsequently agreed by the NHS Staff Council and implemented in June 2023.

Note 10.1 Retirements due to ill-health

During 2023/24 there were eight early retirements from the trust agreed on the grounds of ill-health (four in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £465k (£520k in 2022/23).

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 two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 Government Financial Reporting Manual (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 2024 is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% from 1 April 2024 (previously 20.6%).

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.

	2023/24	2022/23
	£000	£000
Interest on bank accounts	9,465	4,992
Total finance income	**9,465**	**4,992**

Note 13 Finance expenditure

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

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	373	414
Interest on lease obligations	434	426
Total interest expense	**807**	**840**
Unwinding of discount on provisions	1,002	-
Other finance costs	154	-
Total finance costs	**1,963**	**840**

Note 14 Other gains / (losses)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	6	382
Losses on disposal of assets	-	(3,190)
Total gains / (losses) on disposal of assets	**6**	**(2,808)**

Note 15 – Intangible assets

Note 15.1 Intangible assets - 2023/24

	Information Technology	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**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 - brought forward	**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 15.2 Intangible assets - 2022/23

	Information Technology	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**34,756**	**-**	**34,756**
Additions	3,489	2,197	**5,686**
Reclassifications	391	(391)	**-**
Disposals / derecognition	(5,400)	-	**(5,400)**
Valuation / gross cost at 31 March 2023	**33,236**	**1,806**	**35,042**
Amortisation at 1 April 2022 - as previously stated	**15,772**	**-**	**15,772**
Provided during the year	5,738	-	**5,738**
Disposals / derecognition	(5,400)	-	**(5,400)**
Amortisation at 31 March 2023	**16,110**	**-**	**16,110**
Net book value at 31 March 2023	**17,126**	**1,806**	**18,932**
Net book value at 1 April 2022	**18,984**	**-**	**18,984**

Note 16 Property, plant & equipment

Note 16.1 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 - brought forward	**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 - brought forward	**-**	**-**	**-**	**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 16.2 Property, plant and equipment - 2022/23

	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 2022 - as previously stated	**151,121**	**343,309**	**23,655**	**223,239**	**77,985**	**2,400**	**821,709**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	(3,918)	-	(875)	(3,464)	-	**(8,257)**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	66,162	43,157	13,774	2,606	-	**125,699**
Impairments	(13,479)	(113)	(54)	-	-	-	**(13,646)**
Revaluations	(12,161)	(58,697)	-	-	-	-	**(70,858)**
Reclassifications	-	26,611	(36,195)	7,223	2,362	-	**0**
Disposals / derecognition	-	-	-	(60,767)	(22,855)	(229)	**(83,851)**
Valuation/gross cost at 31 March 2023	**125,481**	**373,353**	**30,563**	**182,594**	**56,634**	**2,171**	**770,796**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**-**	**-**	**148,545**	**48,922**	**1,384**	**198,851**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	(64)	(810)	-	**(874)**
Provided during the year	-	25,595	-	12,496	7,852	276	**46,219**
Impairments	12,160	66,533	-	-	-	-	**78,693**
Reversals of impairments	-	(22,988)	-	-	-	-	**(22,988)**
Revaluations	(12,160)	(69,140)	-	-	-	-	**(81,300)**
Disposals / derecognition	-	-	-	(57,577)	(22,855)	(229)	**(80,661)**
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**103,400**	**33,109**	**1,431**	**137,940**
Net book value at 31 March 2023	**125,481**	**373,353**	**30,563**	**79,194**	**23,525**	**740**	**632,856**
Net book value at 1 April 2022	**151,121**	**343,309**	**23,655**	**74,694**	**29,063**	**1,016**	**622,858**

Note 16.3 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 16.4 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	125,481	347,983	30,563	72,495	23,505	740	**600,767**
Owned - donated/granted	-	25,370	-	6,699	20	-	**32,089**
Total net book value at 31 March 2023	**125,481**	**373,353**	**30,563**	**79,194**	**23,525**	**740**	**632,856**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £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 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Subject to an operating lease	-	3,424	-	-	-	-	3,424
Not subject to an operating lease	125,481	369,929	30,563	79,194	23,525	740	629,432
Total net book value at 31 March 2023	**125,481**	**373,353**	**30,563**	**79,194**	**23,525**	**740**	**632,856**

Note 17 Donations of property, plant and equipment

The Trust has recognised grant funding in the year of £2.1m. The funding was provided by the Salix company acting on behalf of the Department for Business, Energy & Industrial Strategy. The grant was awarded to fund decarbonisation works on the Trust's estate. The Trust also received £2.4m of donations from the Imperial Health Charity and others to fund capital investments in line with the Charity's objectives.

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, RICS qualified) to provide valuations, with the work carried out by fully qualified staff. The effective date of the valuation was 31 March 2024.

The valuation was carried out in accordance with International Financial Reporting Standards, The DHSC Group Accounting Manual for 2023/24 and the Royal Institute of Chartered Surveyors (RICS) Global Standards ("Red Book"). Most assets are in use by the Trust for the delivery of healthcare services and are valued on the Depreciated Replacement Cost with reference to the cost of a Modern Equivalent Asset, as set out in the Trust's accounting policies. A small number of assets that are not used for delivery of healthcare services are valued on a fair value basis.

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 2023/24 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 undertaken a project over 2022/23 and 2023/24 to assess its fixed asset register and ensure that fully-depreciated assets that are no longer in use are recorded as disposed. The Trust has disposed of assets with a gross cost (cost when purchased) of £52.2m in 2023/24 with a £0.8m Net Book Value (NBV). Assets with a gross cost of £89.3m (with a nil NBV) were also disposed of in 2022/23. The Trust continues to hold assets on the Statement of Financial Position which are fully depreciated (i.e. have zero NBV) with a gross cost of £43.4m. The assessment of remaining fully-depreciated assets is ongoing and a business as usual disposal process.

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 services.

Note 20.1 Right of use assets - 2023/24

	Property (land and buildings)	Plant & machinery	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£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 Right of use assets - 2022/23

	Property (land and buildings)	Plant & machinery	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2022 - brought forward	-	-	-	-	-
IFRS 16 implementation - reclassification of existing finance leased assets from					
PPE or intangible assets	3,918	875	3,464	**8,257**	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	36,228	4,076	-	**40,304**	11,610
Additions	177	4,670	2,976	**7,823**	-
Remeasurements of the lease liability	1,069	-	-	**1,069**	-
Impairments	(267)	-	-	**(267)**	-
Revaluations	(6,711)	-	-	**(6,711)**	(1,307)
Valuation/gross cost at 31 March 2023	**34,414**	**9,621**	**6,440**	**50,475**	**10,303**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-	-
IFRS 16 implementation - reclassification of existing finance leased assets from					
PPE or intangible assets	-	64	810	**874**	-
Provided during the year	3,337	2,253	1,111	**6,701**	1,912
Impairments	5,686	-	-	**5,686**	1,146
Revaluations	(7,289)	-	-	**(7,289)**	(1,885)
Accumulated depreciation at 31 March 2023	**1,734**	**2,317**	**1,921**	**5,972**	**1,173**
Net book value at 31 March 2023	**32,680**	**7,304**	**4,519**	**44,503**	**9,130**
Net book value at 1 April 2022	-	-	-	-	-
Net book value of right of use assets leased from other NHS providers					2,464
Net book value of right of use assets leased from other DHSC group bodies					6,666

Note 20.2.1 Revaluations of right of use assets

The Trust's Right of Use assets under IFRS 16 were valued as at 31 March 2024 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. 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 2023/24 as compared to previous years.

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.

	2023/24	2022/23
	£000	£000
Carrying value at 31 March	**42,610**	**4,454**
IFRS 16 implementation - adjustments for existing operating leases	-	35,823
Lease additions	3,706	7,823
Lease liability remeasurements	(5,256)	1,069
Interest charge arising in year	434	426
Lease payments (cash outflows)	(8,169)	(6,985)
Carrying value at 31 March	**33,324**	**42,610**

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. Cash outflows in respect of leases recognised on SoFP are disclosed in the reconciliation above.

Note 20.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2023	31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	7,084	1,795	7,565	1,963
- later than one year and not later than five years;	15,811	3,538	15,956	4,164
- later than five years.	11,973	3,380	21,547	3,991
Total gross future lease payments	**34,868**	**8,713**	**45,068**	**10,118**
Finance charges allocated to future periods	(1,544)	(317)	(2,458)	(375)
Net lease liabilities at 31 March 2024	**33,324**	**8,396**	**42,610**	**9,743**
Of which:				
Leased from other NHS providers		3,215		3,623
Leased from other DHSC group bodies		5,181		6,120

Note 21 Inventories

	31 March 2024	31 March 2023
	£000	£000
Drugs	9,082	7,899
Consumables	1,913	8,964
Energy	432	740
Total inventories	**11,427**	**17,604**

Inventories recognised in expenses for the year were £230,465k (2022/23: £220,050k). Write-down of inventories recognised as expenses for the year were £707k (2022/23: £601k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £688k of items purchased by the Department of Health & Social Care (2022/23: £3,033k).

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.

During the year, the Trust has entered into a managed service agreement for the supply of certain lines of consumable items that were previously recognised as inventory held within the Trust. These items are now recognised as expenditure at the point of consumption as responsibility remains with the service provider prior to this.

Note 22 Receivables and allowance for credit losses

Note 22.1 Receivables

	31 March 2024	31 March 2023
	£000	£000
Opening balance	**120,958**	**66,897**
Current		
Contract receivables	123,154	112,377
Allowance for impaired contract receivables / assets	(14,173)	(11,197)
Prepayments (non-PFI)	3,798	4,281
Interest receivable	671	694
PDC dividend receivable	1,086	1,759
VAT receivable	6,005	6,975
Other receivables	6,170	3,251
Total current receivables	**126,711**	**118,140**
Non-current		
Other receivables	2,304	2,818
Total non-current receivables	**2,304**	**2,818**
Closing balance	**129,015**	**120,958**

The comparative contract receivables balance for 2022/23 includes - in line with national guidance - an accrual of £24.7m relating to funding for the Agenda for Change pay award for 2023/24, which included a payment in respect of 2022/23. The funding was confirmed during 2022/23.

Note 22.2 Allowances for credit losses

	2023/24	2022/23
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**11,197**	**9,233**
New allowances arising	3,727	3,276
Utilisation of allowances (write offs)	(751)	(1,312)
Allowances as at 31 Mar 2024	**14,173**	**11,197**

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.

	2023/24	2022/23
	£000	£000
At 1 April	**179,215**	**237,469**
Net change in year	(42,497)	(58,254)
At 31 March	**136,718**	**179,215**
Broken down into:		
Cash at commercial banks and in hand	134	76
Cash with the Government Banking Service	136,584	179,140
Total cash and cash equivalents as in SoFP	**136,718**	**179,215**
Total cash and cash equivalents as in SoCF	**136,718**	**179,215**

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 2024	31 March 2023
	£000	£000
Monies on deposit	82	82
Total third party assets	**82**	**82**

Note 24 Trade and other payables

	31 March 2024	31 March 2023
	£000	£000
Current		
Trade payables	49,747	54,342
Capital payables	29,499	44,198
Accruals	120,629	141,306
Social security costs	11,420	10,936
Other taxes payable	12,514	10,394
Pension contributions payable	12,178	11,399
Other payables	21,515	12,963
Total current trade and other payables	**257,501**	**285,537**
Of which payables to NHS and DHSC group bodies:	19,195	24,304

The accrual balance for 2022/23 includes - in line with national guidance - an accrual of £24.7m relating to the Agenda for Change pay award for 2023/24 which included a payment in respect of 2022/23.

Note 25 Other liabilities

	31 March 2024	31 March 2023
	£000	£000
Opening balance	**34,759**	**32,958**
Current		
Deferred income: contract liabilities	23,726	32,701
Total other current liabilities	**23,726**	**32,701**
Non-current		
Other deferred income	2,058	2,058
Total other non-current liabilities	**2,058**	**2,058**
Closing balance	**25,784**	**34,759**

Note 26 Borrowings and financing activities

Note 26.1 Borrowings

	31 March 2024	31 March 2023
	£000	£000
Current		
Loans from DHSC	1,241	1,243
Other loans	351	551
Lease liabilities	6,726	7,190
Total current borrowings	**8,318**	**8,984**
Non-current		
Loans from DHSC	7,336	8,562
Other loans	2,127	2,477
Lease liabilities	26,598	35,420
Total non-current borrowings	**36,061**	**46,459**

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 continuing until 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	Other loans	Lease Liabilities	Total
	£000	£000	£000	£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**

	Loans from DHSC	Other loans	Lease Liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2022	**11,040**	**3,683**	**4,454**	**19,177**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,226)	(655)	(6,559)	**(8,440)**
Financing cash flows - payments of interest	(423)	-	(426)	**(849)**
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022	-	-	35,823	**35,823**
Additions	-	-	7,823	**7,823**
Lease liability remeasurements	-	-	1,069	**1,069**
Application of effective interest rate	414	-	426	**840**
Carrying value at 31 March 2023	**9,805**	**3,028**	**42,610**	**55,443**

Note 27 Provisions

Note 27.1 Provisions for liabilities and charges analysis

	2023/24	2022/23
	£000	£000
At 1 April 2023	**44,476**	**44,551**
Change in the discount rate	(510)	(1,934)
Arising during the year	15,626	6,190
Utilised during the year	(3,962)	(297)
Reversed unused	(907)	(4,092)
Unwinding of discount	1,156	58
At 31 March 2024	**55,879**	**44,476**
Expected timing of cash flows:		
- not later than one year;	49,839	36,762
- later than one year and not later than five years;	1,794	150
- later than five years.	4,246	7,565
Total	**55,879**	**44,476**

Provision balances include potential liabilities in respect of legal claims, redundancy and exit costs, dilapidation liabilities on leased properties and other repair and maintenances obligation on own properties that may be payable to employees or other third parties.

Note 27.2 Clinical negligence liabilities

At 31 March 2024, £501,300k was included in provisions of NHS Resolution in respect of the Trust's clinical negligence liabilities (31 March 2023: £550,505k).

Note 28 Contingent assets and liabilities

	31 March 2024	31 March 2023
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(79)	(114)
Gross value of contingent liabilities	**(79)**	**(114)**

Note 29 Contractual capital commitments

	31 March 2024	31 March 2023
	£000	£000
Property, plant and equipment	15,892	19,773
Intangible assets	601	-
Total	**16,493**	**19,773**

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 Trust has with commissioners and the way those commissioners are financed mean the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities. The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors 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 at 31 March 2024 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 to identify repayment or refinancing opportunities.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Total book value
	£000	£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**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	107,942	**107,942**
Cash and cash equivalents	179,215	**179,215**
Total at 31 March 2023	**287,157**	**287,157**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£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**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	9,805	**9,805**
Obligations under leases	42,610	**42,610**
Other borrowings	3,028	**3,028**
Trade and other payables excluding non financial liabilities	253,881	**253,881**
Total at 31 March 2023	**309,324**	**309,324**

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 2024	31 March 2023
	£000	£000
In one year or less	230,899	263,616
In more than one year but not more than five years	21,793	22,483
In more than five years	16,395	27,327
Total	**269,087**	**313,426**

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

		2023/24		2022/23
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	14	28	63	31
Bad debts and claims abandoned	187	1,495	269	1,281
Stores losses and damage to property	12	707	12	601
Total losses	**213**	**2,230**	**344**	**1,913**
Special payments				
Ex-gratia payments	84	53	68	777
Special severance payments	1	14	1	14
Total special payments	**85**	**67**	**69**	**791**
Total losses and special payments	**298**	**2,297**	**413**	**2,704**

The 2022/23 disclosure of special payments includes one case with value of £753k, in respect of a voucher for £45 given to all staff prior to Christmas as part of efforts to encourage staff to feel valued and to boost morale during a very challenging period. During the 2022/23 year end process, NHS England had advised providers to disclose small discretionary awards to staff of this type as ex gratia payments, while NHS England considered how these should be treated (and therefore whether any HM Treasury approvals were required). These transactions were therefore included as special payments in the disclosures in the 2022/23 financial statements, and have not been restated. NHS England has subsequently concluded that this type of payment does not represent a special payment (unless other factors mean that a payment is novel, contentious or repercussive), and that no approvals were required. No such payments were made in 2023/24.

The Trust is required to report on individual losses in excess of £300k in value. No such losses were incurred in 2023/24 but one such loss totalling £320k was incurred in 2022/23 upon the write off of a debt related to an overseas visitor (i.e. a foreign national who accessed NHS services without having proper insurance or reciprocal entitlement to health services). The Trust is obliged to provide treatment but in many cases is unable to recover the full value of services chargeable, particularly when the treatment related to long stays in hospital, often including use of intensive care facilities. Overseas visitor debt is included in the calculation of the credit loss allowance.

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 2023/24 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 2024. 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 IAS 24, 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 directors undertake this role) 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 (Medical director) has undertaken private medical practice during 2023/24 through the Trust's private healthcare service. This is carried out on the same basis as work done by other consultants. This work is not included in the remuneration report because it does not pertain to Professor 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 the year, 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. There were no transfers by absorption in 2022/23.

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

	2023/24	2023/24	2022/23	2022/23
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	165,789	655,967	163,462	672,054
Total non-NHS trade invoices paid within target	161,903	601,883	156,979	602,406
Percentage of non-NHS trade invoices paid within target	**97.7%**	**91.8%**	**96.0%**	**89.6%**
NHS Payables				
Total NHS trade invoices paid in the year	5,060	93,887	4,622	58,190
Total NHS trade invoices paid within target	4,445	74,794	3,989	46,222
Percentage of NHS trade invoices paid within target	**87.8%**	**79.7%**	**86.3%**	**79.4%**
Total Payables				
Total trade invoices paid in the year	170,849	749,854	168,084	730,244
Total trade invoices paid within target	166,348	676,677	160,968	648,628
Percentage of total trade invoices paid within target	**97.4%**	**90.2%**	**95.8%**	**88.8%**

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 36 External financing limit

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

	2023/24	2022/23
	£000	**£000**
Cash flow financing	48,607	79,887
External financing requirement	**48,607**	**79,887**
External financing limit (EFL)	48,607	81,312
Under / (over) spend against EFL	**-**	**1,425**

Note 37 Capital resource limit

	2023/24	2022/23
	£000	**£000**
Gross capital expenditure	98,292	140,277
Less: Disposals	(764)	(3,190)
Less: Donated and granted capital additions	(14,404)	(34,261)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	3,190
Charge against Capital Resource Limit	**83,124**	**106,016**
Capital Resource Limit	83,124	107,441
Under / (over) spend against CRL	**-**	**1,425**

Note 38 Breakeven duty financial performance

	2023/24	2022/23
	£000	**£000**
Adjusted financial performance surplus / (deficit) (control total basis)	30	199
Remove impairments scoring to Departmental Expenditure Limit	3,841	126
Breakeven duty financial performance surplus / (deficit)	**3,871**	**325**

Note 39 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Breakeven duty in-year financial performance		9,102	5,146	(8,419)	9,025	15,128	15,405	(47,879)
Breakeven duty cumulative position	24,775	33,877	39,023	30,604	39,629	54,757	70,162	22,283
Operating income		900,234	920,256	941,690	971,274	979,312	1,000,614	1,019,905
Cumulative breakeven position as a percentage of operating income		3.8%	4.2%	3.2%	4.1%	5.6%	7.0%	2.2%

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Breakeven duty in-year financial performance	(15,330)	3,023	32,996	11,255	47	5,005	325	3,871
Breakeven duty cumulative position	6,953	9,976	42,972	54,227	54,274	59,279	59,604	63,475
Operating income	1,096,575	1,160,803	1,212,959	1,300,616	1,422,789	1,483,121	1,601,459	1,714,687
Cumulative breakeven position as a percentage of operating income	0.6%	0.9%	3.5%	4.2%	3.8%	4.0%	3.7%	3.7%

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