WeCare
Our vision, values and behaviours

NHS
Barts Health
NHS Trust

Annual Report and Accounts

2024 - 2025

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Introduction

I was delighted to commence the role of Chair, Barts Health towards the end of the year covered by this annual report. Having spent time at our hospitals in recent weeks, I have been enormously impressed by the quality of our staff and by their commitment to serving our population and patients. Not a surprise but reassuring to see firsthand.

I last worked in North East London 20 years ago as a surgeon and academic. The transformation since then is remarkable. It includes: impressive investment in infrastructure including our two new hospital builds; the benefits of scale achieved by bringing together our 5 hospitals to create one of the largest NHS Trusts; continuous improvements in the quality of care we provide; the creation of local, national and international centres of excellence; the strengthening of our NHS, academic and community partnerships; and critically a relentless focus on the care and compassion with which our work is conducted.

One thing that has not changed in the last 20 years is the health needs of our population. We serve a growing population, with health challenges related to socioeconomic issues, chronic disease and ageing. On top of that we must live within financial constraints, whilst maintaining and improving the quality of care we provide and adapting to rapid changes in NHS structures. The challenges and the change are real but I am in no doubt that Barts Health is well placed to respond to them.

My thanks to everyone involved in the work of Barts Health – our staff, our patients, our volunteers, our partners, our supporters in the community. You are delivering the ambition of Barts Health to be an exemplar of outstanding healthcare delivery, innovation and compassionate care. It is a privilege to work with you as we respond to today's challenges, whilst also building the NHS of the future.

Prof Ian Jacobs
Chair

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Foreword

We are one of the biggest and busiest NHS trusts in the country. More than 7,000 patients came through our doors every day last year, a ten per cent increase on the previous 12 months. During winter more patients were treated in our emergency departments than anywhere else in England. At least 7 out of 10 are seen within the national 4-hour standard. Thanks to smart new ways of working – like same-day emergency care and virtual wards – we've been able to treat many people faster and help others recover safely at home.

Meanwhile our teams worked hard to reduce waiting times and make sure everyone across northeast London gets the care they need when they need it. Over the year we reduced by 80% the number of people waiting too long for routine procedures. We made progress in key areas like combating cancer, faster diagnosis, and mental health support. We're also focused on making maternity services safer, and making sure care is fair and equal for all our communities. Every decision we make keeps patients at the heart.

Having teamed up with our neighbours at Homerton Healthcare and in Barking, Havering, and Redbridge hospitals to pool spare elective capacity, we are now seeking to collaborate more closely on some key surgical specialties. Already by sharing staff, ideas, and resources with local partners, we secured £33 million funding for new women's health hubs and diagnostic centres across northeast London. Together, we're doing more for our patients – and doing it better.

We can't disguise that the government's decision to defer building a new hospital at Whipps Cross for at least five years was a blow, not only for staff and patients but all those in the community who would benefit from the redevelopment of the site as a health and housing hub. But this report demonstrates that we are not passively waiting for handouts to improve services. Innovations in recovery from hip fractures at Whipps has reduced hospital length of stay by 7 days. And new approaches at Newham hospital have reduced hospital-acquired pressure ulcers by a quarter and patient falls by almost two-thirds, so fewer people are experiencing preventable harm while in our care.

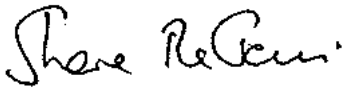
We refreshed our long-term clinical strategy to guide us over the next five years. We will be constantly raising standards of treatment and care across the group. We will be working with partners to integrate care across hospital and community settings and relish the opportunity to take a leadership role within northeast London. We will also build centres of excellence for key specialities in our hospitals. This year we celebrate the tenth anniversary of the Barts Heart Centre at St Bartholomew's hospital, a showcase for how a centre of excellence can provide better quality care more quickly to more patients – and has saved thousands of lives.

Technology is helping us go further. More than 259,000 patients now use the Patient Knows Best app to manage their own care – from booking appointments to checking test results. It's part of our plan to give people more control and make care work around their lives.

Behind the scenes, we've been making every penny count. We balanced our £2.5bn budget, posting a deficit of less than half a percent, to give us a firm foundation on which to face fierce financial pressures over the coming months. More permanent staff and fewer vacancies will mean better, more consistent care for patients – and savings too. With help from Barts Charity, we've invested in digital tools, research, and state-of-the-art treatments, including robotic surgery and early neurology care.

Research is a major part of who we are because we believe the future of healthcare depends on it. This year we became home to a new research delivery network for the whole of north London. We're the UK's top recruiter to clinical trials and opened the third most studies in the country. In partnership with Queen Mary University of London and Barts Charity we launched the Academic Centre for Healthy Ageing at Whipps Cross, bringing a specialist research dimension to a local hospital. And we look forward to opening a Clinical Research Facility at The Royal London as the next step towards creating a world-class life sciences hub in Whitechapel.

None of this would be possible without our incredible staff and the welcoming and inclusive environment they foster. Their passion and professionalism shine through, and it's fantastic to see more of them recommending Barts Health as a great place to work. NHS England commended us for improving our staff survey scores on all nine NHS people promises this year. Our multi-ethnic workforce is proud to serve some of the most diverse communities in Britain. We know there's more to do – to make everyone feel safe, respected, and supported – and we're committed to getting there.



Shane DeGaris
Group Chief Executive

Performance overview

The purpose of this section is to outline the framework for delivering high quality care, comprising details of structures, performance reporting tools and performance management mechanisms.

Details of Trust performance during 2024/25 have been provided in the monthly integrated performance report (IPR) published on the Trust website under the section 'about us/our board/board papers'. Performance on quality standards and service transformation during 2024/25 is published in the annual Quality Account, as a key accompaniment to the annual report and accounts.

In addition to the IPR, progress against the group operational plan set at the outset of the year was reported on a quarterly basis – and a summary of outputs is provided in this annual report. Details of our objectives and the risks and issues to delivery of our operational plan are detailed in subsequent sections of this annual report (the accountability report and annual governance statement). During 2024/25, additional performance reporting was provided to complement the monthly integrated performance report and board assurance framework risks. Taking the objectives set in the plan, success measures were identified that aligned to the operational plan and progress against these were tracked and reported quarterly (as summarised below). In doing so, this was linked to BAF risks to identify whether any divergence from plan may affect the Trust's risk profile. Looking ahead this approach will be refined further; a set of headline success measures identified in the 2025/26 operational plan will be incorporated into the primary reporting tool (the published IPR).

Context - clinical and organisational strategy; and operational planning

The Trust's clinical and organisational strategy provides a framework within which the Trust Board seeks to deliver its immediate and long-term operational priorities. The Trust Board has will approve a refreshed five-year clinical strategy early in 2025/26, with an accompanying board-level strategy and partnerships committee being established to consider the Trust's strategic direction and outlook over three, five and ten year timeframes.

The Trust's vision is to be a high-performing integrated group of hospitals, renowned for excellence and innovation, and providing equitable safe and compassionate care to our patients in east London and beyond. We aspire to achieve this in everything we do, by living our WeCare values of being welcoming, engaging, collaborative, accountable, respectful and equitable. The Trust's WeImprove approach to listening, learning and trialling change as part of continuous quality improvement (QI) evolved into a more mature phase with a commitment to a quality management system (QMS) approach.

In May 2025, we published We are Barts Health, a summary of our strategic direction linked closely to the strategy for north east London agreed with integrated care system partners.

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Our 2025/26 operational plan sets out three strategic objectives relating to:

- Our Patients (Care) - provide excellent and equitable health and care efficiently.
- Our People (Culture) - be an outstanding inclusive place to work.
- Our Partnerships (Collaboration) - work with our local communities to improve health and wellbeing.

Each strategic objective is underpinned by 5-year group priorities, and a series of annual goals. The annual plan also sets out the key enablers for delivery

- Sustainable investment – a long term Financial Plan.
- Improving infrastructure – Estates and Digital.
- Driving innovation - Life sciences and Research
- Group Model – evolving a Well Led organisation.
- WeImprove – Integrating improvement into everything we do making continuous improvement part of daily work.

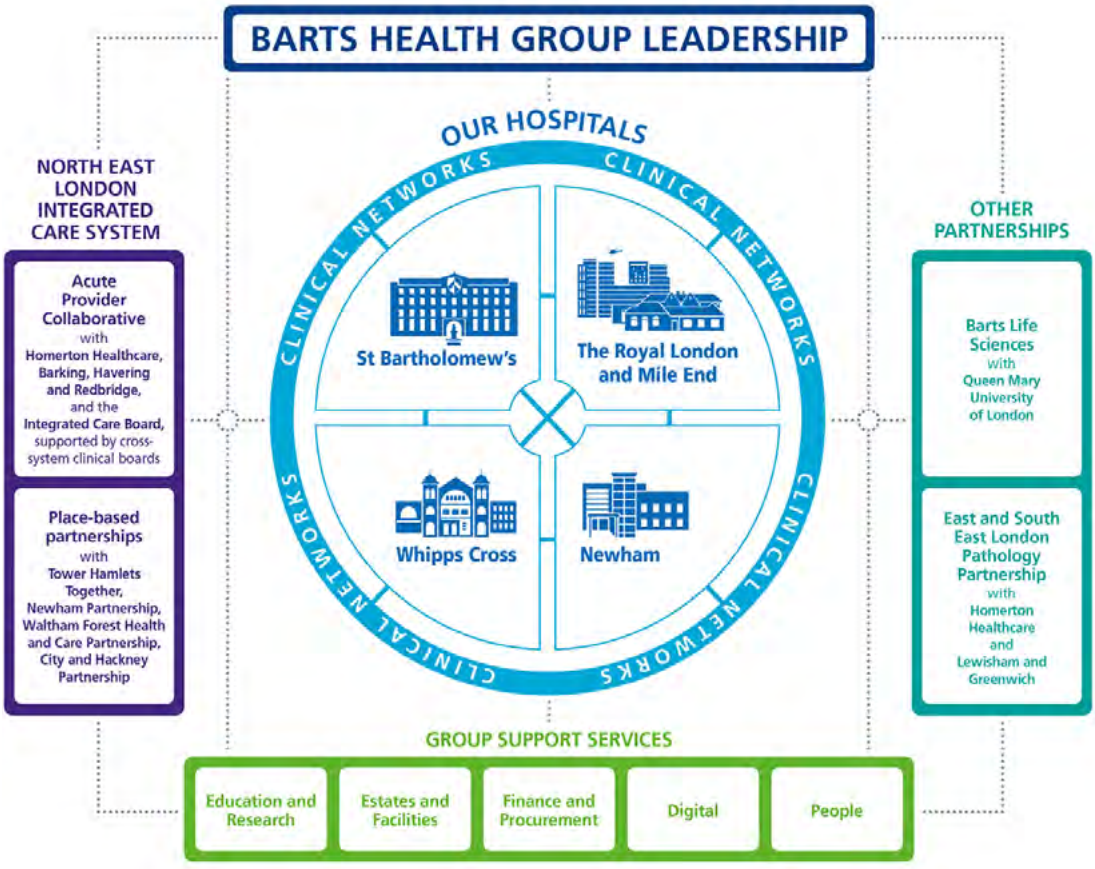
Context - group model

The Trust's organisational model is based on a group structure initially devised in 2015. The Barts Health operating model has a supporting accountability framework, which was updated during 2024/25. This group accountability framework sets out the respective roles of the component elements involved in delivery of healthcare services:

- Group leadership comprises the board, group executive, hospital chief executives and the executive's direct support - responsible for ensuring that the Trust effectively discharges its statutory responsibilities as a public body, holding hospitals and group support services (GSS) to account and commissioning group support services.
- Hospitals are led by a hospital chief executive who reports to the group chief executive and is supported by a hospital executive board. Each hospital has a divisional structure based on clinical specialties. The hospitals are responsible for the oversight and delivery of their respective clinical services; accordingly the majority of Barts Health's staff and resources are managed by the hospitals.
- Group support services (GSS) accountable to group leadership and the hospitals for the delivery of corporate services. A performance review mechanism was introduced in-year to support challenge on delivery of service standards.
- The East and South East London (ESEL) Pathology Partnership combines the pathology services of three London NHS trusts: Barts Health NHS Trust, Homerton Healthcare NHS Foundation Trust and Lewisham and Greenwich NHS Trust. A partnership board and hosting review meeting mechanism supports delivery of the partnership's objectives.
- Clinical networks support clinical service strategies, setting standards and minimising variation, supporting group collaboration with and a specific input to research and innovation

In north east London, the identified benefits of closer integration have resulted in the commitment to develop an acute provider collaborative. Further details on provider and other sector integration are provided elsewhere in this report.

Fig 1. Our group model



Performance management – reporting against the group operational plan

During 2024/25 performance reporting was consolidated to complement the monthly integrated performance report and BAF. Taking the objectives set in the plan, success measures were identified that aligned to both the operational plan and the BAF. This complementary reporting reflected the need to track progress against milestones for objectives throughout the year – including those objectives not relating to operational or finance performance (that had historically been covered in some detail in the IPR) and to support discussions of any key barriers in-year.

This quarterly reporting was provided to the trust board and board committees throughout 2024/25. For the identified key success measures, this reporting identified whether progress was either on track; behind trajectory; with limited assurance on likelihood of delivery; or would not be delivered. This approach supported intervention on areas furthest from planned trajectory in a more timely way.

At quarter 4, the final assessment of delivery against the Trust's objectives (under the headings of 'Patients, People, Partnerships) and supporting enablers highlighted the following:

Patients

Achievements

- Preventing ill health measures ahead of annual plan target.
- Delivery on key quality and safety metrics.

Key Challenges

- Operational performance targets whilst seeing continual improvement, continued to be behind trajectory. Diagnostics has seen improvements but fallen behind trajectory, with MRI being the most significant challenge across the Group.

People

Achievements

- Team based rostering ahead of roll out plan with positive staff feedback.
- Reduction of agency spend as a percentage of pay bill continued to deliver ahead of trajectory.

Key Challenges

- Appraisal rates and fill rates reflected continued improvement but below the annual target.

Partnerships

Achievements

- Self-assessed 'good' rating for well-led quarterly milestones across the year.
- Anchor institution focus on increasing the number of local young people and adults employed.

Key Challenges

- Infrastructure programmes developed to agreed internal trajectories (albeit with some challenges including revised building regulations). Delays on external approvals and funding arrangements included significant delay on Whipps Cross Redevelopment until 2032-2034.

Enablers

Achievements

- Good delivery across many of the Enablers metrics.
- Communications engagement statistics improved every quarter
- Research participant recruitment numbers exceeded target.

Key Challenges

- Delivery of medium-term financial resilience remained a challenge.

The approach taken has generated helpful discussion at board level and some refinements are planned as a result of introducing this approach. This approach will provide greater transparency on the in-year quarterly trajectories required to be met to support delivery of objectives. In year performance reporting against the 2024/25 group operational plan will strengthen the reporting of identified measures routinely through regular reporting ensuring that we maintain a focus on the objectives of the plan:

- Headline success measures in the operational plan will be reported via the Board IPR. All identified headline metrics (and a series of supporting metrics) will be built into the IPR scorecards for monthly reporting in the Board IPR and then consequently through Hospital and Divisional PR governance.
- Headline metrics will have in year trajectories to enable tracking of progress against plan quarter by quarter, removing a subjective forecast of year end delivery.
- Concise quarterly reports will report YTD performance against all objectives, cross referenced to IPR and agreed trajectories.

Performance management – structure and tools

To support and assure on delivery of its strategic objectives, the Trust's performance management approach comprises performance review and quality deep dive governance mechanisms supported by robust management information. The Trust's business intelligence unit leads on production of the Trust's integrated performance report (IPR), a key resource published monthly on the website, reporting on a suite of key metrics – including constitutional standards and locally agreed priorities - at group level (for the Trust Board and executive review) and at hospital or divisional level where greater granularity is required. The IPR is replicated at hospital and divisional level and provides the principal tool for each of the components of the group structure to assess progress on operational delivery. Associated details of hospital level performance and key clinical activities are routinely reported across associated boards including elective recovery board, people board, quality board and annually in the Quality Account. The Trust's director of performance has a key role in ensuring that this reporting, supported by the business intelligence unit, meets the needs of the organisation.

Monthly performance reviews of hospitals are held by group leadership, supported by regular separate quality and finance and performance deep dives. Each hospital in turn has arrangements in place for performance reviews of its clinical divisions.

External oversight of Barts Health's operational performance has been provided jointly by NHSE as well as the NEL integrated care board. From a regulatory perspective, the CQC remains the principal body for monitoring compliance with the fundamental standards of quality and safety in its delivery of services.

Performance – management information

The Trust has structured its business intelligence offering to improve its analytics and insights capability in response to key lines of enquiry generated by clinical teams and national NHS priorities.

Internal reporting includes a variety of Qlik reports, with a programme continuing to move the reporting layer into the more advanced Qlik Sense environment, hosted on the WeInform platform. A variety of dashboards have been built to user specifications with more in development, currently available dashboards provide detailed data-views of patient care, equity, and outcome metrics, including the Board's integrated performance report, hospital integrated performance reports and dashboards providing oversight in relation to quality governance, maternity services, equity and access and operational efficiency. Reporting also includes automated patient waiting-lists, as well as individual patient views of referral to treatment, A&E, cancer, and diagnostic waiting times. Board- level assessment of progress against the annual plan during 2024/25 has informed the integrated performance report format including highlighting priority success measures key to delivery of each trust objective.

Analysis within the board integrated performance report covers patient feedback from a range of sources including the friends and family test, national patient and staff annual surveys, as well as risk and incident reporting to draw out themes and specific areas that require improvement, while a clinical effectiveness unit provides a discrete clinical audit function across the Trust. In line with the NHS reporting standard, Making Data Count, the integrated performance report has evolved to provide more intuitive and descriptive data presentations and narrative with data visualisations presented in statistical process control (XmR) charts, a type of control chart used to monitor process performance and identify changes over time. A Trust Board awareness session on Making Data Count was held during the year to explore best practice and consider future developments in reporting methodology. The Making Data Count team has developed a set of recommended data visualisations and data presentation techniques designed to rapidly lead the reader to points of statistically significant change, improvement or deterioration. These include the use of statistical process control and Pareto charting methods as well as other data presentation approaches. The business intelligence team have committed to fully adopting the Making Data Count board reporting template by October 2025 and extending this to hospital site and divisional level reporting by January 2026.

Waiting list and reporting data quality

With the NHS applying a focus on getting patients treated and reducing long waits the trust commissioned two independent data quality audits designed to provide assurance on the quality, accuracy, and completeness of its waiting lists, including referral to treatment, cancer and diagnostic pathways as well as the robustness of data quality systems and processes and data quality governance structures and assurance systems.

As part of a data quality improvement programme, the Trust is implementing a new waiting list reporting solution (LUNA) to provide assurance against every patient pathway recorded in the Electronic Patient Record (EPR) including whether the pathway is closed, or whether the patient is waiting for treatment. This enables all patient pathways to be visible to clinicians in a single system - with detailed views of patients waiting for outpatient appointments, diagnostic tests, or admission for treatment. The system also provides detailed data quality checks designed to identify incorrectly recorded pathways alerting clinicians and administrative staff should the electronic patient record need to be investigated and potentially corrected. The build out of the LUNA reporting solution is nearing completion with validation of its outputs also nearing completion, with a cutover to LUNA, reporting May 2025 data during June 2025. Alongside this deployment, the Trust's data quality team have built a data quality dashboard providing individual EPR operator views of patient pathway data accuracy and consistency. Where individuals and teams are making errors, a targeted training intervention is implemented with follow-up monitoring applied. A data quality dashboard supports monitoring of progress against key data quality metrics.

Assuring the accuracy and completeness of reported data

In order to ensure the consistency and accuracy of data produced for internal and external audiences, the Business Intelligence team has been building a catalogue of key performance indicators, each indicator is being specified in relation to its technical definition, data-source, numerator, denominator and data presentation style. Resulting data outputs are peer reviewed and subject to review and sign-off by data owners. Additionally, during the year the Business Intelligence team has adopted and deployed a kite-marking methodology for all integrated performance report metrics. Kite Marking assesses each metric, through a rolling annual plan, against four domains: timeliness, completeness, validity and process; in the event of a domain not achieving required benchmarks this is reported in the IPR with an action plan and follow up audit implemented to an agreed timescale.

Next steps on data quality and refining performance management information

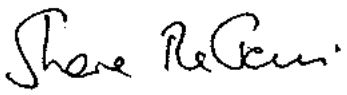
19 June 2024

The Trust's well-led plan includes recommendations to refine data quality through centralising and standardising information in a data warehouse with single data sources for key data feeds reflecting operations, finance, workforce, quality, and safety performance resulting in consistent reporting across departments, the group and externally. The corporate performance team uses a next generation reporting platform called 'WeInform', using Qlik Sense as the key reporting tool. The platform additionally enables users to access the data and dashboards from the WeInform platform on mobile devices and can alert users to a specific metric and data point. The data feeding the WeInform platform is sourced from the reporting database in the data warehouse, which is validated for data accuracy and consistency. The reporting database is continuously improved and being equipped with more datasets. The next step in the journey, is to migrate all the Qlik dashboards into the modern WeInform platform and build additional clinical and operational dashboards, including predictive analytics such as demand and capacity modelling. Additionally, the WeInform team are collaborating with quality governance team colleagues to advance the insight and application of performance information.

For 2025/26 the Trust, supported by the business intelligence team, is assessing the potential role of new technologies across the reporting layer, this includes Microsoft's Power BI, Power Automate and Co Pilot products, further enhancing reporting and dashboard build capabilities and reducing the degree of manual intervention required for data management.

Going concern basis

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



Shane DeGaris
Group Chief Executive

18 June 2025

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Corporate governance report

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

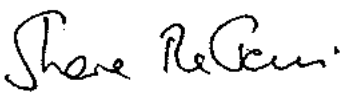
The chief executive of NHS England has designated that the group chief executive should be the accountable officer of the Trust. The relevant responsibilities of accountable officers are set out in the NHS Trust accountable officer memorandum. These include ensuring that:

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

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

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

Signed:



Shane DeGaris
Group Chief Executive Officer

18 June 2025

Barts Health
NHS Trust

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

This year has marked a significant period of transition for both the NHS and the Department of Health & Social Care, with recent announcements focused on reducing over regulation and enhancing national decision-making processes. These changes closely align with the strategic direction we have pursued in recent years, as we continue to prioritise equitable, safe, and compassionate care for all our patients.

Despite the ongoing challenges, we worked closely with our partners in the NHS North East London Integrated Care System to meet our collective financial target, ending the year with a small deficit of £11.7 million (0.4% of turnover). This represents a significant improvement on last year's deficit of £43.9 million and reflects the impact of difficult but necessary financial decisions made in a challenging economic environment. We remain committed to continuing our programme of driving efficiency and productivity to further strengthen financial sustainability, while maintaining the high standards of care our patients, staff, and stakeholders expect and deserve.

Over the past year, we invested £113 million in capital infrastructure and equipment to support and enhance the delivery of our services. This investment was funded through a combination of Public Dividend Capital from the Department of Health & Social Care, internal resources, and generous support from Barts Charity. We continue to work closely with partners locally across the east London sector and nationally to secure the funding needed to meet the evolving needs of our Trust. Whilst the pausing of all national New Hospital Programme schemes has been a disappointing development, we remain committed to the Whipps Cross Hospital redevelopment. We believe our patients deserve access to first-class care in a modern, fit-for-purpose facility that reflects the quality of treatment we strive to deliver every day.

We anticipate continued financial challenges in the year ahead as national-level changes begin to take effect. To address these, we will maintain our focus on improving productivity and efficiency, with a particular emphasis on long-term workforce sustainability and the adoption of digital innovations.

Robust financial governance, underpinned by strong collaboration with our partners and stakeholders, will be essential to maintaining financial control. By working collectively and implementing strategic, forward-looking measures, we will be better positioned to navigate the challenges ahead while continuing to deliver high-quality care and services to our patients.

We remain dedicated to serving not only our immediate community, but also to extending our care beyond geographical boundaries. By maintaining open and transparent communication with patients, staff, and stakeholders, we strive to ensure that the needs, concerns, and voices of all those we serve are heard and addressed effectively.

Hardev Virdee
Group chief finance officer

Trust Board role

The Trust Board is a unitary board accountable for setting the Trust's strategic direction, vision and values, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the local community. The board consists of the chair, chief executive, four executive directors and seven non-executive directors (NEDs) all with voting rights, plus nine other executive directors, two associate NEDs and a NExT Director who attend board meetings in a non-voting capacity. The number of NEDs is one higher than most NHS trusts, reflecting the size and complexity of Barts Health NHS Trust. The addition of hospital chief executives to the Board in September 2023 reflected their increasingly strategic role in leading place-based and clinical operational service developments.

As at 31 March 2025, there were no vacancies in Trust Board membership. The Trust Board seeks to reflect the local population it serves and, as part of succession planning, includes two additional associate non-executive director roles and a NExT Director. The Trust has participated in the national NExT director programme in recent years, which is designed to identify the next generation of non-executive directors from under-represented groups (with one current NED having successfully transitioned from a NExT director role).

The Trust Board has overall responsibility for the Trust's strategy, quality and safety of healthcare services, education, training and research. Day-to-day responsibility for implementing the Trust's strategy and delivering operational requirements is delegated through the group chief executive to the group executive directors and their teams. Key duties are set out in the Trust's standing orders and standing financial instructions and board terms of reference, which are reviewed regularly (with the SOs and SFIs last reviewed on 19 January 2022 and board terms of reference approved in May 2023). A review of SOs and SFIs is scheduled during 2025/26. The Trust Board meet regularly in public to discharge its duties and met 6 times in public during 2024/25, excluding the annual general meeting.

Board appointments

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

Independence of NEDs

One of the NEDs (Professor Sir Mark Caulfield) is nominated by Queen Mary University of London. All other NEDs are appointed in an independent capacity. The revised NHS code of governance indicates that generally NED appointments will be for an initial three-year term, with the potential for reappointment of NEDs for further terms of office (within a maximum length of service of six years). The chair leads on monitoring the composition of the board, ensuring that it provides an appropriate balance of skills, experience and knowledge. National guidance reflects the wider collaboration across the NHS with increasing numbers of NEDs serving on more than one trust board. Adam Sharples is the senior independent director and vice chair of the Trust.

Board members – biographies of board members (as at 31 March 2025)

The below provides a summary with full biographies including career backgrounds detailed on the Trust's website.

Professor Ian Jacobs (chair) was appointed chair of Barts Health in March 2025. Born in East London, he worked in the Trust initially as a resident doctor, graduating to roles as a consultant and director of the Barts Cancer Institute. He has returned to Barts Health, following roles in health and academic leadership in London, Manchester and Sydney.

Shane DeGaris (group chief executive) joined Barts Health in September 2018 and is currently the group chief executive. Prior to joining Barts Health, Shane was chief executive of The Hillingdon Hospitals NHS Foundation Trust in north west London, having originally trained as a physiotherapist in South Australia.

Adam Sharples CB (non-executive director, vice chair and senior independent director) joined Barts Health in May 2022 from University College London Hospitals, where he previously served as a non-executive director. Formerly, he was a senior civil servant for many years and worked at the Treasury and the Department for Work and Pensions.

Professor Sir Mark Caulfield (university nominated non-executive director) has served as the vice-principal (health) at Queen Mary's University London since October 2021 and as a non-executive director at Barts Health and at Barking, Havering and Redbridge University Hospitals NHS Trust. He has previously served as Chief Executive of Barts Life Sciences and Chief Scientist at Genomics England

Professor Hilary Thomas (non-executive director) joined in July 2024 as a joint non executive director, serving also at Barking, Havering and Redbridge University Hospitals NHS Trust. As an academic and clinician, Hilary specialised initially in oncology and previously served as medical director at The Royal Surrey County Hospital and continues to work as a partner at PA Consulting.

Lesley Seary CBE (non-executive director) joined Barts Health NHS Trust in February 2022 and is also a non-executive director at Barking, Havering and Redbridge University Hospitals NHS Trust. Previously she had worked in local government as a senior leader including serving as chief executive of Islington Council from 2011-2019 and subsequently as acting chief executive at Redbridge Council.

Kim Kinnaird (non-executive director) was appointed to her current role in February 2020 having previously served as an associate non executive director and NExT director on the board. Kim is currently the chief operating officer for Lloyd Banking Group's business and commercial bank and was recently appointed to a board role with the affiliated TMB plc.

Joni Nelson-Ferns (non-executive director) joined Barts Health NHS Trust in September 2022. She is the chief operating officer of Sigma Labs XYZ, a tech start up focused on social mobility. In her previous role, Joni served as Police Now's chief operating officer executive sponsor for diversity and inclusion.

Helen Spice (non-executive director) joined Barts Health NHS Trust in July 2022. Helen is an experienced finance professional with a 35-year career in the corporate, health and social care and not for profit sectors. She has held a number of senior positions; most recently Helen was Chief Financial Officer of Turning Point, a social enterprise working with people to support their mental health, drug and alcohol use and people with a learning disability.

Clyde Williams (associate non-executive director) has been an associate NED since September 2020, having previously served on the board at East London NHS Foundation Trust. He is currently a director of ShoNet, a cloud computing technology business based in London and New Delhi which helps implement digital systems for health organisations.

Sarah Teather (associate non-executive director) has been an associate NED since September 2022. Sarah is interim CEO at Kidscape PLC and was formerly director of the Jesuit Refugee Service UK. Prior to this, Sarah was an MP for Brent Central and served as Minister for Children and Families.

Siva Anandaciva (NExT Director) joined Barts Health in January 2025 as a NExT Director. Siva is the Director of Policy, Events and Partnerships at The King's Fund.

Caroline Alexander CBE (chief nurse) graduated as a nurse in 1987 from Edinburgh University (BSc/RGN) and took up her current role of chief nurse for Barts Health in March 2016, following time with NHS England as regional chief nurse for London.

Professor Alistair Chesser (chief medical officer) has served as chief medical officer since 2016. Alistair has previously worked as associate dean for undergraduates and as the clinical academic group director for emergency care and acute medicine at Barts Health.

Hardev Virdee (chief finance officer) joined Barts Health in November 2019 and has worked in the NHS for many years, including a successful three-year spell as CFO at Central and North West London NHS Foundation Trust.

Daniel Waldron (director of people) joined Barts Health in August 2021. Previously he had served as director of workforce and organisational development at Guy's and St Thomas' NHS Foundation Trust.

Andrew Hines (director of group development) joined Barts Health in 2017 to lead the development of the group operating model. Prior to this he was London regional chief operating officer for NHS Improvement, and he has held other system leadership roles as interim London regional director for the NHS Trust Development Authority, and with NHS London.

Rebecca Carlton (chief operating officer) took up her current role at Barts Health in January 2023. Prior to joining Barts Health, Rebecca has held a number of executive roles, including most recently chief operating officer at East Kent NHS FT.

Mr Ajit Abraham (director of equity and inclusion) has served in his current board role since May 2022. As a consultant hepato-pancreato-biliary (HPB) and trauma surgeon he has held a number of clinical and leadership roles internationally and locally.

Ann Hepworth (director of strategy and partnerships) joined Barts Health in July 2024 following her previous role at Barking, Havering and Redbridge University Hospitals NHS Trust.

Dr Neil Ashman (chief executive of Royal London and Mile End hospitals) is a consultant nephrologist (kidney expert) and was formerly deputy chief executive at RLH, and group executive director of transformation. Neil was appointed to the hospital CEO role in October 2021 and joined the trust board in September 2023.

Simon Ashton (chief executive, Newham Hospital) has combined clinical roles with various leadership roles, including at Whipps Cross, where he started working in 2001, prior to the formation of Barts Health. Simon took up the position of hospital CEO in December 2021 and joined the trust board in September 2023.

Professor Charles Knight OBE (chief executive of St Bartholomew's Hospital). A consultant cardiologist, Charles was appointed as managing director and then chief executive of St Bartholomew's Hospital in 2015 and joined the trust board in September 2023.

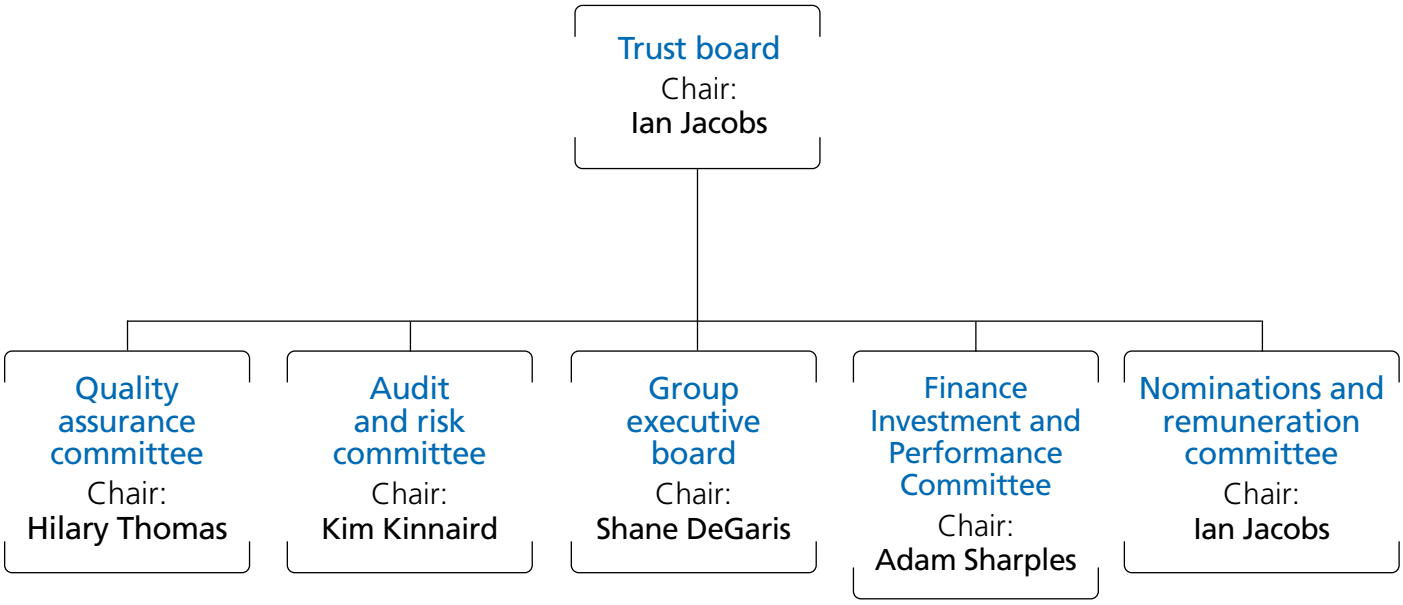
Dr Amanjit Jhund (chief executive, Whipps Cross hospital) joined the trust board in September 2023. This followed spells as an executive and board member at NHS Trusts in both Maidstone and Tunbridge Wells, and Croydon.

Trust Board and board committees

The Trust Board has elected to establish board committees to assist it to carry out its functions, which can include the implementation of time-limited board committees or board committee sub-groups. The approved board committee structure and current chairs as at 31 March 2025 are shown below in Chart 1.

Trust Board meetings are held in public and the papers are made available on the Trust website in advance of each meeting. The Board regularly reviews performance against national standards and regulatory requirements via an Integrated Performance Report. The Board places a strong emphasis on the quality and safety of patient care and, in addition to performance reports, regularly hears directly from patients, carers and staff including through patient and staff stories and a programme of ward and department visits.

Terms of reference for board committees are subject to review on a two-yearly basis. Exception reports are provided to the Trust board (based on use of a standard proforma reporting template) by each of the board committees following their meetings. Board assurance committees produce an annual report summarising how each has met its duties during the year. Terms of reference for the Trust Board, board committees, executive boards and hospital governance structures are published on the Trust's website.



Audit and risk committee

The following are key duties of the audit and risk committee (an assurance committee of the board):

- To provide assurance to the board based on review of the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust's activities that support the achievement of the organisation's objectives. The audit and risk committee is assisted in this duty by the quality assurance committee, which has responsibility for providing assurance in relation to clinical quality and safety aspects.
- To ensure that there is an effective internal audit function put in place by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the audit and risk committee, chief executive and board.

- Consideration of the major findings of internal audit work and the management response and ensuring coordination between the internal and external auditors to optimise audit resources.
- To review the work and findings of the external auditor and consider the management responses to their work.
- To act as an auditor panel, making recommendations to the board on appointment and removal of external audit partners, and to agree the approach to be taken to maintain objectivity of external auditors in the event that the external audit partner is commissioned by the Trust to undertake any non-audit work.
- To review proposed changes to the standing orders and standing financial instructions.
- To review the annual accounts to determine their completeness, objectivity, integrity and accuracy before they are presented to the Trust Board.

The chair of the audit and risk committee has a strong background in corporate finance and audit. Membership consists only of NEDs, in line with good practice recommendations. Exception reports are provided to the Trust Board (based on use of a standard proforma reporting template) following each meeting. On 3 May 2023, the Trust Board approved the committee's revised ToR, which had been updated to reflect a committee effectiveness review conducted during the year.

Membership: 4 non executive directors (Kim Kinnaird – chair, Hilary Thomas, Joni Nelson-Ferns, Helen Spice).

In attendance: chief finance officer, director of group development, group CEO (at least once per year).

Quality assurance committee

The quality assurance committee is a standing assurance committee of the Trust Board and acts on its behalf to monitor, review and report on the quality of clinical services provided by the Trust. In carrying out its role, the quality assurance committee complements the audit and risk committee through providing dedicated time and resources to review, for example, clinical aspects of assurance work carried out by internal audit and the clinical audit functions. There is a shared membership of the audit and risk committee and the quality assurance committee. The chair of the quality assurance committee has relevant clinical experience and qualifications.

The terms of reference include a remit to examine on the board's behalf quality and safety aspects of operational delivery, given its close relationship to the quality agenda. Exception reports were provided to the Trust Board (based on use of a standard proforma reporting template) following each meeting. On 3 May 2023, the Trust Board approved the committee's revised ToR, which had been updated to reflect a committee effectiveness review conducted during the year.

Membership: 4 non executive directors (Prof Hilary Thomas – chair, Prof Sir Mark Caulfield, Joni Nelson-Ferns, Lesley Seary), 1 associate NED (Sarah Teather), chief medical officer, chief nurse, chief operating officer, director of group development and director of quality governance.

Nominations and remuneration committee

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

Exception reports (based on use of a standard proforma reporting template) accompanied by oral updates from the chair are provided to the trust board following each meeting.

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

Membership: chair and all non executive directors. In attendance: group chief executive, trust secretary, director of people

Finance investment and performance committee

In addition to the above statutory committees, the Trust Board is supported by a finance investment and performance committee. This committee undertakes, on behalf of the Trust Board, objective scrutiny of the Trust's financial plans, investment policy and major investment decisions. The committee reviews the trust's monthly financial performance and identifies the key issues and risks requiring discussion or decision by the Trust Board. Exception reports (based on use of a standard proforma reporting template or provided orally) are provided to the Trust Board following each meeting. The finance and investment committee monitors financial performance in line with the key duties set in its terms of reference. On 3 May 2023, the Trust Board approved the committee's revised ToR, which had been updated to reflect a committee effectiveness review conducted during the year.

Membership: Three non executive directors (Adam Sharples – chair, Helen Spice, Kim Kinnaird), one associate NED (Clyde Williams), group chief executive, chief operating officer, chief finance officer, director of people, director of strategy.

Group executive board (executive committee)

While not a Board committee chaired by a NED, the group executive board, chaired by the group chief executive, is the Trust's principal executive committee. It leads on implementation of the Trust's clinical, operational and financial strategy and plans; and ensuring appropriate integration of clinical services and sites, between clinical and corporate functions and within the Trust and with external partners. As part of development of the group model development, this committee has evolved to perform an enhanced oversight but reduced operational role (supported by other executive group boards). It meets with an expanded attendance list once per month as a strategic group executive board.

Membership: group chief executive and executive directors (voting and non-voting), chief of surgery, director of communications and engagement.

A board collaboration committee comprising Barts Health and BHRUT board members met during the year; however, this was stood down during 2024/25 to reflect the evolution of governance for the wider acute provider collaborative. A joint digital advisory group was created to support the ongoing digital collaboration between the two trusts.

Board committee effectiveness

During 2024/25 the members of the principal board committees – the audit and risk committee, quality assurance committee and finance, investment and performance committee undertook a self-assessment survey of committee effectiveness with outputs currently being compiled for consideration by the Board in July 2025. This reprised a similar exercise reported to the Trust Board in May 2023.

Attendance by members of board committees, 2024/25

The below figures indicate the number of meetings attended by the relevant member/total number of meetings held during their period in post

Board member	Trust board part 1 (excluding AGM)	Trust board part 2	Audit and risk committee	Quality assurance committee	Nominations and remuneration committee	Finance investment and performance committee
Jacqui Smith	1/1 (100%)	1/1 (100%)			1/1 (100%)	
Ian Jacobs	1/1 (100%)	1/1 (100%)				
Adam Sharples	6/6 (100%)	6/6 (100%)	2/2 (100%)		3/3 (100%)	9/9 (100%)
Kim Kinnaird	5/6 (83%)	5/6 (83%)	6/6 (100%)		3/3 (100%)	7/9 (78%)
Mark Caulfield	4/6 (67%)	4/6 (67%)		2/6 (33%)	2/3 (67%)	
Kathy McLean	1/1 (100%)	1/1 (100%)	2/2 (100%)	1/1 (100%)	2/2 (100%)	
Lesley Seary	5/6 (83%)	5/6 (83%)		6/6 (100%)	2/3 (67%)	
Helen Spice	6/6 (100%)	6/6 (100%)	4/6 (67%)		1/3 (33%)	8/9 (89%)
Joni Nelson-Ferns	3/6 (50%)	3/6 (50%)	1/1 (100%)	4/6 (67%)	2/3 (67%)	3/6 (50%)
Clyde Williams	5/6 (83%)	5/6 (83%)			3/3 (100%)	6/9 (67%)
Sarah Teather	5/6 (83%)	5/6 (83%)		6/6 (100%)	2/3 (67%)	
Shane DeGaris	6/6 (100%)	6/6 (100%)				8/9 (89%)
Alistair Chesser	5/6 (83%)	5/6 (83%)		6/6 (100%)		
Caroline Alexander	5/6 (83%)	5/6 (83%)		5/6 (83%)		

Hardev Virdee	6/6 (100%)	6/6 (100%)				9/9 (100%)
Matthew Trainer	1/3 (33%)	0/3 (0%)				

Board member	Trust board part 1 (excluding AGM)	Trust board part 2	Audit and risk committee	Quality assurance committee	Nominations and remuneration committee	Finance investment and performance committee
Daniel Waldron	6/6 (100%)	6/6 (100%)				9/9 (100%)
Rebecca Carlton	6/6 (100%)	6/6 (100%)				7/9 (78%)
Ajit Abraham	5/6 (83%)	5/6 (83%)		3/6 (50%)		
Ann Hepworth	4/4 (100%)	4/4 (100%)				3/3 (100%)
Andrew Hines	5/6 (83%)	5/6 (83%)		5/6 (83%)		
Neil Ashman	6/6 (100%)	6/6 (100%)				
Charles Knight	3/6 (50%)	3/6 (50%)				
Simon Ashton	6/6 (100%)	6/6 (100%)				
Amanjit Jhund	5/6 (83%)	5/6 (83%)				

Board effectiveness

During 2024/25, substantive appointments and reappointments have been made to board roles to strengthen and consolidate the effectiveness of the Trust Board and in support of the group model. In line with best practice, the Trust has updated well-led improvement plans informed by a self assessment exercise carried out during 2024/25. This approach aligns with other key organisational development activity including the development of a trust-wide quality management system, leadership development initiatives and equalities and inclusion plans. These plans reflect the organisation's wider system leadership role and incorporate a collaborative working approach.

Trust board appraisals

The process for appraisals has been established with the chair and regional director of NHSE responsible for overseeing appraisals of the trust chair; the chair conducting appraisals for the non-executive directors and the chief executive; and the chief executive conducting appraisals for executive directors. These are completed on an annual basis, typically during quarter one each year. Annual appraisals of non-executive director performance are due to be completed by the chair and appraisals of executives are due to be completed by the group CEO by 31 July 2025. The output of the review of executives' performance against objectives will be reported to the trust's nominations and remuneration committee for review, in line with the committee's terms of reference. Summary details will be included in a chair's report to be shared with NHSE in line with revised fit and proper person's framework arrangements.

Modern Slavery Act – Board Statement

On 1 March 2017, the Trust Board issued a declaration regarding its arrangements to support compliance with the Modern Slavery Act 2015 and this has been reproduced below to reconfirm this commitment.

Barts Health NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015, and we expect our staff and suppliers to comply with the legislation.

The Trust has updated relevant Trust policies to highlight obligations where any issues of modern slavery or human trafficking might arise, particularly in our guidelines on safeguarding adults and children, tendering for goods and services, and recruitment and retention.

The procurement process has been reviewed to ensure that human trafficking and modern slavery issues are considered at an early stage, with self-certification for potential suppliers that their supply chains comply with the law. We procure many goods and services under frameworks endorsed by the Cabinet Office and Department of Health, under which suppliers such as Crown Commercial Services and NHS Supply Chain adhere to a code of conduct on forced labour. We uphold professional practices relating to procurement and supply and ensure procurement staff attend regular training on changes to procurement legislation.

The Trust requires all new staff to complete a safeguarding course, which covers obligations under the Act. We also require external agencies supplying temporary staff to demonstrate compliance with the legislation. All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices.

The Trust Board believes that the Trust is following good practice in implementing steps to prevent slavery and human trafficking.

Anchor institution

As a major employer of local east London residents (with around 42% of staff drawn from this population) and a large procurer of services and goods, the Trust is a well developed Anchor institution. In 2024 it revised its anchor framework to reflect on the priorities in its WeBelong strategy.

In 2024/25 over 946 residents and school students have been supported to progress their careers in the NHS. 749 work experience or placement sessions were undertaken and 171 residents were helped into work. 68 of these were young people and a further 19 jobs were secured by young people with severe learning disabilities and/or autism. The *Healthcare Horizons* programme continued to engage with 37 schools in east London and has supported over 500 school students into health related degrees.

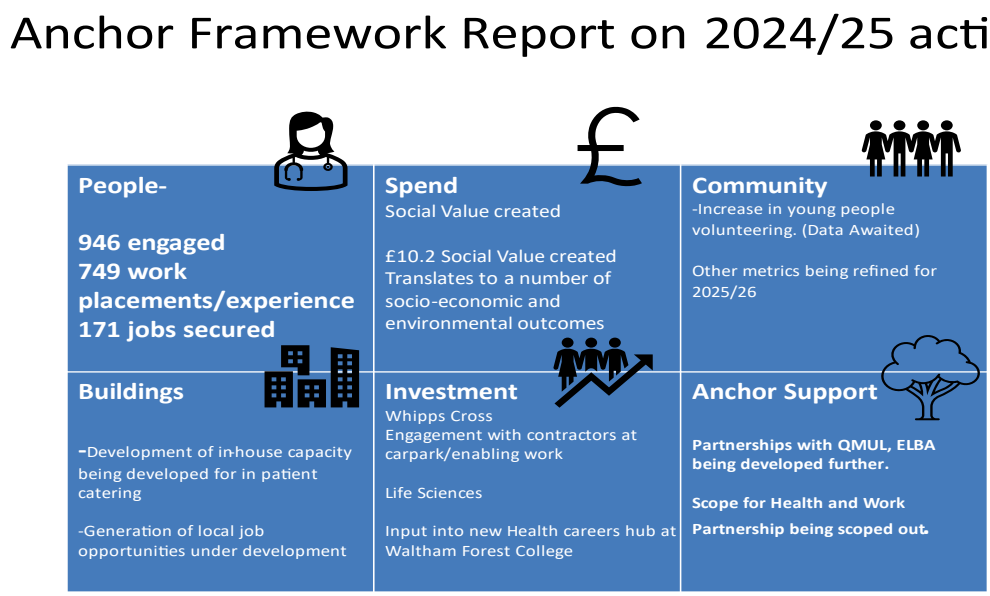
Working with local authorities, JobCentre Plus, housing associations and local further education colleges this partnership approach has made a huge difference to our local communities. In 2025 we

were pleased to advise Waltham Forest College in selecting the equipment of their new training suite for health and social care as part of our Bart Life Science approach to broadening knowledge.

In 2024/25 we generated over £10.2 million of social value through our procurement system. This is already generating job opportunities, apprenticeships and volunteering offers. This sum is expected to rise in future years and our aim will be to links these efforts closely to supporting local communities.

Our anchor programme is part of being a health promoting hospital. As part of this mission we continued to work towards cleaner air quality at our hospitals, reduce waste and support our aim to be carbon neutral by 2040. At Newham Hospital we engaged with London Metropolitan University with an Innovation Grant that will further the aims of being a healthy hospital. This will help with the learning process for maximising the potential of hospitals as sustainable anchor institutions.

Moving forward, the challenge for Barts Health will be to develop its role as an anchor institution in ways that support its efficiency as a healthcare provider and continue to meet its aims of supporting the health of its patients and local communities.



Equity of access

The Trust has committed to publishing a yearly equity of access report to the Trust Board. This provides the Trust's primary source of reporting on the key data and issues relevant to the equitable delivery of healthcare for our diverse local populations.

Additionally, NHS England have set out data reporting requirements for health inequalities that all relevant NHS bodies should collect, analyse and publish annually as part of their annual reports. In response, Barts Health has committed to publishing the following data requirement measures for acute providers, excluding those recommended for Mental Health services not provided:

1. Elective Activity vs Pre-Pandemic Levels for Under 20s and Over 19s, disaggregated by deprivation and ethnicity.
2. Emergency Admissions for Under 20s, disaggregated by deprivation and ethnicity.
3. Proportion of adult acute inpatient settings offering smoking cessation services.
4. Proportion of maternity inpatient settings offering smoking cessation services.
5. Tooth extractions due to decay for children admitted as inpatients to hospital, aged 9 years and under, disaggregated by deprivation and ethnicity.

For each of these measures we provide narrative as to any health inequalities identified and the relevant steps being taken to address these. These measures are not an exhaustive list of the work ongoing at Barts Health to reduce health inequalities. The equity programme works to identify and address disparities in access, outcomes, treatment and experience, and routinely monitors our patient list and performance measures for differences disaggregated by gender, ethnicity, deprivation, age, and learning disability status (which is published quarterly in the Integrated Performance Report).

1a. Under 20s Elective Activity Pre-Pandemic (2019/20) by deprivation

IMD Quintile	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
1 (most deprived)	3,114	241,404	1,289.9538	1,245.0405	1,336.0732	95%	rate per 100000	Byars
2	4,665	344,075	1,355.8091	1,317.1786	1,395.2648	95%	rate per 100000	Byars
3	1,640	183,613	893.1829	850.4727	937.4826	95%	rate per 100000	Byars
4	1,035	133,250	776.7355	730.1292	825.5366	95%	rate per 100000	Byars
5 (least deprived)	779	110,644	704.0599	655.4797	755.2674	95%	rate per 100000	Byars

1b. Under 20s Elective Activity Post-Pandemic (2024/25) levels by deprivation

IMD Quintile	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
1 (most deprived)	3,251	226,806	1,433.3836	1,384.5302	1,483.5207	95%	rate per 100000	Byars
2	4,810	345,120	1,393.7181	1,354.6064	1,433.6725	95%	rate per 100000	Byars
3	1,653	165,171	682.6684	650.1679	936.7648	95%	rate per 100000	Byars
4	1,079	138,180	780.8655	734.9621	828.8850	95%	rate per 100000	Byars
5 (least deprived)	650	94,896	684.9604	633.3077	739.7032	95%	rate per 100000	Byars

1c. Over 19s Elective Activity Pre-Pandemic (2019/20) Deprivation

IMD Quintile	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
1 (most deprived)	30,649	1,318,445	2,324.6324	2,298.6791	2,350.8057	95%	rate per 100000	Byars
2	52,703	2,315,913	2,275.6900	2,256.3022	2,295.2029	95%	rate per 100000	Byars
3	21,810	2,047,194	1,065.3607	1,051.2681	1,079.5950	95%	rate per 100000	Byars
4	15,577	1,780,894	874.6731	860.9908	888.5185	95%	rate per 100000	Byars
5 (least deprived)	11,234	1,806,352	621.9164	610.4686	633.5251	95%	rate per 100000	Byars

1d. Over 19s Post-Pandemic (2024/25) Levels Deprivation

IMD Quintile	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
1 (most deprived)	33,328	1,104,274	3,018.0915	2,985.7751	3,050.6708	95%	rate per 100000	Byars
2	56,640	2,051,354	2,761.1032	2,736.4105	2,783.9371	95%	rate per 100000	Byars
3	22,172	1,833,963	1,208.9866	1,193.1050	1,224.9864	95%	rate per 100000	Byars
4	14,972	1,602,775	934.1299	919.2262	949.2147	95%	rate per 100000	Byars
5 (least deprived)	10,752	1,688,911	636.6232	624.6461	648.7723	95%	rate per 100000	Byars

1e. Over 19s Elective Activity Pre-Pandemic (2019/20) Ethnicity

Ethnic Category	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
Asian	28,639	550,243	5,204.781	5,144.684	5,265.426	95%	rate per 100000	Byars
Black	17,164	290,660	5,905.181	5,817.165	5,994.196	95%	rate per 100000	Byars
Mixed	2,196	32,695	6,722.740	6,444.599	7,009.798	95%	rate per 100000	Byars
Other	7,247	101,227	7,159.157	6,995.267	7,325.918	95%	rate per 100000	Byars
White	68,202	4,914,807	1,387.684	1,377.289	1,398.136	95%	rate per 100000	Byars

1f. Over 19s Elective Activity Post-Pandemic (2024/25) Ethnicity

Ethnic Category	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
Asian	33,824	540,779	6,254.681	6,188.200	6,321.698	95%	rate per 100000	Byars
Black	19,596	271,405	7,220.206	7,119.464	7,322.017	95%	rate per 100000	Byars
Mixed	3,207	39,098	8,202.466	7,921.010	8,491.368	95%	rate per 100000	Byars
Other	7,512	102,064	7,360.088	7,194.579	7,528.443	95%	rate per 100000	Byars
White	67,321	4,751,360	1,416.879	1,406.195	1,427.623	95%	rate per 100000	Byars

Data tables show elective admissions per 100,000 by ethnicity and deprivation, as shown in the 'values' column. Elective activity shows significant variation by deprivation, with those from our most deprived backgrounds showing higher rates of elective admission per population when compared to those from least deprived backgrounds. There is also significant variation by ethnicity, with higher rates of activity in patients from non-white backgrounds. These findings are consistent across under 20 and over 19 age groups, and in both pre- and post- pandemic analysis. To understand and improve barriers to access in elective care, the equity programme is working to embed disaggregated data into our regular performance reviews.

2a. Emergency admissions for under 20 year olds – Deprivation

IMD Quintile	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
1 (most deprived)	3,424	207,335	1,651.4337	1,596.5768	1,707.6945	95%	rate per 100000	Byars
2	5,306	278,889	1,902.5490	1,851.6976	1,954.4431	95%	rate per 100000	Byars
3	1,560	137,434	1,135.0903	1,079.4554	1,192.8492	95%	rate per 100000	Byars
4	854	80,104	1,066.1141	996.8002	1,140.0826	95%	rate per 100000	Byars
5 (least deprived)	415	51,524	805.4499	729.8096	886.7998	95%	rate per 100000	Byars

2b. Emergency admissions for under 20 year olds – Ethnicity

Ethnic Category	Admissions	Popn	value	lowercl	uppercl	confidence	statistic	method
Asian	5,439	163,085	3,334.866	3,246.621	3,424.694	95%	rate per 100000	Byars
Black	1,383	53,548	2,582.730	2,448.388	2,722.525	95%	rate per 100000	Byars
Mixed	688	18,400	3,739.130	3,464.911	4,029.281	95%	rate per 100000	Byars
Other	870	16,119	5,397.357	5,044.616	5,768.258	95%	rate per 100000	Byars
White	2,952	184,392	1,600.937	1,543.701	1,659.753	95%	rate per 100000	Byars

Data tables compare emergency rate per 100,000 by index of deprivation quintile as shown in 'value' column. Emergency care admissions data highlight that our patients from areas of greater deprivation are accessing our ED services at a higher rate than our patients from lesser deprived areas, as well as ethnic differences in how patients are accessing ED, with lowest attendance rates in patients from a white ethnic background.

To monitor this further, we are developing our approach to performance review structures, and are including disaggregated Emergency Care performance data in our regular performance scorecards to better understand demographic differences in how different patient groups, including deprivation and ethnicity, are accessing and experiencing our services. This will allow for regular review of this data as part of our business as usual approach.

There has been further charitable funding for High Intensity User programmes across our hospital sites, working with our highest attending patients to understand how their care needs can be better met, and monitoring the impact of this service on health inequalities.

3. Days wait by Ethnicity and IMD

		Count of Pathways ('000s)						Avg. Wait Time in Days					
		Avg (12m)	2024/25 Q2	2024/25 Q3	*Diff.*	*% Diff*		Avg (12m)	2024/25 Q2	2024/25 Q3	Diff.	*% Diff*	
			A	B	(B -> A)	D			A	B	(B -> A)	D	
Ethnic Category													
Asian	1	41.4 K	41.9 K	42.1 K	*0.2 K*	***0.4%***		137.6	137.4	134.5	-2.9	***-2.1%***	0.0
Black	2	15.9 K	16.2 K	16.0 K	*- 0.2 K*	***-1.1%***		137.5	136.4	134.3	-2.1	***-1.5%***	0.0
Mixed	3	3.3 K	3.3 K	3.3 K	*0.0 K*	***0.5%***		137.5	139.1	133.3	-5.9	***-4.2%***	0.0
White	4	47.6 K	48.3 K	47.8 K	*- 0.4 K*	***-0.9%***		135.9	136.2	134.0	-2.2	***-1.6%***	0.0
Other	5	8.1 K	8.2 K	8.1 K	*0.0 K*	***-0.5%***		137.1	138.7	134.8	-3.9	***-2.8%***	0.0
Unknown	6	9.7 K	9.1 K	10.1 K	*1.1 K*	***11.6%***		125.6	127.0	121.8	-5.3	***-4.1%***	0.0

Ethnic Category		Count of Pathways ('000s) Avg (12m)	2024/25 Q3 A	2024/25 Q4 B	Diff. (B -> A)	% Diff D	Avg. Wait Time in Days Avg (12m)	2024/25 Q3 A	2024/25 Q4 B	Diff. (B -> A)	% Diff D	
Asian	1	41.4 K	42.1 K	41.1 K	- 1.0 K	-2.3%	137.6	134.5	136.3	1.8	1.3%	0.0
Black	2	15.9 K	16.0 K	15.6 K	- 0.4 K	-2.5%	137.5	134.3	136.0	1.8	1.3%	0.0
Mixed	3	3.3 K	3.3 K	3.3 K	0.0 K	0.0%	137.5	133.3	132.8	-0.5	-0.4%	0.0
White	4	47.6 K	47.8 K	46.5 K	- 1.3 K	-2.8%	135.9	134.0	134.5	0.4	0.3%	0.0
Other	5	8.1 K	8.1 K	7.9 K	- 0.2 K	-2.8%	137.1	134.8	134.2	-0.6	-0.4%	0.0
Unknown	6	9.7 K	10.1 K	11.6 K	1.5 K	14.3%	125.6	121.8	120.8	-0.9	-0.8%	0.0

IMD Quintile		Count of Pathways ('000s) Avg (12m)	2024/25 Q2	2024/25 Q3	Diff.	% Diff	Avg. Wait Time in Days Avg (12m)	2024/25 Q2	2024/25 Q3	Diff.	% Diff
1 (most deprived)	7	30.2 K	30.5 K	30.6 K	0.1 K	0.2%	137.2	136.5	133.6	-2.9	-2.1%
2	8	56.7 K	57.2 K	57.3 K	0.1 K	0.1%	137.2	136.6	133.4	-3.3	-2.4%
3	9	20.1 K	20.4 K	20.3 K	- 0.1 K	-0.5%	137.3	136.7	134.4	-2.2	-1.6%
4	10	10.3 K	10.5 K	10.5 K	0.0 K	0.3%	136.4	135.0	133.8	-1.2	-0.9%
5 (least deprived)	11	6.3 K	6.3 K	6.4 K	0.1 K	1.4%	134.4	133.9	132.3	-1.6	-1.2%
Unknown	12	2.2 K	2.0 K	2.5 K	0.5 K	23.8%	126.3	126.9	116.1	-10.8	-8.5%

Data tables compare average (mean) days wait by financial quarter and financial year, disaggregated by ethnicity and Index of Multiple Deprivation (IMD) quintile. Ethnicity data indicates that for known ethnic groups, average days waits are consistent. There are shorter waits observed for 'unknown' ethnicities, which are more likely to be urgent referrals. In this financial year we been exceeding our targets of 95% ethnicity data capture across our inpatient, outpatient, and emergency services.

Deprivation data indicates that there is a 2.8 days difference in average waits between the most deprived and least deprived patients. This difference is not statistically significant, therefore there is limited evidence of a relationship between deprivation and average waits for our outpatient services. To ensure monitoring, our PTL is reviewed by ethnicity, deprivation, gender, and learning disability on a quarterly basis at board level.

4. Proportion of adult acute inpatient settings offering smoking cessation services

Fin Year	Numerator	Denominator	Proportion
2023/24	**1,562**	8,494	**18%**
2024/25	**3,246**	8,706	**37%**

Numerator: All inpatients with a tobacco dependence review

Denominator: All inpatients with a tobacco dependence review

Smoking remains the leading cause of preventable ill health, disability and premature death. It is also the leading cause of health inequalities. Being in hospital acts as a teachable moment. Hospital

settings are therefore an opportune time where smokers may be more willing to accept support to quit, such as medication to treat nicotine addiction alongside behavioural interventions.

Barts Health established an inpatient and maternity tobacco dependence service in 2022. In 24/25 37% of smokers admitted to an inpatient ward were offered support to quit whilst in hospital, and 100% of pregnant women were offered support throughout pregnancy.

The maternity service has also recently joined a national incentive scheme, meaning pregnant smokers are also offered financial incentives, alongside medication and behavioural support to quit.

5. Tooth extractions due to decay for children admitted as inpatients to hospital, aged under 10 years

- *Deprivation*

IMD Quintile	Discharges	Popn	value	lowercl	uppercl	confidence	statistic	method
1 (most deprived)	268	51,435	521.0460	460.5236	587.3102	95%	rate per 100000	Byars
2	393	75,123	523.1420	472.6915	577.5104	95%	rate per 100000	Byars
3	178	38,475	488.0055	418.9421	565.2019	95%	rate per 100000	Byars
4	71	13,167	539.2289	421.1231	680.1710	95%	rate per 100000	Byars
5 (least deprived)	22	3,952	556.6802	348.7473	842.8588	95%	rate per 100000	Byars

- *Ethnicity*

Ethnic Category	Discharges	Popn	value	lowercl	uppercl	confidence	statistic	method
Asian	278	28,644	970.5348	859.7858	1,091.591	95%	rate per 100000	Byars
Black	57	2,297	2,481.4976	1,879.3470	3,215.127	95%	rate per 100000	Byars
Mixed	36	1,080	3,333.3333	2,334.3007	4,614.875	95%	rate per 100000	Byars
Other	61	950	6,421.0526	4,911.3286	8,248.250	95%	rate per 100000	Byars
White	245	22,652	1,081.5822	950.3728	1,225.841	95%	rate per 100000	Byars

The data presented covers tooth extractions from March 2024 to February 2025.

The Royal London Hospital provides comprehensive and therapeutic oral health care for children, including care for children who demonstrate intellectual, medical, physical, psychological and/or emotional problems. Treatment is provided under local anaesthetic, sedation (reversible happy gas) and general anaesthetic. Surgical procedures and advanced restorative care of children with complex dental needs are carried out e.g. dental anomalies, cleft patients. Emergency and long term treatment of children with trauma to the teeth and oral soft tissues is also provided. Our pathways include services that help make the experience less traumatic for children.

Given the small numbers, it is hard to draw definitive conclusions about the rates of extraction by ethnicity or deprivation. The majority the population served are in the most deprived quintiles (IMD 1 and 2), and the majority of extractions are in these deprivation quintiles. However, they do not appear to be overrepresented when compared to patients in less deprived quintiles. With regards to ethnicity, most extractions took place in Asian and White patients. However, Black, Mixed, and Other appear to have higher rates of extraction, as a proportion of the population.

System development and integrated care

During 2024/25, the Trust continued to engage in important work with system partners at integrated care system (ICS), borough (‘place’), and acute provider collaborative level (as well as wider pan-London and national coordination). The Health and Social Care Act 2022 establishes the principles for closer integration of healthcare services and underpins developments in the following areas:

- At north east London level, the Trust is a key stakeholder in the NHS North East London integrated care system with representation on the statutory integrated care board (via the group chief executive) and the integrated care partnership (via the chair).

- The development of a sector wide acute provider collaborative (comprising the NEL ICB, Barts Health NHS Trust, Barking, Havering and Redbridge University Hospitals NHS Trust and Homerton Healthcare NHS Foundation Trust). This has established key change programmes (led at chief executive level) to identify and deliver improvements that will enhance equity, quality and outcomes for the rapidly growing population of north east London. Activities were organised under three strategic priority programme boards, each chaired by a Trust CEO:
    - Delivering high quality clinical services.
    - Accelerating access to care.
    - Implementing a sustainable financial model.

- At borough or 'place' level, our hospitals work closely with primary, community and social care partners in our boroughs – with seven place based partnerships meeting across NEL. These partnerships enable improved planning for how health and social care work together, equipping local people to manage their own health and wellbeing and to access the health and care services which best meet their needs, as close to home as possible.

- Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust set up a shared pathology service in May 2021. The East and South East London Pathology Partnership hosted by Barts Health, its purpose is to provide patients and clinicians with a high-quality, cost-effective service that ensures the long-term sustainability of NHS pathology services. The partnership has an operating budget of c.£123m per annum, with a workforce establishment of c.900 WTE staff. Over the next few years, this pathology partnership will move to a hub and essential service laboratory structure across the three Trusts.

- The Trust has over a number of years played a leading role in a number of pan-London partnerships, including the north east London cancer alliance (established to improve survival and earlier diagnosis), the East London maternity system (set up to reduce still births and maternal mortality and improve continuity of care), an integrated Stroke Delivery Network across east London and a north London specialised children's services network. This work has informed the newer sector arrangements in NEL.

- The planned new hospital redevelopment at Whipps Cross is part of the first wave of the national HIP1 (Hospital Improvement Programme). Barts Health is awaiting approval to move to the next stage of business case development for the Whipps Cross redevelopment programme. The design and plans for this redevelopment (and the redesign of local pathways to optimise care settings) are being developed in partnership with patient and stakeholder representative groups, North East London Health and Care Partnership, London Borough of Waltham Forest, North East London NHS Foundation Trust and neighbouring Clinical Commissioning Groups. Progress has been made on funding and approvals for essential enabling works (including a car park construction). Plans to support the hospitals local identity include the development of a Whipps Cross centre for healthy ageing – with professorial appointments made to lead on research-led care.

- The Trust is a member of UCL Partners which operates across north east and north central London with a particular focus on collaborative clinical research and the adoption of innovation. The Trust successfully bid to host the North London Research Delivery Network from 1 April 2024. The Trust achieved the highest recruitment of patients to commercial drug trials in the UK and seventh highest recruiter overall to all trials. However, the Trust's ambition remains to boost research activity at all of its hospitals, building on some recent success (notably at Newham hospital). The development of a Lifesciences campus and clinical research facility at

Whitechapel represents a highly significant opportunity to bring together leading health, research and commercial partners in the capital and this will increasingly be a focus of the Trust's strategic plans.

Acute provider collaborative

The above section describes the NE London context and a model similar to other regions (or sectors) nationally in terms of having an Integrated Care System and supporting collaboratives representing key provider groups, and 'place' based borough working. A guiding principle for this joint working has been to focus on those aspects that will most swiftly deliver benefits – in terms of access and clinical outcomes – for our local populations. This commitment to joint working has been reflected in joint appointments working across both Barts Health and Barking, Havering and Redbridge University Hospitals NHS Trust. The acute provider collaborative is working currently to coordinate clinical strategy, culture, and leadership across the NEL acute hospitals. A number of collaboration enabling workstreams have been identified as early priorities and will be a feature of further collaboration across the sector. Areas for immediate focus include:

- Reducing reliance on agency staff by aligning temporary pay rates.
- Getting best value from Bank staff through a common approach.
- Sharing expertise on procurement practice.
- Establishing a joint sustainability team to become net zero.
- Enabling BHRUT to develop an electronic patient record system (with procurement of the same EPR in use at Barts Health and Homerton, thereby enabling improved records sharing and continuity of care for all NEL patients). Similar joint digital initiatives are in development for maternity and pathology.

Benefits of integrated working

As indicated above, the approach to accelerating our integrated working has been shaped by the potential for delivering the greatest benefits for our populations. Some highlights identified during 2024/25 of this approach include:

- Securing inward investment of £62m to north east London for theatre, ITU and bed expansion to meet high demand.
- Finalising a three-year funding settlement of £33m for implementing community diagnostic centres to provide patients with speedier and more convenient access for their scans.
- Extension of the successful NEL critical care retrieval service to cover the London region.
- Close working on cancer performance providing for consistently strong compared with other London regions.

Risk management and systems of control

The Trust Board is accountable for delivery of the Trust's objectives and robust risk reporting is a key aspect of this. There has been considerable work in 2024/25 to strengthen risk management maturity, including:

- Further development of the board assurance framework supported by a risk appetite domain and risk tolerance triggers. During 2024/25 this was also produced in conjunction with a quarterly report tracking progress against the objectives set in the group operating plan and shared success measures.
- A '*substantial'* assurance internal audit opinion on the board assurance framework (with a 'reasonable' rating for wider group risk management arrangements) in terms of design, content and application. This assessment is supported by the 2019 independent Deloitte review of the Trust's risk management arrangements (as part of

mandated Well Led activity), indicating that the Trust's risk management board benchmarked well with other NHS organisations.

- Increased granularity of reporting to the Audit and Risk Committee and time spent by this committee on discussing the highest-scored risks appearing on the risk register; horizon-scanning for risk; and thematic reporting considered by the executive risk management board.
- The increasingly effective work of a trust wide risk review group to support hospitals and group support services in implementing the risk management policy consistently across the group.
- Consistent reporting of risk as part of performance review meetings in addition to standing risk reports at executive and NED-led quality assurance groups.

Board assurance framework

The board assurance framework (BAF) sets out the principal risks to achievement of the trust's strategic objectives, while the annual governance statement (included in the next section of the report) provides a year-end assessment of the trust's systems of control and key issues that materialised during the year, thereby informing plans for 2025/26.

The principal risks to the Trust objectives in the board assurance framework are detailed in Appendix 1 of this report section. BAF entries are identified following review of the Trust's main risk reporting tool (the risk register) and through discussions with board directors, informed by performance reporting and assurances received in-year. The board assurance framework format includes an explicit link between the strategic risk entries shown and the related high risks appearing on the risk register. The format and use of the BAF was strengthened to reflect prior year audit recommendations, with no high priority management actions identified as a result in the 2024/25 audit. The Trust Board owns the board assurance framework, while the executive risk management board plays a central role in regularly monitoring the key risks to the organisation and the audit and risk committee assures on the overall system of control and risk management. The board also seeks assurances directly or through its assurance committees on BAF risks (with specific lead roles assigned to board committees for each of the BAF entries) and a programme of deep dive reports to support monitoring of progress on a prioritised basis.

The BAF entries describe the principal risks to the Trust's operational, clinical quality, financial, workforce, strategic and academic objectives. The Trust Board noted moderate success in mitigating board assurance framework risk scores downwards during 2024/25, with the BAF reflecting risk scores moving in both directions. This year-end BAF reflected a relatively high proportion of high risks associated with waiting lists (in part linked to recovery from the pandemic), finances and the impact of industrial action. Despite ongoing operational risks, progress was identified internally and by external stakeholders and regulators in managing these (including the Trust's exit of regulatory scrutiny and support mechanisms for cancer access).

Risk register and overarching risk management system

During the year work has continued to strengthen and improve risk management systems and processes across the organisation. The last CQC well-led inspections in 2018 indicated that risk management systems and processes were well embedded at a hospital-level and group level. The overall rating for this year's Internal Audit review reflected the highest available '*substantial*' assurance rating for the design and application of the BAF.

The development of the group model and enhanced site-based leadership has contributed to improved risk management maturity, reflected in the overall CQC rating of 'good' for the Trust's compliance with NHS England's well-led framework. The trust risk management board has met monthly throughout the year and maintains corporate oversight of risk in the organisation, reporting regularly to the group executive board on its work (in addition to standing items on risk management at audit and risk committee and quality assurance committee meetings). At each meeting, the risk management board reviews the trust's highest risks and reviews quarterly progress on key risk metrics. A risk management strategy is supported by an approved risk management policy.

The risk management function conducted a comprehensive training needs assessment and launched new training materials to be used as part of essential staff training. We will continue to offer training on risk management, targeting staff with key roles on risk management leadership.

Thematic review of our risks has continued to inform the approach to mitigation. This has worked well in the case of risks related to medical equipment and triangulation with capital investment processes. This informs the process of replacement of medical equipment, allowing equipment to be replaced in a prioritised way so that we make best use of the finite resource available. Similar risk assessment has informed the prioritisation of funding for fire safety improvements and ICT infrastructure as well as focusing attention on post pandemic elective waiting time risks.

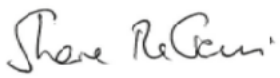
Other risk and control framework details - interests, gifts and hospitality; fit and proper persons regulations; declarations and expenses

The staff policies and remuneration section of this report includes details of all non-executive director and executive director interests, including related party transactions. As a standing item at every board and board committee meeting, members are asked to declare any new interests, gifts or hospitality and these are minuted. Board members are also required to complete and sign a declaration of interest form on an annual basis (details of declared interests are included in this annual report). Fit and proper persons self-assessments are completed annually in line with national fit and proper persons regulations and the Trust SOP (which sets out the scope and application of the regulations within the Trust). The Trust Office (on behalf of the chair) maintains records of the following for each executive director and non-executive director:

- An annual self-declaration on fitness to practice completed and signed by each individual.
- Evidence of disclosure and barring service status checks.
- Confirmation of a central check against register of individuals subject to bankruptcy restrictions, sequestration or debt relief orders.
- Confirmation of professional qualifications and professional registration (for clinicians or relevant others).

The Trust's fit and proper persons arrangements were last examined from a regulatory perspective as part of the CQC well led assessment during 2018/19 (with no issues identified). An update was provided to the nominations and remuneration committee on implementation of a revised fit and proper persons framework via the Trust's standard operating procedure during 2024/25.

The annual accounts include a summary of non-executive director and executive director expenses claimed, with key details reported to the audit and risk committee during the year.



18 June 2025

group chief executive **date**

ANNUAL GOVERNANCE STATEMENT 2024/25

BARTS HEALTH NHS TRUST

1. Scope of responsibility

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

2. The purpose of the system of internal control

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

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and

- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Barts Health NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Following the reintroduction of the system oversight framework (SOF) in 2021/22, ratings were determined for each integrated care system (ICS) and NHS trust (including foundation trusts). This rating sought to reflect the scale and general nature of support needs, ranging from no specific support needs (SOF 1) to a requirement for mandated intensive support (SOF 4). The Trust is currently rated as SOF 3, with the wider NE London system rated as SOF 3. Despite recognition of improved Trust financial resilience, the financial outlook for 2025/26 appears challenging. In addition to national policy announcements on reducing overheads and clear expectations that productivity improvements are made, the Trust will be operating in a new regulatory environment and with some uncertainty on new structures. The operational and financial plan for 2025/26 reflects a growing emphasis on working as a system to deliver greater financial stability for NE London health and care systems. This has been reflected in early work with the whole sector on financial strategy and as part of the acute provider collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust and Homerton Healthcare NHS Foundation Trust.

The CQC's inspection activity during 2024/25 was limited to a review of urgent and emergency care services at Whipps Cross Hospital inspection in July 2024. A number of concerns were initially raised by the CQC including those in relation to triage, mental health patient capacity and hand hygiene. Since this inspection the hospital's action plan has produced improvements and there were no changes to the overall service CQC rating of *requires improvement*. Plans to reconfigure the physical infrastructure and work with partners on urgent treatment centre use will be a priority in 2025/26.

Progress was made during the year on evolving the acute provider collaboration (APC) between Barts Health NHS Trust and Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) and Homerton Healthcare NHS FT. Meetings of the three boards, the acute provider collaborative board and the APC executive met to identify joint working

opportunities that would benefit the patient populations in NE London. This collaboration built on existing close links between the three organisations (with historically close links between clinical service teams) and some specific corporate collaborative initiatives including those for procurement, non-emergency transport and digital development. Three priority workstreams focusing on quality, access and financial sustainability to support integration across the NEL acute hospitals footprint have been supported by strategic boards led by a CEO.

The Trust's group model continues to evolve with an accountability framework refreshed during 2024/25. This framework sets out the respective roles of each element of the group's leadership and governance structures. The integration agenda across NEL has also been reflected in the increasingly developed 'place-based' governance (linking more closely each hospital with its respective local boroughs). Work to reposition clinical networks is under way with new operational delivery networks in place to co-ordinate and support consistency across the group for key specialties.

The Trust's group operational and financial plan sets out an ambitious agenda for the Trust in 2025/26, requiring increased activity, workforce productivity and control of expenditure – its success is likely to be predicated on closer integration (and efficiencies) in the context of reduced income opportunities. During 2024/25, the Trust Board was able to closely monitor progress against its operational plan with a series of quarterly reports tracking against objectives and targets set out at the start of the year. This approach has been refined to ensure that this complements the Trust's primary monthly reporting tool (the integrated performance report). More details on the outputs of this process are included elsewhere in the performance section of this annual report.

Trust Board and Committee structure

The role of the Trust Board is to govern the organisation effectively and to build public and stakeholder confidence that their health and healthcare is in safe hands - providing high quality, patient-centred care. The Board has complied with the relevant aspects of the NHS code of governance and self-certified compliance with all licence conditions. With reference to the requirements of the Trust's standing orders and standing financial instructions, the group chief finance officer and the trust secretary retain oversight of the arrangements for the discharge of statutory functions and no gaps in legal compliance have been identified during the year. The below section supports the Trust's approach to compliance with NHS provider licence condition 4 in terms of effective governance structures, responsibilities of directors and subcommittees, the submission of timely and effective information, reporting lines and board oversight.

Across the country NHS providers are exploring ways of working together in groups of hospitals in order to overcome mutual challenges and deliver better care. There is no blueprint to follow, so we can identify the model that best meets our aim to offer faster access to services, higher quality treatment and improved experience of care. In north east London, Barts Health began collaborating with Barking, Havering and Redbridge University Hospitals Trust (BHRUT) and both are now working closely with Homerton Healthcare NHS FT as well as part of a wider acute provider collaborative. The governance arrangements for this remain in development currently and will build on the significant collaboration arrangements developed over the last two years (including dedicated workstreams and joint appointments).

There were a number of changes to the Trust Board's membership during 2024/25, including the appointment of Prof Ian Jacobs as chair, Prof Hilary Thomas as a non executive director, Ms Ann Hepworth as director of strategy and partnerships and Mr Siva Anandaciva as a NExT Director. Prof Sanjiv Sharma was appointed as chief medical officer with effect from April 2025 and Ms Rachael Corser announced as the incoming chief nurse, due to take up post in September 2025. There were no board vacancies at the end of the financial year.

The principal committees established by the Trust Board to support it in undertaking its responsibilities are the audit and risk committee, quality assurance committee, nominations and remuneration committee, finance investment and performance committee, and group executive board (which is the principal executive committee). A board collaboration committee was

disestablished during the year, reflecting the maturing of acute provider collaborative governance across the three acute trusts in NEL. A new digital advisory group was established in its place to reflect the specific joint work on digital development across Barts Health and BHRUT. Details of the roles of these committees are provided in the accountability section of this report. During the year, the chairs of board committees reported on their discussions and drew issues to the attention of the Trust Board as appropriate through sharing of minutes and exception reports to each board meeting held in public. On a two-yearly cycle, board committees review and update terms of reference; provide reports on compliance with terms of reference; and undertake self-assessment reviews of their effectiveness. The outputs of a self assessment exercise were last reviewed and approved by the Trust Board in May 2023 with the next update on the most recent exercise due to be reported in July 2025.

Review of economy, efficiency and effectiveness of the use of resources

The Trust Board and its assurance committees have a key role in review of the effective use of resources. The Trust Board retains oversight of the overall business planning process, budgets and use of staffing resources and establishment. The finance investment and performance committee meets monthly and has a key role in review of investment decisions and monthly financial performance (including, specifically progress against the annual revenue plan and capital programme). In 2024/25, the audit and risk committee was supported by a comprehensive audit programme and recognised improvements on timely implementation of Internal Audit-recommended management actions (following some disruption to this following the pandemic). The internal audit programme, providing audit reviews of key controls such as the board assurance framework, CQC regulations and payroll informed an assessment of the effectiveness of the Trust's system of controls (with the 2024/25 head of internal audit opinion indicating a 'reasonable' assurance rating on his assessment). The risk-based internal audit programme prioritises high risk / materiality topics covering all areas of the Trust's activities (in addition to some essential regular core financial system reviews).

In terms of the level of assurance gained from internal audit reviews of controls systems completed during the year 11 were assigned 'substantial' assurance (7 in 2023/24), 18 (18 in 2023/24) 'reasonable' assurance; and 4 (9 in 2023/24) 'limited' assurance.

The quality assurance committee complements the role of the audit and risk committee in providing assurance to the Trust Board via a combination of quality reporting, hospital and thematic reports and review of internal audits relevant to efficient and effective patient care. The quality assurance committee also monitored progress against the Trust's quality improvement plan, operational and workforce plans and key safety metrics.

The Trust's assessment of its efficiency was last formally reviewed externally by a CQC and NHS Improvement 'use of resources' review in 2018 (which identified strong productivity and procurement performance). The Trust remains at an overall 'requires improvement' CQC rating for its quality of services and use of resources; and 'good' for the Well Led domain.

Quality Accounts

The Trust's directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Barts Health NHS Trust produces its quality accounts as a companion to its annual report and accounts, providing a focus on care quality performance. The timetable for the quality account for 2024/25 reflects a target for publication of 30 June 2025.

The accuracy of the Trust's quality account and an assessment of whether this presents a balanced view of controls in place is provided through internal review; stakeholder engagement and consultation; and data checking processes as part of the Trust's data quality arrangements.

3. The risk and control framework and risk assessment

As designated accountable officer, I have overall accountability for risk management in the Trust. During 2024/25, the director of group development has been delegated to lead on risk management issues at board level.

Capacity to handle risk

The governance arrangements for risk management are summarised below:

- The audit and risk committee meets formally at least five times a year and oversees the overall performance of the risk management system. It provides assurance to the Trust Board that effective governance, risk management and internal control systems are in place across the Trust's activities, including oversight of processes underpinning the board assurance framework and reporting on the high risk register and risk management metrics. Steps have been taken to embed reporting on horizon-scanning and to report on key findings of thematic risk reviews conducted by the executive risk management board.

- The quality assurance committee meets on a bimonthly basis and monitors, reviews and reports on the quality of services provided by the Trust. Its agenda includes reporting on high risks relating to quality and safety; and assurances via quality and safety oriented Internal Audit reviews. It receives and reports on assurances to the audit and risk committee and the Trust Board in relation to the mechanisms and controls in place to deliver safe, high quality, patient-centred care. Key risks and quality performance issues are highlighted to and reviewed by the Trust Board both as part of its regular monitoring of performance and in the context of specific issues that may arise via regular hospital reports and thematic exception reporting.

- The Trust's risk management board, which is chaired by the director of group development, provides executive oversight of risk management. The risk management board meets monthly and is responsible for ensuring the development and implementation of effective systems and processes for risk management at each level of the Trust and providing assurance to the audit and risk committee that this is the case. The risk management board reports into the group executive board via an exception report (with standing reports from the risk management board also provided to the audit and risk committee and quality assurance committee highlighting key risk themes, details of high risks and key risk management activity).

- Risk management training is delivered to staff in accordance with the Trust's risk management training needs analysis. The training programme was updated during 2024/25 and includes a focus on differentiated training reflecting the different roles and responsibilities of staff groups in relation to risk management.

- The Trust Board received assurance reporting during 2024/25 on a self-assessment of its services against the Care Quality Commission and NHS England well-led framework.

The Risk and Control Framework

The Trust has a comprehensive risk management policy and this is available to all staff on the Trust's intranet site. The Trust also has a risk management strategy and arrangements for assessing on an annual basis the risk management maturity of the organisation. This year, the Trust's risk maturity rating was self-assessed by the risk management board at level 3 'embedded and improving' on the HM Treasury levels 1-5 risk maturity scale. This was supported by an Internal Audit analysis of the self-assessment process and outcome. The audit and risk committee approved a revised risk management strategy for 2022-25 which sets out the vision for further improving the organisation's risk maturity, support continuous improvement and the aim to achieve 'good' and 'outstanding' CQC ratings. The Trust's risk management policy describes the Trust's overall risk management approach, responsibilities for risk at each level of the organisation, the risk management process and the Trust's risk

identification, evaluation and control system. The latter includes a 5 x 5 (consequence x likelihood) risk scoring matrix used to evaluate risks in the Trust.

- The risk management board reviews the Trust's high risks on an ongoing basis. All new risks with a proposed score of 15 and above (classified as 'high') are reviewed by the risk management board at each meeting. The risk management board has also undertaken a rolling review of hospital and corporate directorate medium and high risks as well as deep dive thematic reviews. The risk management board reviews all risk register entries with a score of 20 or above at each meeting (which are also considered at each audit and risk committee meeting). The audit and risk committee and quality assurance committee both receive regular reports on the board assurance framework and high risks as part of an integrated risk report.

- The risk management function is focused on integrated risk management – the process of identification, assessment, analysis and management of risks at every level in the organisation and the aggregation of risks at a corporate level. Steps are taken to ensure consistency between risks described on the board assurance framework, hospital site assurance frameworks and the risk register.

- For each of the Trust's hospitals, a hospital executive director (as nominated by the respective hospital chief executive) chairs a dedicated risk committee, leads on risk issues and is responsible for coordinating and embedding risk management processes within their hospital, including management of local risks on the risk register. Hospital executive boards have responsibility for monitoring, managing (and where necessary escalating) risks – delegating key duties to their hospital risk management / risk and regulation committees. Risk training has been undertaken with input from hospital leads during the year to help strengthen risk identification, evaluation and monitoring, with a forum dedicated to support key risk processes across the group (the risk review group). Staff at all levels are encouraged to report incidents and record risks on the Trust's Datix information systems. Monthly hospital performance review meetings, chaired by the group CEO, include a standing review of each hospital's highest risks.

- The director of group development is the Trust's senior information risk owner (SIRO). Working closely with the Trust's caldicott guardian, the SIRO has been responsible for taking ownership of information risk at Board level and advising the group chief executive accordingly.

- The Trust Board and its board committees monitor assurances on the systems of control supporting constitutional standards performance and received an update on compliance with its licence conditions in June 2024.

Board Assurance Framework

The principal risks on the Trust's board assurance framework as at the end of 2024/25 are summarised at appendix 1. The board assurance framework is based on the Trust's strategic objectives and identifies the principal risks to the achievement of those objectives, the key controls in place to manage those risks and the sources of assurance about the effectiveness of those controls. It also details the identified risk appetite linked to the relevant objective/enabler and any gaps in control and assurance in relation to the risks, together with actions to address them.

The board assurance framework (BAF) is reviewed by the risk management board at each meeting and is formally reviewed by the Trust Board three times a year. Risks on the board assurance framework are assigned both a lead director and a lead trust board committee. The respective board committees, at each of their meetings, reviews the alignment of its agenda with the BAF risks assigned to the committee; with a supporting schedule of deep dive reviews of BAF principal risks to objectives as part of its workplan.

During 2024/25, the format of the BAF was supported by a refreshed risk appetite dimension, RAG rating of each line of assurance and the inclusion of risk tolerance 'triggers' (aligned with the operational plan's key success measures). Steps were also taken to provide a consistent format of deep dive reporting to support challenge on progress against identified controls. The board assurance framework (BAF) is updated through both a 'top down' assessment of strategic risks by the trust board and executive directors; and a 'bottom up' review of high and significant risks recorded by all staff on the Trust's risk register. The BAF is further supported by each hospital's development of equivalent hospital assurance frameworks which reflects on their key strategic risks. The 2024/25 internal audit report on the board assurance framework indicated a 'substantial' assurance rating regarding the design and use of the BAF to manage risk across the organisation (with a 'reasonable' assurance rating in relation to other aspects of the Trust's risk management systems). Reflecting on refinements that have been made over a number of years to implement prior year audit recommendations, there were no significant management actions identified to improve the BAF's format and use.

Counter Fraud

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

Fraud is deterred through mandatory training and by publicising proven cases of NHS fraud and staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature across the Trust's sites. The Head of Investigations liaises with internal audit to capture any fraud risks from internal audits undertaken within the Trust. Counter fraud reports are presented to the audit and risk committee as a standing item (with two detailed counter fraud items each year, focusing on the workplan and an analysis of investigations findings respectively). The yearly counter fraud report highlighted that the Trust's benchmarked performance was top quartile on numbers of referrals (indicating a healthy reporting culture) and losses recovery.

External assurance

The Care Quality Commission's last Well Led review report in 2018/19, in conjunction with outputs from internal audit reviews, confirmed an embedded risk management systems and processes, with extensive use of risk registers and assurance frameworks. Further improvement and greater consistency remain a priority for the hospitals and for the Barts Health group as a whole (as referenced previously in this report in relation to risk maturity assessments).

Stakeholder involvement

Partners and stakeholders are involved and engaged in the Trust's business and risks which impact on them through their contributions, including for example:

Patients and the public

- The work of the local healthwatches, overview and scrutiny committees and health and wellbeing boards.
- Regular meetings of the Trust Board held in public which include patient stories and the opportunity for patients and members of the public to ask questions. Visits to hospital departments held on the day of each board meeting provide a further opportunity for board members to hear directly from patients and staff in these areas

- Feedback provided via the Trust's patient advice and liaison service and specific patient representative groups, the national inpatient survey (and other specific national surveys of areas including cancer services and maternity) and the results of friends and family test surveys. The development of a more cohesive approach to identifying and use of survey themes was led by the Trust's director of insight.
- Specific public engagement activities held as part of the Whipps Cross redevelopment programme.

Staff

- The application of a WeImprove quality improvement approach to sustaining and driving innovation in the context of elective recovery. Staff have been engaged in the design and implementation of many QI initiatives, with steps taken this year to embed a quality systems approach in planning processes.
- A focus on the WeBelong inclusion strategy, with a number of engagement activities including regular webinars.
- Activities to engage and develop staff include leadership development and talent management work; and campaigns responding to staff survey feedback this year included a focus on sexual safety.
- Embedding the work of a number of representative groups including the Trust's diversity networks, the local negotiating committee and staff partnership forum.
- Monitoring of national staff survey findings. Benchmarked results indicate that the Trust's results were improving but remained in the bottom quartile, albeit at the upper range (and broadly consistent with other London acute trusts).
- Encouraging staff to raise concerns through Guardian of Safe Working and Freedom to Speak Up routes.

Partners

- Regular performance discussions have involved NEL Integrated Care Board (ICB), local partner provider organisations and NHS England. A collaborative sector-led approach to healthcare as formalised through the Health and Care Act has been embedded locally through the work of the ICB and APC (as below).
- An acute provider collaborative comprising Barts Health NHS Trust, Barking, Havering and Redbridge University Hospitals NHS Trust and Homerton Healthcare NHS Foundation Trust has established core clinical and corporate workstreams for closer integration. Each workstream aims to identify and deliver improvements that will enhance equity, quality and outcomes for the sector's diverse and growing population.
- Borough-level 'place-based' structures have matured over the last year. This partnership approach reflects the important connections between each borough and its local hospital, with opportunities to cooperate more closely on public health initiatives and the social care interface with hospitals.
- Joint strategic planning with healthcare and academic partners, including NHSE, Barking, Havering and Redbridge University Hospitals NHS Trust, Homerton Healthcare NHS FT, Queen Mary University of London and UCL Partners.
- Ongoing close working with Barts Charity to invest in health priorities.

Compliance issues

The Trust is compliant with registration requirements of the CQC. Details of compliance with CQC essential standards of quality and safety are set out in Section 4.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This is overseen by the Trust Board with regular reporting on access and diversity led by the Board's director of equity and inclusion.

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

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

Sustainability

The Trust continued to make good progress delivering the Board approved Green Plan addressing key objectives set out in the Trust's 2024/25 Annual Plan relating to sustainability. The Trust has undertaken risk assessments on the effects of climate change and severe weather informing its Green Plan and following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust has established a comprehensive governance framework to oversee the delivery of the Trust's Green Plan and established a Sustainability team made up of subject matter experts to help the Trust and the group's hospitals deliver the actions needed to deliver the NHS Net-Zero targets and other climate change requirements set out in the Green Plan. The Trust Board established the Green Plan Delivery Oversight Group (GPDOG) in 2022, chaired by the Trust's Director of Strategy, the nominated Board member lead for sustainability, that meets bi-monthly with a specific remit to ensure that the Trust has a credible plan to deliver the Green Plan and its objectives. The oversight meeting reviews a carbon dashboard that monitors the Trust's carbon emissions compared to the 2018 baseline and progress towards the NHS Net-Zero targets.

The Trust has established eight 'Green Groups' covering all the carbon emitting activities caried out by the Trust. These groups meet regularly to develop and deliver specific initiatives to deliver the Green Plan and improve sustainability across the Trust. There are four 'specialist' Green Groups that are responsible for specific areas of Trust activity that impact on carbon emissions plus four 'place' based Green Groups at each of the Trust's hospitals that are responsible for ensuring that there is a plan to deliver the Green Plan at each hospital. Each of the hospital Green Groups is chaired by a member of the Hospital's Executive Boards (HEBs) with exception reports provided to the hospital HEBs and to the GPDOG. The chairs of all eight Green Groups attend the GPDOG. All the Green Groups have agreed terms of reference and memberships drawn from across the Trust to ensure that all areas of activity contribute to the development and delivery of the Green Plan.

The four specialist Green Groups are:

- Estates & Facilities Green Group – Chaired by the Group Director EFM with a remit to deliver carbon reductions of the built estate, waste management, transport and climate change adaption.

- Finance & Procurement Green Group – Chaired by the Deputy Director of Procurement with a remit to align the procurement of goods and services more sustainably and for the Trust to have financial plans that align with the capital and revenue implications of delivering the Green Plan.

- Clinical Transformation Green Group – Chaired by the BHRUT Clinical Group Director of Nursing with a remit of changing clinical practice to become more sustainable.

- Air Quality and Sustainable Travel Green Group – Chaired by the Associate Director Public Health with a remit to improve air quality and promote active and sustainable travel.

The Sustainability team maintain a comprehensive Green Plan Action Plan capturing all the specific actions being carried out across the Trust that contribute to delivering the Green Plan.

Progress is reported to the GPDOG and each of the eight Green Groups to ensure that Green Plan initiatives are coordinated and delivered in a consistent way across the group and to ensure good practice is shared and adopted widely. The Green Plan Action Plan identifies all the carbon reducing initiatives being delivered across the Trust's Green Groups to enable a trajectory of future carbon emissions to be produced and monitored to provide assurance that the Trust has a credible plan to deliver the Green Plan net zero targets. The Action Plan is a live document that at the end of 2024/25 had identified 174 actions of which 97 had been completed or closed. Collectively the Plan identifies over 50k tonnes of carbon dioxide emission (CO2) reductions that are planned to deliver by 2030 that will enable the initial 80% reduction in direct CO2 emissions by 2028-2030 to be achieved.

The Trust's 2024/25 Annual Plan set out key objectives related to sustainability and delivery of the Green Plan. Highlights included:

- Delivering the Trust's Waste & Re-Use Strategy by insourcing waste services across the group and establishing new specialist waste contracts based on best practice and intended to make the Trust a leader in this field. New recycling services were mobilised with a target of raising overall recycling rates to over 50% from the 11% in 2022/23. Achieving 50% recycling rate would make the Trust the best performing in the NHS. The new waste services were procured working in partnership with the NHS Special Business Services (SBS) as part of the procurement of a new national Waste Framework. This collaborative work was recognised by the award of the prestigious Health Care Supply Association (HCAS) Excellence in Supply Award.

- Comprehensive Hospital Decarbonisation Plans (HDP) for each of the Trust's Hospitals were developed with grant funding support from the Low Carbon Skills Fund (LCSF). These set out how each hospital can deliver their net zero carbon targets in relation to eliminating fossil fuels.

- Successfully bid for £13.75m of grant funding from the Public Sector decarbonisation Scheme (PSDS) round 4 to carry out works to decarbonise Newham University Hospital. The works will take two years to complete in March 2027 by which time Newham Hospital will be the first Trust Hospital to deliver their scope 1 net-zero decarbonisation target.

On 20 January 2025, the Secretary of State announced the outcome of the New Hospitals Programme (NHP) Review that placed the new Whipps Cross Hospital in the second investment wave, delaying the anticipated opening from 2031 to 2036 at the earliest. The new hospital will be net zero from inception so the delay means that Whipps Cross Hospital will no longer meet the NHS target of 80% reduction in carbon dioxide emissions by 2032 through the hospital building programme. The implications of this are being assessed, with an emerging estimate of £54m additional capital investment being required to adapt the existing hospital facilities to meet the NHS net zero target set for the hospital.

The Sustainability Team consists of subject matter experts related to all aspects of delivering the Green Plan and responding to climate change. They are part of the Group Estates & Facilities Division and led by the Whipps Cross Director of Estates & Facilities and Trust Sustainability Lead. The team consists of carbon/energy management engineers, waste and environmental management specialists plus a dedicated Sustainable Travel Officer. The team work across the group providing support to the eight Green Groups to develop and deliver initiatives related to improved environmental impact, reducing carbon emissions, environmental compliance and climate change adaption. Delivery of the Green Plan is supported by enabling teams including; Estates & Facilities, Capital Projects, Procurement, Communications and Quality Improvement teams.

The Trust's Sustainability Annual Report 2024/25 will be considered by GPDOG in July and subsequently at a Trust Board meeting. Future sustainability annual reports will be considered by the Trust Board each year.

Task Force on Climate-Related Financial Disclosures (TCFD)

NHS England's NHS Trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of 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.

The Trust has complied with the TCFD recommendations and disclosure requirements of the governance pillar for 2024/25. We have defined a clear governance structure to ensure accountability for managing climate-related issues and the implementation of the Trust's Green Plan. As outlined in the 'Green Plan' section of this report, key actions relating to climate change are identified, considered, and managed via the Sustainable Action Plan. The Trust regularly reports our progress against this action plan and towards our net-zero carbon targets to the Trust Board. The Strategic 'Green Plan Delivery Oversight Group' (GPDOG) reports our progress and provides an annual update to Trust Board, measuring progress against strategic milestones.

Management plays an active role in assessing and managing climate-related issues. The Sustainability team meets regularly with the Trust's specialist and hospital place based Green Groups, Director of E&F as the Executive Sponsor for this programme, to provide updates on the programme. Separately, bi-monthly E&F, Finance and Performance reports are presented to GPDOG, providing a strategic overview of the Green Plan and performance against carbon targets.

Our governance structure ensures that we maintain continual progress against our objectives and overarching Net-Zero target. We continue to provide transparent and validated reporting on our impacts, with a standing sustainability section included in our annual report.

Climate-Related Financial Disclosures - risk management pillar

The Trust has a green plan with monitoring of detailed actions by a dedicated group on progress against key milestones to achieve climate targets. This is accompanied by horizon-scanning and impact assessment processes; these will inform recording of any risks using the Trust's standard risk management methodology.

The Trust records details of principal risks to climate-related objectives, with a particular focus on backlog maintenance and responsiveness to changing environmental conditions. Examples include specific risks identified in relation to flooding at the Whipps Cross hospital site and overheating risks in wards and departments during summer months. Risk scores relating to net zero objectives will be revisited during the year in the context of delays to planned modernisation (including new hospitals redevelopment) and to reflect scheduled improvements at the Newham hospital site. The Trust's emergency preparedness, planning and responsiveness function supports business continuity preparations in the event of significant climate-related events.

Climate-Related Financial Disclosures – metrics and target pillar

The key metrics used to track progress against climate objectives include: trajectory (over a 10 year timeframe) towards net zero of direct influenceable emissions by 2040 with an 80% reduction achieved by 2028-2032; and net zero of all emissions by 2045 with an 80% reduction achieved by 2036-2040. Further details of metrics are provided in the Trust's green plan (scheduled for review by the Trust Board during 2025/26). These include setting target dates for implementation of new decarbonisation and waste strategies, delivery of waste recycling improvements, updates to car parking policies and implementation of theatres ventilation plant controls. Other key metrics monitored relate to clean air, water conservation and climate change adaption. The Trust has worked with other acute sector partners

(including Barking, Havering and Redbridge NHS University Hospitals Trust) to adopt a coherent sector-wide approach to green objectives.

Information governance and data security

Information governance provides the framework for handling information in a secure and confidential manner. Covering the collection, storage and sharing of information, it provides assurance that personal and sensitive data is managed legally, securely, efficiently and effectively in order to deliver the best possible care and service.

The director of group development (who is also the senior information risk officer) chairs the Trust's information governance committee, the principal body overseeing the management of information risks. This group reports into the quality board and oversees the development and submission of the Trust's annual data security and protection toolkit.

The Trust's control and assurance processes for information governance include:

- Information asset owners covering patient and staff personal data areas.
- A trained Caldicott Guardian, a trained senior information risk owner and a trained data protection officer.
- A risk management and incident reporting process and related risk register.
- Mandatory data security training for all staff.
- Data protection, information security, records management and confidentiality policies.
- An annual report submitted to the audit and risk committee summarising key information governance activities and compliance with requirements (including introduction of the data security and protection toolkit, work of the caldicott guardian, general data protection regulation arrangements, freedom of information, national data opt out compliance, IG risks, training and priorities).

The NHS Digital data security and protection toolkit has an annual deadline of 30 June each year. This year, the standard has changed to align with the Cyber Assurance Framework, and we are actively working towards meeting these new requirements for our June 2025 submission. Our goal is to ensure that patient information remains safe and secure while we continue to strengthen our cyber resilience.

An annual internal audit review of the data security and protection toolkit is undertaken and outputs reported to the audit and risk committee.

In 2024/25 there were eight personal data breaches that met the threshold for reporting to the Information Commissioner's Office (ICO):

- Five incidents of inappropriate access or use of patient data by a member of staff.
- A member of agency staff working at one of our hospitals posted videos on social media that included patients.
- An internal confidential report was disclosed to the Sunday Times by a member of staff.
- A technical issue temporarily made the summary record of 12 patients who had opted out visible to their GP.

In six cases the ICO have closed the matter with no further action, however in some cases recommendations have been made that the Trust has either completed or will be considering. The Trust has two open cases awaiting an ICO review.

The information governance committee routinely receives assurance that recommendations arising from ICO-reportable incidents have been actioned within the organisation.

To ensure the secure management of patient and staff information, the Trust continually seeks to further develop and improve its information security systems and processes, with several policies updated during 2024/25 and procedures in place ensuring that staff receive appropriate information governance training.

Safe Staffing Assurance

Each year the Trust Board agrees a group operational plan that includes finance, demand and workforce planning for the year in line with *'developing workforce safeguards'* published in October 2018.

As a part of the annual planning process for 2024/25, the Trust Board agreed nursing, midwifery and allied health professional safer staffing workforce plans and establishments. Safe staffing plans are developed at ward, hospital and then group level informed by benchmarking tools such as BirthRate+ for maternity services staffing. The monthly integrated performance report details ward-level safer staffing metrics including fill rates and care hours per patient day. The Trust Board also receives a yearly report from the Trust's guardian of safe working, providing assurance that doctors in training working hours are safe and compliant with their terms and conditions of service.

Elective waiting time data

The Trust has reported on elective waiting times throughout the year, supported by continued pathway validation exercises, to validate waiting time data recorded for all patients currently waiting for treatment. The challenges of longer waiting times since the pandemic continue and NHS national targets reflects steps to promote elective activity accompanied with a focus on productivity improvements.

The Trust has rolled out training and analysis for staff on management and reporting on waiting lists helping to identify any training needs, followed by meaningful intervention. A data quality dashboard has been introduced to support staff to manage data quality and track themes in terms of improvement and errors. This is actively used by the corporate and operational teams. Accompanying this monitoring, the Trust employs a well-established clinical harm process to assess the extent of any harm associated with long waits.

Steps to strengthen the Trust's waiting list arrangements and patient tracking list (PTL) during 2024/25 have included the introduction of the LUNA health system, providing enhanced visibility of all patient cohorts. The introduction of a new insights and intelligence board strengthened governance and management reporting, providing confidence in the accuracy of all key performance indicators and metrics. The introduction of data quality kite-marking for key performance indicators in the Trust's integrated performance report, and an awareness session held on 'making data count' methodology during 2024/25, will enhance the Board's ability to understand, challenge and improve waiting list performance (as well as use of wider management information) in the short and medium term.

Update on significant control issues reported in 2023/24

The Trust identified the following significant control issues in its annual governance statement for 2023/24 - with three of the issues appearing in bullets below carried forward to appear as significant control issues in 2024/25 (see section 5).

- Performance against constitutional access standards.
- Newham fire safety arrangements.
- Maternity care and CQC regulations compliance.
- Whipps Cross redevelopment delays.

Update on control issues reported in 2023/24 not reappearing in 2024/25

There has been significant senior management focus on Newham fire safety issues in 2024/25, with a number of issues arising initially from an enforcement notice received from London Fire Brigade (LFB) in 2020. Following completion of phase 3 improvement works in 2024/25, a further five phases of works have been identified. Recognising the multi-year nature of the required works (while maintaining core clinical service delivery), a process of annual review and extensions of the original enforcement notice has now been agreed with LFB with a rolling programme to prioritise capital investment agreed with the NEL ICB and sector partners.

4. Review of effectiveness of risk management and internal control

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review has been informed by:

- Executives and managers within the organisation, who have responsibility for the development and maintenance of the system of risk management and internal control.

- Performance against national and local standards and segmentation under the single oversight framework.
- The Trust's ongoing self-assessment of compliance with the CQC's *essential standards of quality and safety* across all hospital facilities and the findings of inspections of services at Whipps Cross University Hospital by the Care Quality Commission (CQC).
- The head of internal audit opinion on the overall arrangements for gaining assurance through the board assurance framework and on the controls reviewed as part of internal audit's annual work plan. the head of internal audit opinion for 2024/25 concluded that, for the systems that have been reviewed, reasonable assurance can be given that controls are generally sound and operating effectively.
- The work of internal audit through the year, with coverage of the audit plan determined by risk-based assessment. None of the finalised audit reports contained findings that internal audit regarded as significant control issues requiring disclosure in this annual governance statement.
- The outcomes of the Trust's clinical audit programme and reports from its clinical effectiveness function.
- The results of external audit's work on the Trust's annual accounts and local tailored performance management reviews.
- Patient and staff surveys and feedback and other sources of external scrutiny and accreditation including clinical peer review arrangements.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the risk management board, quality assurance committee and the audit and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Key roles have been as follows:

- The Trust Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the integrated performance report comprising operational, financial, quality and workforce elements; through board and committee reporting on progress against strategic objectives; and through oversight of the board assurance framework. A performance review mechanism has enabled the executive to retain effective oversight of the progress of hospitals in delivering their operational plans.
- The audit and risk committee (ARC) in conjunction with the quality assurance committee (QAC) has overseen the effectiveness of risk management arrangements and the board assurance framework, supported by an executive risk management board (RMB) undertaking regular reviews of the Trust's risk register and the board assurance framework. ARC and RMB monitored key clinical and non-clinical risks highlighted by hospitals, directorates and other committees. Executives have ensured that key risks have been highlighted and monitored within their functional areas and the necessary action taken to address them.
- Both internal and external audit have provided scrutiny and assurance in relation to governance and control arrangements across a wide range of the Trust's activities.

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

Constitutional access standards (urgent and emergency care access, elective, cancer and diagnostics)

An enduring impact of the Covid-19 pandemic nationally has been an increased length of waiting lists, including the cohorts of patients waiting for very long periods. Recovery of elective activity during 2024/25 was significant and ahead of the Trust's operational plan targets. However, translating this into reduced waiting times remained challenged by a number of pressures (including ongoing emergency care pressures and capacity issues associated with discharges and out of hospital social care capacity). This resulted in year end elective access performance remaining below the progressively more challenging national targets on eliminating the longest waiting cohorts and. Eliminating the cohort of patients waiting over 104 weeks represented progress. As at March 2025 the numbers of patients waiting over 78 weeks had been reduced to fewer than 20, and the number of 65-week waits reduced by 80%. While the Trust's emergency care performance through winter compared favourably with peers, the impact for patients of long urgent and emergency care waits remained a significant concern and risk during the year. Progress was made towards the end of the year on addressing diagnostics backlogs, particularly in relation to MRI following investment in additional capacity. Cancer access performance remained a concern and despite consistent achievement of the 31-day access standard, the Trust remained below trajectory on the 62-day standard and faster diagnosis standard for the majority of the year.

Financial sustainability and performance
The Trust and NEL sector faced continued financial challenges during 2024/25 in terms of the income and expenditure position, with acknowledgement of a relatively low comparative level of capital investment in the sector. The Trust's anticipated [£11.7m] deficit outturn, in the context of higher provider deficits in the sector, was not an outlier. However, the challenges of addressing an underlying deficit and delivering the productivity requirements to achieve 2025/26 financial targets impacts on the Trust's financial sustainability.

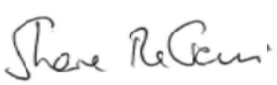
Whipps Cross Hospital redevelopment programme delays
The confirmation received during the year from HM Government regarding delays to the wave 2 new hospital programme has significantly impeded the plans for Whipps Cross Hospital redevelopment. In the absence of a new hospital, the costs and safety implications associated with maintaining the current estate will need to be assessed and closely monitored.

5. Conclusion

My review has established that Barts Health NHS Trust has a sound system of internal controls that supports the achievement of the trusts policies, aims and objectives. The below significant internal control issues (detailed in the above section) have associated plans to ensure that these have been or are being addressed:

- Performance against national access standards for emergency care, elective access, diagnostics and cancer.
- Financial sustainability and performance.
- Whipps Cross Hospital redevelopment.

During 2024/25, the Trust has further embedded its operating model and supporting governance arrangements at sector, group and hospital level (as defined in its accountability framework) to strengthen the Trust's systems and processes for controls and assurance and support the delivery of the Trust's quality and financial improvement plans.



Shane DeGaris
Group Chief Executive
Barts Health NHS Trust **18 June 2025**

Appendix 1: Board Assurance Framework - principal risks at 31 March 2025

1. Failure to develop a consistent well-led, inclusive, leadership culture and behaviours – impairs staff engagement – impacting on staff retention and care quality
2. Failure to improve workforce productivity – impacts on activity and workforce plans - impairing operational plan delivery
3. A failure to develop system-wide 24/7 services - impairs access to hospital and out of hospital care - and consistent delivery of emergency care access standards
4. Failure to embed a WeImprove quality management system and approach – impairs the ability to deliver change at the required scale - impacting on our ability to transform services
5. Failure to embed the group maternity model and insufficient leadership capacity and capability to drive maternity improvements – affects our ability to improve maternity care – impairs ability to exit support programme, meet enhanced quality standards and secure incentive funding
6. Failure to embed patient / staff insight and surveillance to monitor key quality standards (such as cleaning) – impairs effective management and consistency of care delivery - impacting on delivery of CQC and regulatory compliance
7. Failure to optimise cross-site clinical and operational collaboration within the Trust's group operating model – affects capacity and unwarranted variation – impacting on waiting times and effectiveness as a leader in the NEL acute provider collaborative
8. Failure to develop mature and effective place-based partnerships – affects the management of emergency care mental health pathways in the short term and co-ordination of demand management in the medium term - impairing the response to population growth, and improving equity of access, experience and outcomes
9. Capital funding constraints and business case delays – prevents necessary investment in estates and infrastructure, including major works at Whipps Cross and Newham – resulting in regulatory non-compliance and suboptimal care settings.
10.Failure to address drivers of deficits - risks delivery of the Trust's medium term financial strategy and optimal use of resources– resulting in breach of the statutory breakeven duty and sector financial targets
11. An increased incidence of cyber attacks on public sector organisations – results in a breach of the Trust's enhanced systems security – impacting on clinical service delivery, continuity of care and confidence of patients and the public
12. Delays to deliver major strategic investments (including Clinical Research Facility and lifesciences programmes) to support research activity – impairs progress on translational research – resulting in poorer health outcomes, limiting ambitions to provide world-class research, education and equitable care

Staff Policies

Key workforce policies are held on the Trust's WeShare intranet site with accompanying guidance, support and forms to assist staff using these.

These policies include Human Rights, Equality and Diversity, and Recruitment and Selection policies which set out the process for ensuring fair employment, training and career development opportunities for individuals with protected characteristics.

Remuneration policies

For the purposes of this report, this section relates to substantive officers of the Trust whose remuneration is not governed by national policy, such as Agenda for Change terms and conditions, and specifically applies to voting and non-voting Trust Board members.

The Secretary of State for Health determines nationally the remuneration of the Chair and non-executive directors, with terms of appointment and renewal determined by NHS England.

Appointment and removal, remuneration, allowances and terms and conditions of office for executive directors (and the remuneration, allowances and terms and conditions of office for other defined senior officers) is determined by the Trust's Nominations and Remuneration Committee with due regard to national guidance.

Executive director performance against organisational and individual objectives is monitored through the formal appraisal process.

Annual salary increases are ordinarily in line with increases for the wider NHS workforce, but may be higher

where there is a significant change to an individual's responsibilities.

In order to attract high quality candidates to senior posts and to support retention, the Nominations and Remuneration Committee will:

- make decisions in the context of the current market
- take into account independently sourced benchmark data and analysis of pay within relevant NHS, private

health and non-healthcare markets

- compare pay with other staff on nationally agreed Agenda for Change and medical consultant terms and conditions.

Salaries & Allowances (Information Subject to Audit)

Note	Name and title	2024-25 Salary (bands of £5000) £000	Expense Payments (taxable) (to nearest £100) £00	Performance pay and Bonuses (bands of £5000) £000	Long term Performance pay and bonuses (bands of £5000) £000	All Pension-Related Benefits* (bands of £2,500) £000	Total (bands of £5000) £000
	Executive Directors						
1	Shane DeGaris, Group Chief Executive	300 to 305	0	0	0	47.5 to 50	350 to 355
2	Matthew Trainer, Group Deputy Chief Executive (to 06.11.2024)	0	0	0	0	0	0
3	Hardev Virdee, Group Chief Financial Officer	210 to 215	0	0	0	0	210 to 215
4	Caroline Alexander CBE, Group Chief Nurse	175 to 180	0	0	0	0	175 to 180
	Andrew Hines, Director of Group Development	170 to 175	0	0	0	7.5 to 10	180 to 185
	Rebecca Carlton, Group Chief Operating Officer	175 to 180	0	0	0	25 to 27.5	200 to 205
	Daniel Waldron, Group Director of People	180 to 185	0	0	0	32.5 to 35	215 to 220
5	Ajit Abraham, Group Director of Inclusion and Equity	230 to 235	0	0	0	185 to 187.5	420 to 425
5	Professor Alistair Chesser, Group Chief Medical Officer	260 to 265	0	0	0	195 to 197.5	460 to 465
	Ann Hepworth, Director of Strategy and Partnerships (from 23.07.2024)	115 to 120	0	0	0	50 to 52.5	170 to 175
	Dr Neil Ashman, Chief Executive, Royal London and Mile End	235 to 240	0	0	0	72.5 to 75	310 to 315
4	Professor Charles Knight, Chief Executive, St Bartholomew's Hospital	190 to 195	0	0	0	0	190 to 195
3	Simon Ashton, Chief Executive, Newham	170 to 175	0	0	0	0	170 to 175
	Dr Amanjit Jhund, Chief Executive, Whipps Cross	170 to 175	0	0	0	45 to 47.5	215 to 220
	Non Executive Directors						
6	Rt Hon Jacqui Smith, Chair (to 08.07.2024)	10 to 15	0	0	0	0	10 to 15
	Professor Ian Jacobs, Chair (from 01.03.2025)	5 to 10	0	0	0	0	5 to 10
	Adam Sharples, Non-Executive Director, Acting Chair (from 08.07.2024 to 28.02.25) and Vice Chair	45 to 50	0	0	0	0	45 to 50
7	Dr Kathy McLean OBE, Non-Executive Director (to 30.06.2024)	0 to 5	4	0	0	0	0 to 5
8	Professor Hilary Thomas, Non-Executive Director (from 01.07.2024)	5 to 10	0	0	0	0	5 to 10
	Kim Kinnaird, Non-Executive Director	15 to 20	0	0	0	0	15 to 20
9	Professor Sir Mark Caulfield, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
9	Lesley Seary CBE, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Joni Ferns, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Helen Spice, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Clyde Williams, Associate Non Executive Director	10 to 15	0	0	0	0	10 to 15
	Sarah Teather, Associate Non Executive Director	10 to 15	0	0	0	0	10 to 15
10	Siva Anandaciva, NExT Director (from 06.01.2025)	0	0	0	0	0	0

Note 1: The Group Chief Executive had shared responsibility for both Barts Health NHS Trust and Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) until 06.11.2024. The salary shown above was paid in full by Barts Health NHS Trust, and there were no salary recharge arrangements with BHRUT.

Note 2: The Group Deputy Chief Executive had shared responsibility for both Barts Health NHS Trust and BHRUT until 06.11.2024. This officer was appointed and paid in full by BHRUT, and there were no salary recharge arrangements with Barts Health NHS Trust. The salary banding of this director was £160k to £165k for his time as a joint board member until 06.11.2024 during the 2024-25 financial year.

Note 3: Where the Pension Related Benefits (PRB) calculation results in a negative figure, a nil figure is reported, which is the case for this director. Please see explanatory note below, which provides a brief summary of how the PRB figure is calculated.

Note 4: The Pension Related Benefits figures for these Executive Directors are nil, as they do not contribute to the NHS Pensions Scheme.

Note 5: The Pension Related Benefits for these directors is high because an increase in pay results in a large movement in the overall value of the estimated pension entitlement. The Pension Related Benefits figure does not represent an amount that will be received by the individual, and is calculated as per the formula in the Finance Act 2004. Please refer to the explanatory note below, and the 2024-25 Pensions table.

Note 6: The Trust Chair post was shared jointly with BHRUT until 08.07.2024. The salary cost in the table above represents Barts Health NHS Trust's 50% share of these costs for her time in post. The total salary across both trusts for the period to 08.07.2024 was in the banding £20k to £25k.

Note 7: This Non-Executive Director post was shared jointly with BHRUT. The salary costs in the table above represents Barts Health NHS Trust's 50% share of these costs. The total salary across both trusts was in the banding £5k to £10k. Taxable travel expense payments of £388 were paid in 2024-25, and is shown in hundreds, and not thousands, in line with reporting requirements.

Note 8: This Non-Executive Director post is shared jointly with BHRUT. The salary costs in the table above represents Barts Health NHS Trust's 50% share of these costs. The total salary across both trusts is in the banding £15k to £20k.

Note 9: These Non-Executive Director posts are shared jointly with BHRUT. The salary costs in the table above represents Barts Health NHS Trust's 50% share of these costs. The total salary for each individual across both trusts is in the banding £20k to £25k.

Note 10: Siva Anandaciva is an unpaid NExT Director. The NExT Director Scheme is a development programme created and designed to help find and support the next generation of talented people from groups who are currently under-represented on NHS boards.

***Pension-Related Benefits**

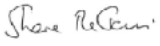
The value of pension benefits accrued during the year is calculated according to the formula set out in the Finance Act 2004, and is the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The Pensions table provides further information on the pension benefits accruing to the individual.

Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a "zero" should be substituted for any negative figures.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits;
- A change in the pension scheme itself;
- Changes in the contribution rates;
- Changes in the wider remuneration package of an individual.

There are no entries in respect of pensions for non-executive members, as they do not receive pensionable remuneration.



Shane DeGaris, Group Chief Executive

18 June 2025

Date

Note	Name and title	2023-24 Salary	Expense Payments (taxable)	Performance pay and Bonuses	Long term Performance pay and bonuses	All Pension-Related Benefits*	Total
		(bands of £5000)	(to nearest £100)	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5000)
		£000	£00	£000	£000	£000	£000
	Executive Directors						
1	Shane DeGaris, Group Chief Executive	285 to 290	0	0	0	165 to 167.5	450 to 455
2	Matthew Trainer, Group Deputy Chief Executive	0	0	0	0	0	0
3	Professor Alistair Chesser, Group Chief Medical Officer	250 to 255	0	0	0	0	250 to 255
3	Rebecca Carlton, Group Chief Operating Officer	165 to 170	0	0	0	0	165 to 170
4	Caroline Alexander CBE, Group Chief Nurse	170 to 175	0	0	0	0	170 to 175
	Hardev Virdee, Group Chief Financial Officer	205 to 210	0	0	0	22.5 to 25	230 to 235
	Daniel Waldron, Group Director of People	170 to 175	0	0	0	45 to 47.5	215 to 220
5	Mark Turner, Interim Group Director of Strategy (to 30.09.2023)	80 to 85	0	0	0	0	80 to 85
3	Andrew Hines, Director of Group Development	165 to 170	0	0	0	0	165 to 170
3	Ajit Abraham, Group Director of Inclusion and Equity	200 to 205	0	0	0	0	200 to 205
6	Dr Amanjit Jhund, Chief Executive, Whipps Cross (from 01.09.2023)	90 to 95	0	0	0	100 to 102.5	195 to 200
3	Simon Ashton, Chief Executive, Newham (from 01.09.2023)	90 to 95	0	0	0	0	90 to 95
3	Dr Neil Ashman, Chief Executive, Royal London and Mile End (from 01.09.2023)	125 to 130	0	0	0	0	125 to 130
4	Professor Charles Knight, Chief Executive, St Bartholomew's Hospital (from 01.09.2023)	155 to 160	0	0	0	0	155 to 160
	Non Executive Directors						
7	Rt Hon Jacqui Smith, Chair	40 to 45	0	0	0	0	40 to 45
	Adam Sharples, Non-Executive Director and Vice Chair	20 to 25	0	0	0	0	20 to 25
8	Dr Kathy McLean OBE, Non-Executive Director	10 to 15	7	0	0	0	10 to 15
	Kim Kinnaird, Non-Executive Director	15 to 20	0	0	0	0	15 to 20
9	Professor Sir Mark Caulfield, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
9	Lesley Seary CBE, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Joni Ferns, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Helen Spice, Non-Executive Director	10 to 15	0	0	0	0	10 to 15
	Clyde Williams, Associate Non Executive Director	10 to 15	0	0	0	0	10 to 15
	Sarah Teather, Associate Non Executive Director	10 to 15	0	0	0	0	10 to 15

Note 1: The Group Chief Executive officer has shared responsibility as Group Chief Executive with Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT). There are no shared remuneration or recharge arrangements. The salary shown above was paid in full by Barts Health NHS Trust.
The "Pension-Related Benefits" does not represent an amount that will be received by the individual, and is high because an increase in pay results in a large movement, as calculated by the formula set out in the Finance act 2004. Please see explanatory note below, and the 2023-24 Pensions table.
Note 2: The Group Deputy Chief Executive is appointed by BHRUT, and has shared responsibility as Group Deputy Chief Executive with Barts Health. There are no shared remuneration or salary recharge arrangements. The salary banding of this director was £235k to £240k, and was paid in full by BHRUT.
Note 3: Where the Pensions Related Benefits calculation results in a negative figure, a nil figure is reported, which is the case for this director. Please see explanatory note below, which provides a brief summary of how the figure is calculated.

Note 4: The Pension-Related Benefits figures for these Executive Directors are nil, as they do not contribute to the NHS Pensions Scheme.

Note 5: The Interim Group Director of Strategy opted out of the NHS Pensions Scheme in the middle of 2022-23, hence the Pensions Related Benefits figure is shown as zero in 2023-24.

Note 6: The Pensions-Related Benefits for this director is high because an increase in pay results in a large movement in the overall value of the estimated pension entitlement. The "Pension-Related Benefits" does not represent an amount that will be received by the individual, and is calculated as per the formula in the Finance Act 2004. Please refer to the explanatory note below, and the 2023-24 Pensions table.
Note 7: The Trust Chair post is shared jointly with BHRUT. The salary cost in the table above represents Barts' 50% share of these costs. The total salary across both trusts is in the banding £80k to £85k.

Note 8: This Non-Executive Director post is shared jointly with BHRUT. The salary costs in the table above represents Barts' 50% share of these costs. The total salary across both trusts is in the banding £20k to £25k.
Expense payments (taxable benefits) are shown in hundreds, and not thousands, in line with reporting requirements. The expense payment is £655, and relates to travel expenses.

Note 9: These Non-Executive Director posts are shared jointly with BHRUT. The salary costs in the table above represents Barts' 50% share of these costs. The total salary for each individual across both trusts is in the banding £20k to £25k.

***Pension-Related Benefits**

The value of pension benefits accrued during the year is calculated according to the formula set out in the Finance Act 2004, and is the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Where there has been only a small increase in pension and lump sum benefits current year compared to last year, this formula can sometimes generate a negative figure. Where this is the case, Department of Health guidance states that a "zero" should be substituted for any negative figures.
Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits;
- A change in the pension scheme itself;
- Changes in the contribution rates;
- Changes in the wider remuneration package of an individual.

There are no entries in respect of pensions for non-executive members, as they do not receive pensionable remuneration.

Pensions Table (Information Subject to Audit)

2024/25									
Note	Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31st March 2025	Lump sum at pension age related to accrued pension at 31st March 2025	Cash equivalent transfer value at 1st April 2024	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2025	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
		£000	£000	£000	£000	£000	£000	£000	£000
1	Shane DeGaris, Group Chief Executive	2.5 to 5	0	100 to 105	35 to 40	1,541	51	1,733	0
1	Hardev Virdee, Group Chief Financial Officer	0 to 2.5	0	75 to 80	190 to 195	1,544	0	1,668	0
1	Andrew Hines, Director of Group Development	0 to 2.5	0	65 to 70	175 to 180	1,439	15	1,572	0
1	Rebecca Carlton, Group Chief Operating Officer	2.5 to 5	0	55 to 60	145 to 150	1,165	28	1,293	0
2	Daniel Waldron, Group Director of People	2.5 to 5	0	45 to 50	0	684	29	781	0
	Ajit Abraham, Group Director of Inclusion and Equity	7.5 to 10	17.5 to 20	55 to 60	140 to 145	1,119	210	1,429	0
1 & 3	Professor Alistair Chesser, Group Chief Medical Officer	10 to 12.5	17.5 to 20	125 to 130	340 to 345	2,787	0	251	0
	Ann Hepworth, Director of Strategy and Partnerships (from 23.07.2024)	0 to 2.5	0 to 2.5	30 to 35	50 to 55	562	28	662	0
	Dr Neil Ashman, Chief Executive, Royal London and Mile End	2.5 to 5	2.5 to 5	75 to 80	200 to 205	1,644	91	1,868	0
1	Simon Ashton, Chief Executive, Newham	0 to 2.5	0	50 to 55	130 to 135	1,055	0	1,144	0
2	Dr Amanjit Jhund, Chief Executive, Whipps Cross	2.5 to 5	0	20 to 25	0	226	25	287	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Note 1: Where the real increase in pension, lump sum or cash equivalent transfer value results in a negative figure, a zero is reported, which is the case for these directors. This is consistent with the guidance for negative figures in the DHSC's Group Accounting Manual and in the NHS Business Services Authority's Greenbury guidance. Some of these directors are affected by the Public Service Pension Scheme Remedy (see below)

Note 2: These officers are in the 2015 Scheme, under which taking a lump sum on retirement is optional, therefore lump sum figures have not been provided by NHS Pensions.

Note 3: This officer is over the Normal Retirement Age for the 1995 Scheme, therefore the CETV figure as at 31 March 2025 relates only to the 2015 Scheme, which has a later retirement age.

The Public Service Pension Scheme Remedy (McCloud)

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called "rollback".

Where a member is affected by rollback the benefits in respect of their rolled back pensionable service during the remedy period are valued as being in the 1995/2008 Scheme. Where this results in negative real increase in pension, lump sum or CETV the negative figures must not be shown and a zero must be substituted. This is consistent with the guidance for negative figures in the DHSC's Group Accounting Manual and in the NHS Business Services Authority's Greenbury guidance.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

2023/24									
Note	Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31st March 2024	Lump sum at pension age related to accrued pension at 31st March 2024	Cash equivalent transfer value at 1st April 2023	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2024	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
		£000	£000	£000	£000	£000	£000	£000	£000
	Shane DeGaris, Group Chief Executive	10 to 12.5	0 to 2.5	90 to 95	35 to 40	1,047	350	1,541	0
1	Professor Alistair Chesser, Group Chief Medical Officer	0	55 to 57.5	110 to 115	300 to 305	2,265	250	2,787	0
1	Rebecca Carlton, Group Chief Operating Officer	0	40 to 42.5	50 to 55	140 to 145	858	199	1,165	0
1	Hardev Virdee, Group Chief Financial Officer	0	57.5 to 60	65 to 70	185 to 190	1,086	321	1,544	0
2	Daniel Waldron, Group Director of People	2.5 to 5	0	40 to 45	0	467	147	684	0
1	Andrew Hines, Director of Group Development	0	37.5 to 40	60 to 65	170 to 175	1,108	197	1,439	0
1	Ajit Abraham, Group Director of Inclusion and Equity	0	20 to 22.5	45 to 50	115 to 120	953	48	1,119	0
2	Dr Amanjit Jhund, Chief Executive, Whipps Cross (from 01.09.2023)	2.5 to 5	0	15 to 20	0	114	46	226	0
1	Simon Ashton, Chief Executive, Newham (from 01.09.2023)	0 to 2.5	0	45 to 50	130 to 135	964	0	1,055	0
1	Dr Neil Ashman, Chief Executive, Royal London and Mile End (from 01.09.2023)	0	25 to 27.5	65 to 70	185 to 190	1,336	87	1,644	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Note 1: Where the real increase in pension, lump sum or cash equivalent transfer value results in a negative figure, a zero is reported, which is the case for these directors. This is consistent with the guidance for negative figures in the DHSC's Group Accounting Manual and in the NHS Business Services Authority's Greenbury guidance. Some of these directors are affected by the Public Service Pension Scheme Remedy (see below)

The Public Service Pension Scheme Remedy (McCloud)

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called "rollback".

Where a member is affected by rollback the benefits in respect of their rolled back pensionable service during the remedy period are valued as being in the 1995/2008 Scheme. Where this results in negative real increase in pension, lump sum or CETV the negative figures must not be shown and a zero must be substituted. This is consistent with the guidance for negative figures in the DHSC's Group Accounting Manual and in the NHS Business Services Authority's Greenbury guidance.

Note 2: These officers are in the 2015 Scheme, under which taking a lump sum on retirement is optional, therefore lump sum figures have not been provided by NHS Pensions.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Register of Interests - Directors

Title	Organisation of Interest	Description of Interest	Interest Start	Interest End
Non-Executive Directors				
Rt Hon Jacqui Smith	Jo Cox Foundation	Chair	01/10/2021	06/07/2024
	UCL Partners	Board member	01/10/2021	26/07/2024
	Sandwell Children's Trust	Chair	01/10/2021	06/07/2024
	King's Fund	Trustee	01/10/2021	
	Jacqui Smith Advisory Ltd	Director	01/10/2021	
	Flint Global	Specialist Partner	01/10/2023	
	Dalgety Ltd	Director	01/10/2021	06/07/2024
	Barking, Havering & Redbridge NHS Trust	Chair in Common	01/10/2021	08/07/2024
	Barts Charity	Trustee	01/10/2021	
Professor Ian Jacobs	City and St George's University of London	Chair of Governing Council	04/02/2025	
	Eve Appeal	Trustee and Chair Research Committee	04/02/2025	
	University College London	Honorary Professor	04/02/2025	
	University of New South Wales	Emeritus Professor	04/02/2025	
	Women's Health Specialists Ltd	Director and consultancy advisor	04/02/2025	
	Barts Charity	Trustee	04/02/2025	
Ms Lesley Seary CBE	Lesley Seary Ltd		01/02/2022	
	Zen Housing Ltd	Chair	01/02/2022	
	The Big House	Trustee	01/02/2022	
	Barking, Havering and Redbridge NHS Trust	Non Executive Director	01/02/2022	
Professor Mark Caulfield	UCL Partners	Board Member	13/04/2023	
	Barking, Havering and Redbridge NHS Trust	Non-Executive Director	13/04/2023	
	United Arab Emirates government	Genomics - consultancy advice	01/07/2021	
	The British Pharmacological Society	President	13/04/2023	
	Queen Mary University of London	Vice Principal (Health)	01/01/2022	
	Medical Schools Council	Member Medical Schools Council	13/04/2023	
	Medical Research Council	Medical Research Council (MRC) grant funding for research.	13/04/2023	
	Global Alliance for Genomic Health	Co-Chair, Genomic Healthcare Implementation Forum	01/07/2021	
	Barts Charity	Board Member	13/04/2023	
	Barts Health NHS Trust	Grant funding		
	Medcity	Non-Executive Director for the MedCity Board	13/04/2023	
Dr Kathy McLean OBE	Derby and Burton University Hospitals NHS FT	Chair	01/08/2019	30/04/2024
	Derby and Derbyshire ICB	Chair	01/05/2024	
	Barking, Havering and Redbridge NHS Trust	Non Executive Director	01/08/2022	30/06/2024
	Public Services Consultancy	Senior Clinical Advisor	01/09/2019	
	Oxehealth	Member of Advisory Board	01/04/2022	
	Nottingham and Nottinghamshire ICB and ICP	Chair	01/02/2021	
	NHS Providers	Trustee/Director on NHS Providers Board	24/06/2021	01/05/2024
	NHS Employers	Policy board member	24/06/2021	
	Kathy McLean Limited	Private limited company to offer health related advice	04/09/2019	
Mr Clyde Williams	ShoNet Ltd		11/09/2020	
Ms Kim Kinnaird	TMB Plc	Director	25/07/2023	
	Lloyds Banking Group	Full-time Employment	01/03/2010	
Ms Sarah Teather	Kidscape	Interim CEO	11/03/2025	
	Jesuit Refugee Service UK	Director	08/07/2022	
Miss Joni Nelson-Ferns	Sigma Labs XYZ	Chief Operating Officer	01/08/2023	
Mr Adam Sharples	New Economics Foundation	Chair	14/08/2024	
Ms Helen Spice	Great Western Hospitals NHS Foundation	Non Executive Director	01/04/2021	
	Make a Wish Foundation	Non Executive Director	03/02/2020	
	Mental Health and Employment Partnership	Non Executive Director	17/05/2017	
Professor Hilary Thomas	PA Consulting Ltd	Director	01/07/2025	
	Barking, Havering and Redbridge NHS Trust	Non Executive Director	01/07/2025	
Mr Siva Anandaciva	King's Fund	Director; member of the Office of Health Economics policy committee; the steering group of the BRACE Rapid Evaluation Centre; and an expert advisor	01/01/2025	
Executive Directors				
Professor Charles Knight	National Heart and Lung Institute	Trustee	08/03/2021	
	Culture Mile BID	Trustee	04/01/2023	
	Barts Heritage Trust	Trustee	01/05/2017	
Ms Caroline Alexander	Foundation of Nursing Studies (FONS)	Trustee	01/02/2019	
Mr Shane DeGaris	Barking, Havering and Redbridge NHS Trust	Group Chief Executive	01/09/2022	01/11/2024
	UCL Partners	Board member	09/07/2024	
Mr Hardev Virdee	CIPFA	Chair - Workforce forum	01/08/2021	
	Public Finance and Management Board	Member	01/08/2021	27/03/2025
	Power to Change	Trustee	01/06/2022	
	Equality and Inclusion Board	Member	01/08/2021	
	King's Fund	Member - General Advisory Council	01/01/2020	
Dr Amanjit Singh Jhund	Faculty of Public Health	Board member (lay member)	19/10/2022	
	Labour Party	Member of the UK Labour Party and former parliamentary	01/08/2008	
	University of East London	Independent Governor	07/07/2022	
Mr Matthew Trainer	Barking, Havering and Redbridge NHS Trust	Chief Executive	01/08/2021	
Mr Daniel Waldron	NEL Health and Care Partnership	System Workforce Lead	01/12/2024	
Ms Ann Hepworth	Advantage Mentoring CIC	Director	20/06/2024	
Professor Alistair Chesser	No Interests Declared			
Dr Neil Ashman	No Interests Declared			
Mr Ajit Abraham	No Interests Declared			
Mr Simon Ashton	No Interests Declared			
Mr Andrew Hines	No Interests Declared			
Ms Rebecca Carlton	No Interests Declared			

Senior Manager (Board Member) numbers by salary band

A number of the Board Members in the table below were in post for only part of the financial year 2024-25 (please refer to the Salaries table), and hence their salary bandings in the table below reflect their part year salaries only.

Band	Number of senior managers
£0 - £5,000	3
£5,001 - £10,000	2
£10,001 - £15,000	7
£15,001 - £20,000	1
£45,000 - £50,000	1
£115,000 - £120,000	1
£170,000 - £175,000	3
£175,001 - £180,000	2
£180,001 - £185,000	1
£190,000 - £195,000	1
£210,000 - £215,000	1
£230,000 - £235,000	1
£235,001 - £240,000	1
£260,000 - £265,000	1
£300,000 - £305,000	1
Total	**27**

Composition of Senior Managers (Board Members) by Gender

Gender	Headcount	%
Female	11	41%
Male	16	59%
Total	**27**	**100%**

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

In 2024-25 and 2023-24, there were no such compensation payments.

Payments to past directors (Information Subject to Audit)

In 2024-25 and 2023-24, there were no such payments.

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

The Government Financial Reporting Manual (FReM) requires NHS trusts to disclose the median remuneration and the ratio between median remuneration and the banded remuneration of the highest paid director.

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

These requirements are reported below, and a glossary to explain some of the technical terms used in this disclosure is also included.

a. The percentage change in remuneration of the highest paid director (mid point)

	2024-25	2023-24	Change (%)
Salary Component **mid-point** of highest paid director **(£)**	302,500	287,500	5.2

In 2024-25, there was an increase of 5.2% from the last financial year in the remuneration of the highest paid director using the mid-point of the salary banding. The actual increase of the highest paid director was 5% exactly, which is in line with national NHS guidance on the annual pay award of Very Senior Managers.

No performance related pay or bonuses were paid to the highest paid director in both 2024-25 and 2023-24 financial years.

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

	2024-25	2023-24	Change (%)
Average Pay (£)	49,201	46,344	6.2

None of the employees of the Trust received performance related pay or bonuses in 2024-25, nor in 2023-24.

In 2024-25, there was an increase of 6.2% from 2023-24 in the average percentage change in the remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees).

This was driven by the pay awards for agenda for change (AfC), medical and dental staff group, junior doctors, and the introduction of an intermediate pay point for bands 8a upwards.

c. The range of staff remuneration

The remuneration of all staff (excluding pension benefits), and including the highest paid director, ranged from the bands £10k-£15k to £300k-£305k.

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

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

	2024-25	2023-24
	£	£
25th percentile	31,088	29,468
Median	43,780	41,497
75th percentile	56,698	53,742

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

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

The banded remuneration of the highest paid director / member in Barts Health NHS Trust in the financial year 2024-25 was £300k to £305k (2023-24, £285k to £290k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

	2024-25		2023-24	
	£	Highest Paid Director: Ratio	£	Highest Paid Director: Ratio
25th percentile	31,088	9.7	29,468	9.8
Median	43,780	6.9	41,497	6.9
75th percentile	56,698	5.3	53,742	5.3

g. The highest paid director

In 2024-25, no individual received remuneration in excess of the highest paid Director (none in 2023-24).

Remuneration ranged from the bands £10k-£15k to £300k-£305k (2023-24: £10k-£15k to £285k-£290k).

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

Glossary

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

Staff Costs (Information Subject to Audit)

	2024/25			2023/24		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000s	£000s	£000s	£000s	£000s	£000s
Salaries and wages	**1,230,189**	1,230,189		**1,121,728**	1,121,728	
Social Security costs	**134,457**	134,457		**125,850**	125,850	
Apprenticeship levy	**6,112**	6,112		**5,730**	5,730	
NHS Pensions Scheme	**216,848**	216,848		**168,887**	168,887	
Pension cost - other	**178**	178		**183**	183	
Termination Benefits	**1,170**	1,170		**390**	390	
Temporary staff	**39,413**		39,413	**56,835**		56,835
Total	**1,628,367**	**1,588,954**	**39,413**	**1,479,603**	**1,422,768**	**56,835**
Less: costs capitalised as part of assets	**6,664**	6,664		**5,761**	5,761	0
Less: costs recharged to other bodies	**20,145**	20,145		**19,012**	19,012	0
Total	**1,601,558**	**1,562,145**	**39,413**	**1,454,830**	**1,397,995**	**56,835**

Staff numbers (Information Subject to Audit)

	2024/25			2023/24		
Average staff numbers	Total	Permanently employed	Other	Total	Permanently Employed	Other
Medical and dental	**3,339**	2,972	367	**3,208**	2,812	396
Administration and estates	**6,285**	5,567	718	**6,053**	5,444	609
Healthcare assistants and other support staff	**2,258**	1,691	567	**2,231**	1,716	515
Nursing, midwifery and health visiting staff	**6,944**	5,728	1,216	**6,664**	5,398	1,266
Scientific, therapeutic and technical staff	**2,592**	2,360	232	**2,421**	2,239	182
Healthcare Science Staff	**840**	714	126	**908**	713	195
Total	**22,258**	**19,032**	**3,226**	**21,485**	**18,322**	**3,163**
Of the above - staff engaged on capital projects	**74**	59	15	**69**	54	15

Staff composition (as at 31st March 2025)

Gender	Headcount	%
Female	15,149	70%
Male	6,462	30%
Total	**21,611**	**100%**

Sickness absence data

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

	Calendar Year 2024	Calendar Year 2023
Total days lost	193,980	184,410
Total staff years	19,672	18,594
Average working days lost (per WTE)	**9.9**	**9.9**

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

Additional information can also be found at this link to the NHS Digital publication series on NHS sickness absence rates:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Turnover Percentage

Up to date information on Barts Health NHS Trust's staff turnover figures can be found at the link below to the NHS Digital publication series on NHS staff turnover rates.
The series is an official statistics publication complying with the UK Statistics Authority's Code of Practice. Data is provided for a number of staff groups.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Engagement Percentage Score

The NHS Staff Survey is an important indicator of the health and well-being of our staff.

Despite the NHS facing huge challenges in the past couple of years, more staff than ever shared their views, with 10,152 responses to the NHS Staff Survey being received.

Our response rate is shown below, with the median response rate being 49% (all Acute & Acute and Community Trusts).

2024	2023
49%	43%

Further information on the areas where we performed well, and interactive tools can be found at: https://www.nhsstaffsurveys.com/

Trade Union Facility Time

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

Relevant Union Officials

	2024-25	2023-24
Number of employees who were relevant union officials during 2024/25	**Full-time equivalent employee number**	**Full-time equivalent employee number**
183	172.5	141.9

Percentage of Union Officials time spent on facility time:

	2024-25	2023-24
Percentage of time	**Number of Employees**	**Number of Employees**
0%	101	52
1-50%	81	47
51-99%	0	0
100%	1	1

Percentage of pay bill spent on facility time:

	2024-25	2023-24
	Figures	**Figures**
Total cost of facility time	£167,156	£115,070
Total pay bill	£1,628,367,000	£1,479,603,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.010%	0.008%

Paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	**2024-25**	**2023-24**
Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours x 100	30.62%	28.49%

Exit Packages (Information Subject to Audit)

	2024-25							
	Compulsory Redundancies		Other Departures (see table below)		Total Exit Packages		Special Payments	
Exit package cost band (including any special payment element)	Number	£000s	Number	£000s	Number	£000s	Number	£000s
Less than £10,000	1	6	40	169	**41**	**175**	0	0
£10,000 - £25,000	7	116	7	112	**14**	**228**	0	0
£25,001 - £50,000	5	183	5	163	**10**	**346**	0	0
£50,001 - £100,000	7	421	0	0	**7**	**421**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Totals	**20**	**726**	**52**	**444**	**72**	**1,170**	**0**	**0**

	2023-24							
	Compulsory Redundancies		Other Departures (see table below)		Total Exit Packages		Special Payments	
Exit package cost band (including any special payment element)	Number	£000s	Number	£000s	Number	£000s	Number	£000s
Less than £10,000	0	0	51	199	**51**	**199**	1	3
£10,000 - £25,000	0	0	7	94	**7**	**94**	2	26
£25,001 - £50,000	0	0	0	0	**0**	**0**	0	0
£50,001 - £100,000	1	97	0	0	**1**	**97**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Totals	**1**	**97**	**58**	**293**	**59**	**390**	**3**	**29**

There were no “Special Payments (departures)” in 2024/25 (three in 2023/24).

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

Analysis of Other Departures

2024-25		
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	42	314
Exit payments following Employment Tribunals or court orders	10	130
Non-contractual payments requiring HMT approval**	0	0
Total	**52**	**444**

2023-24		
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	26	132
Exit payments following Employment Tribunals or court orders	29	132
Non-contractual payments requiring HMT approval**	3	29
Total	**58**	**293**

* Any non-contractual payments in lieu of notice are disclosed under “Non-contractual payments requiring HMT approval” below.

**Includes any non-contractual severance payment made following judicial mediation.

Consultancy expenditure (Information Subject to Audit)

	2024-25	2023-24
Consultancy expenditure charged to operating expenses	**£000s**	**£000s**
Consultancy services	852	2,850

Off-payroll Engagements

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

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

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

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

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

	31-Mar-25	31-Mar-24
The number of existing engagements as of 31 March	**8**	**13**
Of which, the number that have existed:		
- for less than 1 year at the time of reporting	3	5
- for between 1 and 2 years at the time of reporting	0	3
- for between 2 and 3 years at the time of reporting	2	2
- for between 3 and 4 years at the time of reporting	2	3
- for 4 or more years at the time of reporting	1	0

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

	2024-25	2023-24
Total number of temporary off-payroll engagements engaged during the financial year	**16**	**37**
Of which, the number:		
- not subject to off-payroll legislation	3	24
- subject to off-payroll legislation and determined as in scope of IR35	0	0
-subject to off-payroll legislation and determined as out of scope of IR35	13	13
The number of engagements reassessed for compliance or assurance purposes during the year	5	1
Of which: number of engagements that saw a change to IR35 status following review	0	0

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

	2024-25	2023-24
The number of **off-payroll** engagements of board members, and /or senior officers with significant financial responsibility, during the financial year	0	0
Total number of individuals on payroll and off-payroll that have been deemed “board members, and / or, senior officials with significant financial responsibility”, during the financial year. **This figure includes both on payroll and off-payroll engagements.**	27	24

Annual Accounts

2024 - 2025

For the year ended
31 March 2025

Statement of Directors' Responsibilities in Respect of the Accounts

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

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

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess Barts Health NHS Trust's performance, business model and strategy.

By order of the Board

18 June 2025

Shane DeGaris
Group Chief Executive

18 June 2025

Hardev Virdee
Group Chief Finance Officer

Independent auditor's report to the Directors of Barts Health NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Barts Health NHS Trust ('the Trust') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2024/25 as contained in the Department of Health and Social Care Group Accounting Manual 2024/25, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended:
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities 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 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, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

Other information

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

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2024/25 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Independent auditor's report to the Directors of Barts Health NHS Trust

Based on our understanding of the Trust, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), Mental Health Capacity Act, Mental Health Act, Access to Health Records Act, Children's Act and Health and Safety Act.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- inquiring with management and the Audit and Risk Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), Mental Health Capacity Act, Mental Health Act, Access to Health Records Act, Children's Act and Health and Safety Act.

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to expenditure recognition (which we pinpointed to the cut-off assertion), revenue recognition (which we pinpointed to the accuracy and occurrence assertions), and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management, Head of Internal Audit and the Audit and Risk Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing;
- addressing the risk of fraud in revenue recognition by performing appropriate sample testing of revenue; and
- addressing the risk of fraud in expenditure recognition by performing appropriate sample testing of expenditure.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit and Risk Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2024, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2025:

Significant weakness in arrangements	Recommendation
Governance and improving economy, efficiency and effectiveness – Whipps Cross University Hospital treatment of disease, disorder or injury In August 2024, the Trust received a section 29A warning notice from the Care Quality Commission (CQC) on the quality of health care provided by Whipps Cross University Hospital for the regulated activities: treatment of disease, disorder or injury. In our view this is evidence of a significant weakness in the governance and improving economy, efficiency and effectiveness reporting criteria.	We recommend that the Trust continues to progress implementing the action plan put in place following the August 2024 section 29A warning notice and ensure that this reflects the delay in the redevelopment of the Whipps Cross site.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 (as amended) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Independent auditor's report to the Directors of Barts Health NHS Trust

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

· the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

· in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
· we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
· we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
· we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Matters to be reported on by exception – Referral to the Secretary of State

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

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

Considering the 'Statutory breakeven duty: a guide for NHS trusts' issued in April 2018, we have reason to believe that Barts Health NHS Trust has breached its breakeven duty for the period ending 31 March 2025 (requiring a referral under section 30(a) of the 2014 Act) and have begun a course of action that will breach the same duty for the period ending 31 March 2025 (requiring a referral under section 30(b) of the 2014 Act).

Use of the audit report

This report is made solely to the Board of Directors of Barts Health NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Suresh Patel
Key Audit Partner
For and on behalf of Forvis Mazars
30, Old Bailey,
Forvis Mazars,
EC4M 7AU
19 June 2025

Statement of Comprehensive Income

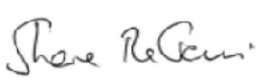
	Note	2024-25 £000	2023-24 £000
Operating income from patient care activities	7	2,404,579	2,177,469
Other operating income	8	247,560	217,472
Operating expenses	10	(2,567,444)	(2,372,157)
Operating surplus/(deficit)		**84,695**	**22,784**
Finance income	14	5,021	5,714
Finance expenses	15	(136,063)	(268,261)
Net finance costs		**(131,042)**	**(262,547)**
Other gains / (losses)	16	295	177
Surplus / (deficit) for the year	2	**(46,052)**	**(239,586)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	11	(8,069)	(19,397)
Revaluations	18 & 19	29,370	12,875
Total comprehensive income / (expenditure) for the period		**(24,751)**	**(246,108)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	17	6,853	82
Property, plant and equipment	18	1,578,914	1,545,914
Right of use assets	19	34,482	35,669
Receivables	21	16,111	16,268
Total non-current assets		**1,636,360**	**1,597,933**
Current assets			
Inventories	20	37,366	34,112
Receivables	21	139,182	140,808
Cash and cash equivalents	22	46,337	34,373
Total current assets		**222,885**	**209,293**
Current liabilities			
Trade and other payables	23	(327,310)	(295,153)
Borrowings	25	(63,634)	(61,702)
Provisions	26	(3,731)	(10,596)
Other liabilities	24	(11,301)	(9,341)
Total current liabilities		**(405,976)**	**(376,792)**
Total assets less current liabilities		**1,453,269**	**1,430,434**
Non-current liabilities			
Borrowings	25	(1,664,052)	(1,644,298)
Provisions	26	(5,343)	(5,218)
Total non-current liabilities		**(1,669,395)**	**(1,649,516)**
Total assets employed		**(216,126)**	**(219,082)**
Financed by			
Public dividend capital		1,133,084	1,105,377
Revaluation reserve		431,558	410,257
Income and expenditure reserve		(1,780,768)	(1,734,716)
Total taxpayers' equity		**(216,126)**	**(219,082)**

The notes on pages 67 to 95 form part of these accounts.

The financial statements on pages 63 to 95 were approved by the Trust Board on the 18 June 2025 and signed on its behalf by:



18 June 2025

Shane DeGaris, Group Chief Executive

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

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward		**1,105,377**	**410,257**	**(1,734,716)**	**(219,082)**
Surplus/(deficit) for the year	2	0	0	(46,052)	**(46,052)**
Impairments	11	0	(8,069)	0	**(8,069)**
Revaluations	18 & 19	0	29,370	0	**29,370**
Public dividend capital received		27,707	0	0	**27,707**
Taxpayers' equity at 31 March 2025		**1,133,084**	**431,558**	**(1,780,768)**	**(216,126)**

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

		Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' equity at 1 April 2023 - brought forward		**1,080,613**	**416,779**	**(900,937)**	**596,455**
Application of IFRS 16 measurement principles to PFI liabilities on 1 April 2023		0	0	**(594,193)**	**(594,193)**
Surplus/(deficit) for the year	2	0	0	(239,586)	**(239,586)**
Impairments	11	0	(19,397)	0	**(19,397)**
Revaluations	18 & 19	0	12,875	0	**12,875**
Public dividend capital received		24,764	0	0	**24,764**
Taxpayers' equity at 31 March 2024		**1,105,377**	**410,257**	**(1,734,716)**	**(219,082)**

Information about Reserves:

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

Statement of Cash Flows

	Note	2024-25 £000	2023-24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**84,695**	**22,784**
Non-cash income and expense:			
Depreciation and amortisation	10	80,262	77,552
Net impairments charged to operating expenses	10 & 11	15,701	26,168
Income recognised in respect of capital donations	8	(13,089)	(4,318)
(Increase) / decrease in receivables and other assets	21	1,170	5,773
(Increase) / decrease in inventories	20	(3,254)	(2,698)
Increase / (decrease) in payables and other liabilities	23 & 24	34,453	11,114
Increase / (decrease) in provisions	26	(6,811)	7,072
Net cash generated from / (used in) operating activities		**193,127**	**143,447**
Cash flows from investing activities			
Interest received	14	5,021	5,714
Purchase of intangible assets		(7,093)	0
Purchase of property, plant, equipment		(88,659)	(79,066)
Sales of property, plant, equipment	16	295	177
Receipt of cash donations to purchase capital assets		3,914	0
Net cash flows from / (used in) investing activities		**(86,522)**	**(73,175)**
Cash flows from financing activities			
Public dividend capital received		27,707	24,764
Capital element of finance lease liabilities		(12,155)	(12,110)
Capital element of PFI service concessions	30	(50,390)	(48,657)
Other interest	15	0	(2)
Interest paid on finance lease liabilities	15	(502)	(383)
Interest paid on PFI service concessions	30	(59,914)	(58,984)
PDC dividend (paid) / refunded		613	(739)
Net cash generated from / (used in) financing activities		**(94,641)**	**(96,111)**
Increase / (decrease) in cash and cash equivalents		**11,964**	**(25,839)**
Cash and cash equivalents at 1 April - brought forward		**34,373**	**60,212**
Cash and cash equivalents at 31 March	22	**46,337**	**34,373**

1 Accounting policies and other information

1.1 Basis of preparation

The Department of Health and Social Care (DHSC) has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The 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 and right of use assets, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going concern

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

1.3 Joint Operations

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

In May 2021, Barts Health NHS Trust, Lewisham and Greenwich NHS Trust and Homerton University Hospital NHS Foundation Trust set up a shared pathology service, the NHS East and South East London Pathology Partnership, hosted by Barts Health NHS Trust. Its purpose is to provide patients and clinicians with a high-quality, cost-effective service that ensures the long-term sustainability of NHS pathology services. The arrangement is a joint operation as defined by IFRS11, with Barts Health NHS Trust accounting for its share of the assets, liabilities, income and expenses of the service.

1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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

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.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right: instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with 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 integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. 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 the trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research, education and training contracts

Where research, education and training contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS Injury Cost Recovery Scheme

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

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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Disposals

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Expenditure on Staff Costs

Short-term staff costs

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. The schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed 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 is 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. The contributions are charged to operating expenses as and when they become due.

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

National Employment Savings Trust (NEST)

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Schemes, they are entitled to join the National Employment Savings Trust (NEST) scheme.

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

1.8.1 Recognition

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

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

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

1.8.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (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 meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Works of Art are not depreciated as they are deemed to have an indefinite useful life.
Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

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

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

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

1.8.3 De-recognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are derecognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8.4 Donated and grant funded assets

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

1.8.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust.
Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition
In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI liabilities in 2023-24
IFRS 16 liability measurement principles were applied to PFI service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

1.8.6 Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	30	112
Dwellings	122	122
Plant & machinery	2	10
Information technology	5	10
Furniture & fittings	10	10

1.9 Intangible assets

1.9.1 Recognition

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following requirements of IAS 38 can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

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

1.9.2 Measurement

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

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

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

1.9.3 Useful economic life of intangible assets

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

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.12 Financial assets and financial liabilities

Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, 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. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

Expected credit losses are determined by review of individual receivables. As directed by the GAM, expected credit losses are not recognised in relation to other NHS bodies, nor Whole of Government Account (WGA) bodies, as these organisations are a very low credit risk.

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

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

Derecognition

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

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

1.13 Leases

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

1.13.1 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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

1.13.2 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.

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

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

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

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

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

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

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

1.15 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 27 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 28 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in Note 28, unless the probability of a transfer of economic benefits is remote.

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

1.17 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

1.18 Value added tax

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

1.19 Climate change levy

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

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 22.1 to the accounts in accordance with the requirements of HM Treasury's *FReM*.

1.21 Losses and special payments

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

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

1.22 Gifts

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

1.23 Early adoption of standards, amendments and interpretations

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

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2024-25:
- IFRS 17 Insurance Contracts: The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025-26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025-26 is not expected to have a material impact on the financial statements.
- IFRS 18 Presentation and Disclosure in Financial Statements: The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

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

1.25 Changes to non-investment asset valuation

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

Changes to the subsequent measurement of intangible assets and PPE classification / terminology are to be implemented for NHS bodies from 1 April 2025:
- the withdrawal of the revaluation model for intangible assets. The carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- the removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

The following changes to valuation cycles and methodology are to be implemented for NHS bodies in later periods:
- a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- the removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis.

The approach for land has not yet been finalised by HM Treasury.
The impact of applying these changes in future periods has not yet been assessed. PPE and right of use assets currently subject to revaluation have a total net book value of £1.4 billion as at 31 March 2025. Assets valued on an alternative site basis have a total book value of £319m as at 31 March 2025.
Although the impact has not yet been quantified, the revised valuation assumption may have a material or significant impact on PPE measurement in future periods.

1.26 Critical accounting judgements in applying accounting policies

Land & Buildings

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the service potential that those assets have.

In determining the MEA, the Trust has to make assumptions that are practically achievable, however the Trust is not required to have any plans to make such changes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because all staff are contracted to work across all sites, and the catchment area for patients using the services has been taken into account when deciding on an appropriate alternative site.

The Trust does not intend to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purpose of the MEA valuation, the Trust has defined all of St Bartholomew's Hospital and an element of the Royal London Hospital as buildings that provide specialist health care services. The MEA valuation in the accounts assumes that these services could theoretically be provided from a location in the London Borough of Waltham Forest, as all staff are contracted to work across all sites and the patients will need specialist healthcare which will only be available from specialist centres.

For the purpose of the MEA valuation, the Trust has assumed that the modern equivalent asset for Whipps Cross University Hospital would be a multi storey building, which would occupy less land.

For the purpose of the MEA valuation, the Trust has not included unused space, unused land, underutilised space and any space not used for healthcare purposes or required to directly support the delivery of healthcare, in the calculation of modern equivalent asset.

The MEA valuations used by the Trust have been provided to the Trust by the Valuation Office Agency. The Trust has used component lives based upon contractual information provided by the Valuation Office Agency to depreciate buildings and dwellings on a component basis.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) schemes where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

NHS East and South East London Pathology Partnership

The NHS East and South East London Pathology Partnership, hosted by Barts Health NHS Trust, is accounted for as a joint operation under IFRS 11. The three key elements stipulated in the standard for meeting the definition of a joint operation are an arrangement whereby (i) two or more parties have joint control (ii) there is a contractually agreed sharing of control, and (iii) decisions about the relevant activities of the arrangement require the unanimous consent of the parties sharing control. The Trust considered the relevant circumstances of the Pathology Partnership and decided it met these requirements, and this opinion was confirmed by external accounting advice, which was commissioned at the time the arrangement was entered into.

1.27 Key Sources of estimation uncertainty

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

Land and Buildings Valuations – Note 18

Land and Building assets were revalued at 31st March 2025. This valuation was carried out by Emma Curtis, MRICS, Principal Surveyor, DVS Property Services arm of the Valuation Office Agency using a Modern Equivalent Asset valuation methodology. The valuation methodology is set out in the RICS guidance, the Treasury FReM, Treasury Guidance on asset valuations and the IFRS (IAS16) guidance.

Non-Specialised Operational Assets

For those properties where there is market-based evidence to support the use of Existing Use Value (EUV) to arrive at Current Value (e.g. a residence, office or industrial property) the comparative method of valuation has been adopted.

Where a non-specialised property has been valued using the comparative method of valuation, the total value has been apportioned between its residual amount (the land) and depreciable amount (the remainder, effectively the building). Remaining life information has also been provided for the building. It is emphasised that these are informal apportionments produced solely for the purposes of depreciation accounting and do not represent formal valuations of the land and building elements. They should not be relied upon for any other purpose.

Specialised Operational Assets

These assets have been valued under depreciated replacement cost, using the Building Cost Information Service of RICS (BCIS) indices. The BCIS (all price) Tender Price Index (TPI) is based on the BCIS published estimate as at 7th March 2025. BCIS Location Factors are also applied to the national TPI, on a Borough or County specific basis.

The BCIS (all price) Tender Price index (TPI) figure adopted for the DRC valuation in 2024-25 is 399. This is based on the BCIS published estimate as at 7th March 2025. The final TPI figure of 399 is higher than last year's figure of 390, representing a 2.31% increase.

Sensitivity Analysis

Property asset valuations are provided by independent, qualified valuers. Valuations are subject to general price changes in property values across the UK. Asset values might vary from their real market value when assets are disposed of. A 1% variation in value would result in a £14m increase or decrease in the value of land & buildings, and a 5% variation would result in a £70m increase or decrease in the value of land & buildings.

The key assumptions that are most likely to affect the valuations are cost data. For specialised properties that are depreciated on a replacement cost basis, the valuer uses actual cost data where it is available, however this is adjusted to reflect price changes since the construction date, and any differences between these costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available, the valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were to increase by 2% (both locational weighting and BCIS costings), this would increase the value of specialised properties by £25m.

2 Breakeven duty financial performance

The Trust's performance against its Control Total and Breakeven Duty is set out below:

	2024-25	2023-24
	£000	£000
Surplus / (deficit) for the period	**(46,052)**	**(239,586)**
Add back all I&E impairments / (reversals)	15,701	26,168
Remove capital donations / grants / peppercorn lease I&E impact	(9,308)	(1,041)
Remove PFI revenue costs on an IFRS 16 basis	176,626	267,826
Add back PFI revenue costs on an IAS 17 basis (2023-24 only)		(97,222)
Add back PFI revenue costs on a UK GAAP basis	(148,674)	
Adjusted financial performance surplus / (deficit) (control total basis)	**(11,707)**	**(43,855)**
Add back incremental impact of IFRS16 on PFI revenue costs in 2023-24		(170,604)
IFRIC 12 breakeven adjustment	0	157,672
Breakeven duty financial performance surplus / (deficit)	**(11,707)**	**(56,787)**

3 Breakeven duty rolling assessment

	2024-25	2023-24	2022-23	2021-22	2020-21	2019-20	2018-19	2017-18	2016-17	2015-16	2014-15	2013-14	2012-13
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(11,707)	(56,787)	(12,853)	554	123	(73,119)	(84,243)	(108,363)	(69,481)	(134,881)	(79,642)	(38,270)	409
Breakeven duty cumulative position	(668,260)	(656,553)	(599,766)	(586,913)	(587,467)	(587,590)	(514,471)	(430,228)	(321,865)	(252,384)	(117,503)	(37,861)	409
Operating income	2,652,139	2,394,941	2,190,622	2,032,501	1,987,672	1,698,118	1,526,645	1,512,726	1,488,833	1,342,594	1,319,964	1,288,172	1,324,338
Cumulative breakeven position as a percentage of operating income	**(25.2%)**	**(27.4%)**	**(27.4%)**	**(28.9%)**	**(29.6%)**	**(34.6%)**	**(33.7%)**	**(28.4%)**	**(21.6%)**	**(18.8%)**	**(8.9%)**	**(2.9%)**	**0.0%**

NHS England has provided guidance that the first year for consideration for the breakeven duty should be 2009-10.
Barts Health NHS Trust was established on the 1st April 2012, hence the note discloses performance from the 2012-13 financial year.

4 Capital Resource Limit

	2024-25	2023-24
	£000	£000
Gross capital expenditure	118,746	97,622
Less: Termination of Lease	(5,500)	0
Less: Donated and granted capital additions	(13,089)	(4,318)
Charge against Capital Resource Limit	**100,157**	**93,304**
Capital Resource Limit	100,517	96,808
Under / (over) spend against CRL	**360**	**3,504**

5 Operating Segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations, since all policies, procedures and governance arrangements are Trust wide. As an NHS Trust, all services are subject to the same regulatory environment and standards set by our external performance managers. Accordingly, the Trust operates as one segment.

6 Fees and Charges (Income Generation Activities)

HM Treasury requires bodies to provide additional disclosures for fees and charges raised under legislation, for instance dental and prescription charges, where the full cost exceeds £1 million, or the service is otherwise material in relation to the accounts. The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The Trust had no individual income generation activity whose full cost exceeded £1m or was otherwise material (nil in 2023-24).

7 Operating income from patient care activities

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

7.1 Income from patient care activities (by nature)

	2024-25	2023-24
Acute services	**£000**	**£000**
Income from commissioners under API contracts - variable element*	446,794	377,218
Income from commissioners under API contracts - fixed element*	1,561,079	1,473,156
High cost drugs income from commissioners	223,483	207,376
Other NHS clinical income	37,706	25,880
Community services		
Income from commissioners under API contracts*	20,291	19,790
All Services		
Private patient income	3,908	4,049
National pay award central funding**	5,554	935
Additional pension contribution central funding***	85,584	51,235
Other clinical income	20,180	17,830
Total income from activities	**2,404,579**	**2,177,469**

*Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023-25 NHS Payment Scheme documentation: https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Additional funding was made available directly to providers by NHS England in 2024-25 and 2023-24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38%, with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions at 23.7% (2023/24: 20.6%) and related NHS England funding at 9.4% (2023/24: 6.3%) have been recognised in these accounts.

7.2 Income from patient care activities (by source)

	2024-25	2023-24
	£000	**£000**
NHS England	884,340	823,978
Integrated Care Boards	1,470,856	1,311,412
Other NHS providers	14,732	10,096
NHS other	939	1,128
Local authorities	9,625	8,976
Non NHS: private patients	3,908	4,049
Non NHS: overseas patients (chargeable to patient)	12,810	11,147
Injury cost recovery scheme	7,226	6,659
Non NHS: other	143	24
Total income from activities	**2,404,579**	**2,177,469**

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

	2024-25	2023-24
	£000	**£000**
Income recognised in year	12,810	11,147
Cash payments received in year	2,239	1,682
Amounts added to provision for impairment of receivables	14,703	12,429
Amounts written off in-year*	7,925	6,894

*The recovery of overseas visitor debt poses significant challenges, despite best endeavours and with diligent credit control processes in place.

8 Other operating income

	2024-25			2023-24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	80,267	0	**80,267**	63,455	0	**63,455**
Education and training	89,452	0	**89,452**	82,764	0	**82,764**
Non-patient care services to other bodies	32,317		**32,317**	34,794		**34,794**
Receipt of capital grants and donations		13,089	**13,089**		4,318	**4,318**
Charitable and other contributions to expenditure		4,627	**4,627**		2,851	**2,851**
Rental revenue from operating leases		2,517	**2,517**		2,575	**2,575**
Other income (see below)	25,291	0	**25,291**	26,715	0	**26,715**
Total other operating income	**227,327**	**20,233**	**247,560**	**207,728**	**9,744**	**217,472**

8.1 Other Income is analysed in further detail below:

	2024-25	2023-24
	£000	£000
Car Parking income	2,482	2,278
Catering	0	96
Pharmacy sales	854	624
Staff accommodation rental	86	133
Clinical tests	1,794	1,562
Clinical excellence awards	2,698	2,827
Grossing up consortium arrangements	0	1
Other income generation schemes (recognised under IFRS 15)	12,555	14,820
Other income not already covered (recognised under IFRS 15)	4,822	4,374
Total "Other" Contract Income	**25,291**	**26,715**

9 Operating leases - Barts Health NHS Trust as lessor

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

	2024-25	2023-24
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	2,517	2,575
Total	**2,517**	**2,575**
Of which:		
- income generated from owned assets	2,517	2,575

	31 March 2025	31 March 2024
Future minimum lease receipts due:	**£000**	**£000**
- not later than one year	2,486	2,517
- later than one year and not later than two years	2,814	2,486
- later than two years and not later than three years	2,764	2,814
- later than three years and not later than four years	2,648	2,764
- later than four years and not later than five years	2,395	2,648
- later than five years	76,535	78,930
Total	**89,642**	**92,159**

10 Operating expenses

	2024-25	2023-24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	19,636	15,272
Purchase of healthcare from non-NHS and non-DHSC bodies	13,447	13,578
Staff and executive directors costs	1,600,230	1,453,971
Remuneration of non-executive directors	213	253
Supplies and services - clinical (excluding drugs costs)	242,282	211,528
Supplies and services - general	22,835	23,495
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	251,169	229,055
Inventories written down	5	159
Consultancy costs	852	2,850
Establishment	9,916	9,680
Premises	110,068	114,518
Transport (including patient travel)	18,505	17,635
Depreciation on property, plant and equipment and right of use assets	79,940	77,507
Amortisation on intangible assets	322	45
Net impairments (Note 11)	15,701	26,168
Movement in credit loss allowance: contract receivables / contract assets	11,706	10,022
Change in provisions discount rate(s)	12	(187)
Audit fees payable to the external auditor - statutory audit*	216	179
Internal audit costs	602	733
Clinical negligence - amounts payable to NHS Resolution (premium)	74,178	75,358
Legal fees	2,045	1,333
Insurance	266	186
Research and development	32,415	23,846
Education and training	5,542	6,492
Expenditure on short term leases	13	13
Redundancy	726	97
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	36,610	34,536
Hospitality	24	0
Losses, ex gratia & special payments	296	254
Other	17,672	23,581
Total	**2,567,444**	**2,372,157**

*The fee to the external auditors for their audit of the financial statements was £216,367, which included non-recoverable VAT at 20% of £36,061.
(2023-24: £179,310, which included non-recoverable VAT at 20% of £29,885)

No other services were provided by the external auditors in 2024-25 and 2023-24.

10.1 Limitation on auditor's liability

There is no limit on the auditors' liability for external audit work carried out in the financial years 2024-25 and 2023-24.

11 Impairment of assets

	2024-25 £000	2023-24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	2,034	0
Changes in market price	13,667	26,168
Total net impairments charged to operating surplus / deficit	**15,701**	**26,168**
Total net impairments charged to the revaluation reserve	8,069	19,397
Total net impairments	**23,770**	**45,565**

When assets are revalued, upward valuations are charged to the revaluation reserve where there is a ring-fenced fund for each asset. Downwards valuations (impairments) are charged to either the revaluation reserve (as long as there is enough ring-fenced balance to cover that particular asset), or to the operating surplus or deficit for any excess impairment over and above the ring-fenced balance.

12 Staff Costs

	2024-25 Total £000	2023-24 Total £000
Salaries and wages	1,230,189	1,121,728
Social security costs	134,457	125,850
Apprenticeship levy	6,112	5,730
Employer's contribution to NHS pensions*	216,848	168,887
Pension cost (NEST scheme)	178	183
Termination benefits	1,170	390
Temporary staff (including agency)	39,413	56,835
Total gross staff costs	**1,628,367**	**1,479,603**
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure**	(20,145)	(19,012)
Total staff costs	**1,608,222**	**1,460,591**
Of which:		
Costs capitalised as part of assets	6,664	5,761

*In 2024-25, this includes the additional employer pension contribution of £85.584m (9.4%) paid by NHS England on the Trust's behalf (2023-24: £51.234m (6.3%)).
In 2024-25, the total employer's pension contribution rate, including that funded by NHS England was 23.7% (2023-24: 20.6%)

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

12.1 Retirements due to ill-health

During 2024-25 there were 9 early retirements from the Trust agreed on the grounds of ill-health (16 in 2023-24). The estimated additional pension liabilities of these ill-health retirements is £648k (£1,870k in 2023-24).

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

13 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability, as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay.

The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

The Trust estimates that the cost of its employer pension contributions in 2025-26 will be in the region of £216m, which includes NHS England's contribution at 9.4%.

The NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme.

The employer's contribution rate in 2024-25 was 3% (2023-24: 3%).

14 Finance income

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

	2024-25	2023-24
	£000	£000
Interest on bank accounts (Government Banking Service)	5,021	5,714
Total finance income	**5,021**	**5,714**

15 Finance Expenditure

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

15.1 Finance Expenditure for the year

	2024-25	2023-24
	£000	£000
Interest expenses:		
Interest on lease obligations	502	383
Interest on late payment of commercial debt	0	2
Finance costs on PFI service concession arrangements:		
Main finance costs	59,914	58,984
Remeasurement of the liability resulting from change in index or rate	75,576	208,842
Total interest expenses	**135,992**	**268,211**
Unwinding of discount on provisions	71	50
Total finance costs	**136,063**	**268,261**

15.2 The Late Payment of Commercial Debts (interest) Act 1998

	2024-25	2023-24
	£000	£000
Amounts included within interest payable arising from claims under this legislation	0	2

16 Other gains / (losses)

	2024-25 £000	2023-24 £000
Gains on disposal of assets	295	177
Total gains / (losses) on disposal of assets	**295**	**177**

17 Intangible assets

17.1 Intangible assets 2024-25

	Software licences	IT	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**1,834**	**670**	**2,504**
Additions	7,093	0	**7,093**
Disposals / derecognition	(1,406)	0	**(1,406)**
Valuation / gross cost at 31 March 2025	**7,521**	**670**	**8,191**
Amortisation at 1 April 2024 - brought forward	**1,752**	**670**	**2,422**
Provided during the year	322	0	**322**
Disposals / derecognition	(1,406)	0	**(1,406)**
Amortisation at 31 March 2025	**668**	**670**	**1,338**
Net book value at 31 March 2025	**6,853**	**0**	**6,853**
Net book value at 1 April 2024	**82**	**0**	**82**

17.2 Intangible assets 2023-24

	Software licences	IT	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023	**1,834**	**670**	**2,504**
Valuation / gross cost at 31 March 2024	**1,834**	**670**	**2,504**
Amortisation at 1 April 2023	**1,707**	**670**	**2,377**
Provided during the year	45	0	**45**
Amortisation at 31 March 2024	**1,752**	**670**	**2,422**
Net book value at 31 March 2024	**82**	**0**	**82**
Net book value at 1 April 2023	**127**	**0**	**127**

18 Property, plant and equipment

18.1 Property, plant and equipment: 2024-25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**124,572**	**1,262,472**	**2,092**	**29,813**	**204,648**	**0**	**73,834**	**485**	**1,697,916**
Additions	0	41,020	0	25,890	24,221	0	6,367	0	**97,498**
Impairments charged to operating expenses	0	(14,876)	0	(2,034)	0	0	0	0	**(16,910)**
Impairments charged to the revaluation reserve	0	(19,551)	0	0	0	0	0	0	**(19,551)**
Revaluations	0	6,235	36	0	0	0	0	0	**6,271**
Reclassifications	(647)	1,021	0	(2,487)	410	0	454	0	**(1,249)**
Disposals / derecognition	0	0	0	0	(5,488)	0	(8,444)	(269)	**(14,201)**
Valuation/gross cost at 31 March 2025	**123,925**	**1,276,321**	**2,128**	**51,182**	**223,791**	**0**	**72,211**	**216**	**1,749,774**
Accumulated depreciation at 1 April 2024 - brought forward	**0**	**0**	**0**	**0**	**110,935**	**0**	**40,632**	**435**	**152,002**
Provided during the year	0	35,674	33	0	20,327	0	12,723	9	**68,766**
Impairments charged to operating expenses	0	(1,300)	0	0	0	0	0	0	**(1,300)**
Impairments charged to the revaluation reserve	0	(11,482)	0	0	0	0	0	0	**(11,482)**
Revaluations	0	(22,892)	(33)	0	0	0	0	0	**(22,925)**
Disposals / derecognition	0	0	0	0	(5,488)	0	(8,444)	(269)	**(14,201)**
Accumulated depreciation at 31 March 2025	**0**	**0**	**0**	**0**	**125,774**	**0**	**44,911**	**175**	**170,860**
Net book value at 31 March 2025	123,925	1,276,321	2,128	51,182	98,017	0	27,300	41	**1,578,914**
Net book value at 1 April 2024	124,572	1,262,472	2,092	29,813	93,713	0	33,202	50	**1,545,914**

18.2 Property, plant and equipment: 2023-24

	Land (*Restated)	Buildings excluding dwellings (*Restated)	Dwellings (*Restated)	Assets under construction	Plant & machinery (*Restated)	Transport equipment (*Restated)	Information technology	Furniture & fittings	Total (*Restated)
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward (*Restated)	**127,404**	**1,254,266**	**2,100**	**50,625**	**186,661**	**0**	**66,528**	**485**	**1,688,069**
Additions	0	46,788	0	6,517	21,087	0	11,993	0	**86,385**
Impairments charged to operating expenses (*Restated)	(675)	(24,940)	0	0	0	0	0	0	**(25,615)**
Impairments charged to the revaluation reserve (*Restated)	(2,163)	(31,094)	0	0	0	0	0	0	**(33,257)**
Revaluations (*Restated)	6	(7,458)	(8)	0	0	0	0	0	**(7,460)**
Reclassifications	0	24,910	0	(27,329)	2,351	0	68	0	**0**
Disposals / derecognition (*Restated)	0	0	0	0	(5,451)	0	(4,755)	0	**(10,206)**
Valuation/gross cost at 31 March 2024	**124,572**	**1,262,472**	**2,092**	**29,813**	**204,648**	**0**	**73,834**	**485**	**1,697,916**
Accumulated depreciation at 1 April 2023 - brought forward (*Restated)	**0**	**0**	**0**	**0**	**97,258**	**0**	**33,527**	**426**	**131,211**
Provided during the year	0	34,156	33	0	19,128	0	11,860	9	**65,186**
Impairments charged to operating expenses (*Restated)	0	(1,286)	0	0	0	0	0	0	**(1,286)**
Impairments charged to the revaluation reserve (*Restated)	0	(13,860)	0	0	0	0	0	0	**(13,860)**
Revaluations (*Restated)	0	(19,010)	(33)	0	0	0	0	0	**(19,043)**
Disposals / derecognition (*Restated)	0	0	0	0	(5,451)	0	(4,755)	0	**(10,206)**
Accumulated depreciation at 31 March 2024	**0**	**0**	**0**	**0**	**110,935**	**0**	**40,632**	**435**	**152,002**
Net book value at 31 March 2024	124,572	1,262,472	2,092	29,813	93,713	0	33,202	50	**1,545,914**
Net book value at 1 April 2023	127,404	1,254,266	2,100	50,625	89,403	0	33,001	59	**1,556,858**

*The prior year figures have been restated due to (i) a re-interpretation of the DHSC GAM relating to formal valuations, and / or (ii) the removal of assets which have been fully depreciated and have a nil net book value, and which are no longer in use. None of these amendments affect the primary statements, nor do they change the total net book value of assets in either year. These amendments flow through to the totals of each table, and into the carried forward tables in Note 18.1. The rows that have been restated are:

First half of table:

- Gross cost at 1 April 2023: Land from 135m to 127m; Buildings from 1,294m to 1,254m; Dwellings from 2.13m to 2.10m; P&M from 249m to 187m; Transport from 162k to 0; Total from 1,798m to 1,688m. - Impairments charged to operating expenses: Land from 0 to (675)k; Buildings from 0 to (25)m; Total from 0 to (26)m. - Impairments charged to Revaluation Reserve: Land from (2)m to 0; Buildings from (17)m to (14)m; Total from ((19)m to (14)m. - Revaluations: Land from 6k to 0; Buildings from (28)m to (19)m; Dwellings from (5)k to (33)k; Total from (28)m to (19)m. - Disposals/Derecognition (both tables): Plant & Machinery from (2)m to (5)m; Total from (7)m to (10)m.

Second half of table:

- Accumulated Depreciation at 1 April 2023: Land from 8m to 0; Buildings from 39m to 0; Dwellings from 30k to 0; Plant & Machinery from 160m to 97m; Transport Equipment from 162k to 0; Total from to 241m to 131m. - Impairments charged to operating expenses: Land from 675k to 0; Buildings from 24m to (1)m; Total from 24m to (1)m. - Impairments charged to revaluation reserve: Buildings from 0 to (14)m: Total from 0 to (14)m - Revaluations: Buildings from (39)m to (19)m; Dwellings from (30)k to (33)k; Total from (39)m to (19)m.

18.3 Property, plant and equipment financing: 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	123,925	372,206	1,880	47,679	82,029	26,741	10	**654,470**
On-SoFP PFI contracts	0	856,712	0	0	0	0	0	**856,712**
Owned - donated / granted	0	47,403	248	3,503	15,988	559	31	**67,732**
NBV total at 31 March 2025	**123,925**	**1,276,321**	**2,128**	**51,182**	**98,017**	**27,300**	**41**	**1,578,914**

18.4 Property, plant and equipment financing: 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	124,572	374,194	1,849	28,451	85,240	32,536	15	**646,857**
On-SoFP PFI contracts	0	841,154	0	0	0	0	0	**841,154**
Owned - donated / granted	0	47,124	243	1,362	8,473	666	35	**57,903**
NBV total at 31 March 2024	**124,572**	**1,262,472**	**2,092**	**29,813**	**93,713**	**33,202**	**50**	**1,545,914**

18.5 Property plant and equipment assets subject to an operating lease (Barts as a lessor) as at 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	0	4,281	2,128	0	0	0	0	**6,409**
Not subject to an operating lease	123,925	1,272,040	0	51,182	98,017	27,300	41	**1,572,505**
NBV total at 31 March 2025	**123,925**	**1,276,321**	**2,128**	**51,182**	**98,017**	**27,300**	**41**	**1,578,914**

18.6 Property plant and equipment assets subject to an operating lease (Barts as a lessor) as at 31 March 2024

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	0	6,966	0	0	0	0	0	**6,966**
Not subject to an operating lease	124,572	1,255,506	2,092	29,813	93,713	33,202	50	**1,538,948**
NBV total at 31 March 2024	**124,572**	**1,262,472**	**2,092**	**29,813**	**93,713**	**33,202**	**50**	**1,545,914**

19 Right of Use Assets

This note details information about leases for which Barts Health NHS Trust is a lessee.

19.1 Right of use assets: 2024-25

	Property (Land & Buildings)	Plant & machinery	Transport equipment	Information technology	Total	*Of which, leased from DHSC group bodies:*
	£000	£000	£000	£000	£000	*£000*
Valuation / gross cost at 1 April 2024 - brought forward	**39,312**	**12,430**	**6,254**	**5,500**	**63,496**	***13,971***
Additions	11,502	1,407	1,010	0	**13,919**	*1,078*
Remeasurement of lease liability	236	0	0	0	**236**	*219*
Impairments	(91)	0	0	0	**(91)**	*(91)*
Revaluations	174	0	0	0	**174**	*143*
Reclassifications*	1,249	0	0	0	**1,249**	*0*
Disposals / derecognition	0	0	0	(5,500)	**(5,500)**	*0*
Valuation/gross cost at 31 March 2025	**52,382**	**13,837**	**7,264**	**0**	**73,483**	***15,320***

*'This is a reclassification from PPE to ROU of two peppercorn leases. These relate to unadjusted errors from the prior year.

Accumulated depreciation at 1 April 2024 - brought forward	**19,779**	**5,046**	**3,002**	**0**	**27,827**	***7,441***
Provided during the year	6,992	2,592	1,590	0	**11,174**	*1,880*
Accumulated depreciation at 31 March 2025	**26,771**	**7,638**	**4,592**	**0**	**39,001**	***9,321***
Net book value at 31 March 2025	25,611	6,199	2,672	0	**34,482**	***5,999***
Net book value at 1 April 2024	19,533	7,384	3,252	5,500	**35,669**	***6,530***
Net book value of right of use assets leased from other NHS providers						*553*
Net book value of right of use assets leased from other DHSC group bodies						*5,446*

19.2 Right of use assets: 2023-24

	Property (Land & Buildings)	Plant & machinery	Transport equipment	Information technology	Total	*Of which, leased from DHSC group bodies:*
	£000	£000	£000	£000	£000	*£000*
Valuation / gross cost at 1 April 2023 - brought forward	**32,340**	**12,373**	**6,254**	**0**	**50,967**	***11,389***
Additions	4,739	57	0	5,500	**10,296**	*390*
Remeasurements of the lease liability	941	0	0	0	**941**	*900*
Revaluations	1,292	0	0	0	**1,292**	*1,292*
Valuation/gross cost at 31 March 2024	**39,312**	**12,430**	**6,254**	**5,500**	**63,496**	***13,971***
Accumulated depreciation at 1 April 2023 - brought forward	**9,643**	**2,523**	**1,501**	**0**	**13,667**	***2,498***
Provided during the year	8,297	2,523	1,501	0	**12,321**	*3,104*
Impairments	1,839	0	0	0	**1,839**	*1,839*
Accumulated depreciation at 31 March 2024	**19,779**	**5,046**	**3,002**	**0**	**27,827**	***7,441***
Net book value at 31 March 2024	19,533	7,384	3,252	5,500	**35,669**	*6,530*
Net book value at 1 April 2023	22,697	9,850	4,753	0	**37,300**	*8,891*
Net book value of right of use assets leased from other NHS providers						*694*
Net book value of right of use assets leased from other DHSC group bodies						*5,836*

19.3 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.

	2024-25	2023-24
	£000	£000
Brought forward value at 1 April	**36,252**	**37,125**
Lease additions	13,919	10,296
Lease liability remeasurements	236	941
Interest charge arising in year	502	383
Early terminations	(5,500)	0
Lease payments (cash outflows)	(12,657)	(12,493)
Carrying value at 31 March	**32,752**	**36,252**

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 10.

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

19.4 Maturity analysis of future lease payments

	Total 31 March 2025 £000	*Of which, leased from DHSC group bodies: 31 March 2025 £000*	Total 31 March 2024 £000	*Of which, leased from DHSC group bodies: 31 March 2024 £000*
Undiscounted future lease payments payable in:				
- not later than one year;	14,827	*2,661*	14,124	*3,169*
- later than one year and not later than five years;	19,020	*2,395*	22,957	*4,200*
- later than five years.	1,535	*882*	284	*135*
Total gross future lease payments	**35,382**	***5,938***	**37,365**	***7,504***
Finance charges allocated to future periods	(2,630)	*(422)*	(1,113)	*(222)*
Net lease liabilities at 31 March 2025	**32,752**	***5,516***	**36,252**	***7,282***
Of which:				
Leased from other NHS providers		*177*		*746*
Leased from other DHSC group bodies		*5,339*		*6,536*

20 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	12,021	10,928
Consumables	25,236	23,138
Energy	109	46
Total inventories	**37,366**	**34,112**

Inventories recognised in expenses for the year were £395,291k (2023-24: £376,832k).
Write-down of inventories recognised as expenses for the year were £5k (2023-24: £159k).

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 £1,351k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

21 Receivables

21.1 Trade and other Receivables

	31 March 2025	31 March 2024
Current	**£000**	**£000**
Contract receivables	115,960	121,073
Allowance for impaired contract receivables / assets	(39,725)	(37,288)
Prepayments (non-PFI)	10,736	6,097
Prepayments (PFI)	37,665	35,672
PFI lifecycle prepayments	253	253
PDC dividend receivable	0	613
VAT receivable	13,208	12,721
Other receivables	1,085	1,667
Total current trade and other receivables	**139,182**	**140,808**
Non-current		
Contract receivables	7,937	8,242
PFI lifecycle prepayments (revenue)	5,560	5,466
Clinician pension tax provision reimbursement from NHS England	2,614	2,560
Total non-current trade and other receivables	**16,111**	**16,268**
Of which receivables from NHS and DHSC group bodies:		
Current	43,131	58,574
Non-current	2,614	2,560

21.2 Allowances for credit losses: Contract receivables and contract assets

	2024-25	2023-24
	£000	**£000**
Allowances as at 1 April - brought forward	**37,288**	**34,495**
New allowances arising	22,313	19,877
Reversals of allowances (where receivable is collected in-year)	(10,607)	(9,855)
Utilisation of allowances (where receivable is written off)	(9,269)	(7,229)
Allowances as at 31 March	**39,725**	**37,288**

21.3 Exposure to credit risk

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

Included in the contract receivables figure in Note 21.1 are amounts invoiced to non-NHS organisations of £41m (2023-24: £34m). The non impaired values of this debt, by days outstanding, is shown below:

	31 March 2025	31 March 2024
	£000	£000
0 to 30 days	7,914	5,174
30 to 60 days	1,903	1,603
60 to 90 days	823	974
90 to 180 days	87	0
Over 180 days	618	0
Total	**11,345**	**7,751**

22 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2024-25	2023-24
	£000	£000
At 1 April	**34,373**	**60,212**
Net change in year	11,964	(25,839)
At 31 March	**46,337**	**34,373**
Analysed as:		
Cash in hand	7	7
Cash with the Government Banking Service	46,330	34,366
Total cash and cash equivalents as in SoFP	**46,337**	**34,373**
Total cash and cash equivalents as in SoCF	**46,337**	**34,373**

22.1 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Bank balances	21	21
Total third party assets	**21**	**21**

23 Trade and other payables

	31 March 2025	31 March 2024
Current	**£000**	**£000**
Trade payables	135,240	86,305
Capital payables	6,717	7,053
Accruals	125,859	143,927
Social security costs	37,410	37,164
Pension contributions payable	19,329	17,669
Other payables	2,755	3,035
Total current trade and other payables	**327,310**	**295,153**
Of which, payables from NHS and DHSC group bodies:		
Current	31,492	33,199

24 Other liabilities

	31 March 2025	31 March 2024
Current	**£000**	**£000**
Deferred income: contract liabilities (IFRS 15)	11,301	9,341
Total other current liabilities	**11,301**	**9,341**

25 Borrowings

25.1 Borrowings at 31 March

	31 March 2025	31 March 2024
Current	**£000**	**£000**
Lease liabilities	14,579	13,485
Obligations under PFI service concession contracts	49,055	48,217
Total current borrowings	**63,634**	**61,702**
Non-current		
Lease liabilities	18,173	22,767
Obligations under PFI service concession contracts	1,645,879	1,621,531
Total non-current borrowings	**1,664,052**	**1,644,298**

25.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	PFI schemes	Total
	£000	£000	£000
Carrying value at 1 April 2024 - brought forward	**36,252**	**1,669,748**	**1,706,000**
Cash movements:			
Financing cash flows - payments and receipts of principal	(12,155)	(50,390)	(62,545)
Financing cash flows - payments of interest	(502)	(59,914)	(60,416)
Non-cash movements:			
Additions	13,919	0	13,919
Lease liability remeasurements	236	0	236
Remeasurement of PFI liability resulting from change in index or rate		75,576	75,576
Application of effective interest rate	502	59,914	60,416
Early terminations	(5,500)	0	(5,500)
Carrying value at 31 March 2025	**32,752**	**1,694,934**	**1,727,686**

	Lease Liabilities	PFI schemes	Total
	£000	£000	£000
Carrying value at 1 April 2023	**37,125**	**915,370**	**952,495**
Cash movements:			
Financing cash flows - payments and receipts of principal	(12,110)	(48,657)	(60,767)
Financing cash flows - payments of interest	(383)	(58,984)	(59,367)
Non-cash movements:			
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023		594,193	594,193
Additions	10,296	0	10,296
Lease liability remeasurements	941	0	941
Remeasurement of PFI liability resulting from change in index or rate	0	208,842	208,842
Application of effective interest rate	383	58,984	59,367
Carrying value at 31 March 2024 - carried forward	**36,252**	**1,669,748**	**1,706,000**

26 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Redundancy	Other*	Total
	£000	£000	£000	£000	£000
At 1 April 2024	**2,901**	**865**	**569**	**11,479**	**15,814**
Change in the discount rate	12	0	0	(25)	**(13)**
Arising during the year	267	93	123	2,351	**2,834**
Utilised during the year	(257)	(139)	(445)	(5,577)	**(6,418)**
Reversed unused	0	(353)	(124)	(2,869)	**(3,346)**
Unwinding of discount	71	0	0	132	**203**
At 31 March 2025	**2,994**	**466**	**123**	**5,491**	**9,074**
Expected timing of cash flows:					
- not later than one year;	265	466	123	2,877	**3,731**
- later than one year and less than five years;	1,062	0	0	305	**1,367**
- later than five years.	1,667	0	0	2,309	**3,976**
Total	**2,994**	**466**	**123**	**5,491**	**9,074**

*Other provisions include a tax liability of £2.7m for clinicians who are members of the NHS Pension Schemes and who, as a result of work undertaken in 2019/20, face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. These figures use the latest available information on actual uptake of the scheme. The Trust will be re-imbursed by NHS England for this charge, and in accordance with NHS England guidance, a matching receivable of £2.7m has been recognised in these accounts.
Also included in other provisions is £2.8m in relation to potential VAT liabilities.

27 Clinical negligence liabilities

	31 March 2025 £000	31 March 2024 £000
Included in the provisions of NHS Resolution in respect of clinical negligence liabilities of Barts Health NHS Trust	831,150	803,119

28 Contingent assets and liabilities

	31 March 2025	31 March 2024
Value of contingent liabilities	**£000**	**£000**
NHS Resolution legal claims	(168)	(142)
Gross value of contingent liabilities	**(168)**	**(142)**
Net value of contingent liabilities	**(168)**	**(142)**
Net value of contingent assets	**0**	**0**

29 Contractual capital commitments

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	15,953	12,128
Total	**15,953**	**12,128**

The 2024-25 capital commitments relate mainly to estates backlog and other building works as well as equipment purchases. The largest single item for £10.4m relates to the construction of a multi-storey carpark at Whipps Cross Hospital as part of the enabling works for the now delayed new hospital project.

30 On-SoFP PFI service concession arrangements

The main buildings at St Barts Hospital and the Royal London Hospital were completed in 2016 under the Private Finance Initiative (PFI). Part of Newham Hospital was completed in 2006 under the PFI.

These PFI schemes are built and maintained by private developers, who meet the initial capital cost of the building. The Trust contracts to pay an annual charge which is a mix of interest, repayment of capital, service and maintenance costs. These charges are linked to the rate of inflation.

The estimated total future cost of these payments over the life of these schemes is shown as "borrowings" on the Trust's balance sheet (Statement of Financial Position), and the borrowings figures are adjusted each year in line with price movements.

The following obligations in respect of the PFI service concession arrangements are recognised in the Statement of Financial Position:

30.1 On-SOFP PFI service concession arrangement obligations

	31 March 2025	31 March 2024
	£000	£000
Gross PFI service concession liabilities	**2,455,868**	**2,455,079**
Of which liabilities are due:		
- not later than one year;	107,250	105,567
- later than one year and not later than five years;	426,664	410,892
- later than five years.	1,921,954	1,938,620
Finance charges allocated to future periods	(760,934)	(785,331)
Net PFI service concession arrangement obligation	**1,694,934**	**1,669,748**
- not later than one year;	*49,055*	*48,217*
- later than one year and not later than five years;	*211,811*	*198,408*
- later than five years.	*1,434,068*	*1,423,123*

30.2 Total on-SoFP PFI service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2025	31 March 2024 (Restated*)
	£000	£000
Total future payments committed in respect of the PFI service concession arrangements	**3,634,367**	**3,630,724**
Of which payments are due:		
- not later than one year;	*161,883*	*154,826*
- later than one year and not later than five years;	*647,533*	*619,304*
- later than five years.	*2,824,951*	*2,856,594*

*The prior year figures relating to future PFI commitments have been restated to reflect the removal of the estimated impact of future inflation, in line with the DHSC GAM. This note is a standalone disclosure note. The figures do not feed into any of the primary statements, nor are they recognised in the Trust's financial ledger. The total future payments have been restated from £5,095m to £3,631m; payments due not later than one year from 162m to 155m; payments not later than one year and not later than five years from 689m to 619m; payments later than five years from 4,245m to 2,857m.

30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator in the year:

	2024-25	2023-24
	£000	£000
Unitary payment payable to service concession operator	**161,883**	**154,826**
Consisting of:		
- Interest charge	59,914	58,984
- Repayment of balance sheet obligation	50,390	48,657
- Service element and other charges to operating expenditure	36,610	34,536
- Capital lifecycle maintenance	14,969	12,649
	161,883	**154,826**
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment (capitalised)	4,623	4,275
Total amount paid to service concession operator	**166,506**	**159,101**

31 Financial Instruments

31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with its commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. Trust treasury activity is subject to periodic review by the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS England. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2025 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Fair Value

In reporting the value of financial assets and liabilities in notes 32.2 and 32.3, the Trust has assessed that, given the nature of those financial assets and liabilities, fair value is equal to current value, and as such no additional disclosure is required.

31.2 Carrying values of financial assets

	31 March 2025	31 March 2024
	Held at amortised cost	Held at amortised cost
	£000	£000
Trade and other receivables excluding non financial assets	85,173	85,380
Cash and cash equivalents at bank and in hand	46,337	34,373
Total at 31 March	**131,510**	**119,753**

31.3 Carrying value of financial liabilities

	31 March 2025	31 March 2024
	Held at amortised cost	Held at amortised cost
	£000	£000
Obligations under leases	32,752	36,252
Obligations under PFI service concession arrangements	1,694,934	1,669,748
Trade and other payables excluding non financial liabilities	259,395	229,624
Total at 31 March	**1,987,081**	**1,935,624**

31.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025	31 March 2024
	£000	£000
In one year or less	381,472	349,315
In more than one year but not more than five years	445,684	433,849
In more than five years	1,923,489	1,938,904
Total at 31 March	**2,750,645**	**2,722,068**

32 Related parties

During 2024-25 and 2023-24, Barts Health NHS Trust has had a significant number of material transactions (income and expenditure, and outstanding balances including commitments over £1m) with the Department of Health and Social Care (DHSC), and with other entities for which DHSC is regarded as the parent department, and with other Whole of Government Account bodies. These organisations are listed below:

NHS Provider Organisations

Barking, Havering & Redbridge University Hospitals NHST
Central and North West London NHSFT
Chelsea and Westminster Hospital NHS FT
East London NHSFT
Great Ormond Street Hospital for Children NHSFT
Homerton University Hospital NHSFT
Imperial College Healthcare NHST
Lewisham and Greenwich NHST
London Ambulance Service NHST
London North West University Healthcare NHST
Mid and South Essex Hospital Services NHSFT
Moorfields Eye Hospital NHS FT
North East London NHSFT
North London NHSFT (formerly Camden & Islington NHS FT)
Oxford Health NHSFT
Royal Free London NHSFT
University College London Hospitals NHSFT

Other

Care Quality Commission
Community Health Partnerships
Department of Health and Social Care
HM Revenue & Customs
NHS Blood and Transplant
NHS Business Services Authority (inc NHS Pensions)
NHS England (inc Regional Offices & former Health Education England)
NHS Property Services
NHS Resolution

Integrated Care Boards

Bedfordshire, Luton and Milton Keynes ICB
Buckinghamshire, Oxfordshire and Berkshire West ICB
Cambridgeshire and Peterborough ICB
Hertfordshire and West Essex ICB
Kent and Medway ICB
Mid and South Essex ICB
Norfolk and Waveney ICB
North Central London ICB
North East London ICB
North West London ICB
Northamptonshire ICB
South East London ICB
South West London ICB
Suffolk and North East Essex ICB
Surrey Heartlands ICB
Sussex ICB

Local Authorities

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

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

The following members of Barts Health NHS Trust's Board also held senior manager posts at BHRUT during 2024-25 and 2023-24:

- Rt Hon Jacqui Smith (Chair in Common)
- Shane DeGaris (Group Chief Executive)
- Matthew Trainer (Group Deputy Chief Executive)
- Professor Sir Mark Caulfield, Dr Kathy McLean OBE, Lesley Seary CBE and Prof Hilary Thomas (2024-25) (Non-Executive Directors)

Other Related Party Transactions

During 2024-25 and 2023-24, Barts Health NHS Trust had transactions (income and expenditure, and outstanding balances) with a number of organisations who are deemed to be a related party due to the level of control and / or influence that a Barts Health NHS Trust senior manager has within that organisation. These transactions are listed below:

		2024-25				2023-24			
		Revenue	Of which, Receivables	Expenditure	Of which, Payables	Revenue	Of which, Receivables	Expenditure	Of which, Payables
Senior Manager(s)	**Organisation**	£000	£000	£000	£000	£000	£000	£000	£000
Prof Ian Jacobs (trustee), the Rt Hon Jacqui Smith (trustee) and Professor Sir Mark Caulfield (board member)	Barts Charity	17,045	1,243	0	0	9,167	565	0	0
Professor Charles Knight (trustee)	St Bartholomew's Heritage (Barts Heritage)	52	2	0	0	0	0	0	0
Professor Hilary Thomas (partner)	PA Consulting Services Ltd	0	0	733	192	**Not in post in 2023-24**			
Shane DeGaris, the Rt Hon Jacqui Smith and Professor Sir Mark Caulfield (board members)	UCL Partners	96	40	330	7	13	0	434	90
Hardev Virdee (member), the Rt Hon Jacqui Smith (trustee) and Siva Anandaciva (director)	The Kings Fund	0	0	133	0	0	0	358	152

The DHSC has provided a list of the individuals and entities that DHSC identifies as meeting the definition of related parties set out in IAS 24 (Related Party Transactions), and are also deemed to be related parties of entities within the Departmental Group. The transactions relating to these entities is disclosed below:

	2024-25				2023-24			
	Revenue	Of which, Receivables	Expenditure	Of which, Payables	Revenue	Of which, Receivables	Expenditure	Of which, Payables
Organisation	£000	£000	£000	£000	£000	£000	£000	£000
Macmillan Cancer Support	725	16	0	0	**Not on DHSC list in 2023-24**			
NHS Confederation	0	0	27	0	0	0	29	0

33 Better Payment Practice Code

	2024-25		2023-24	
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	220,708	1,482,570	200,454	1,398,385
Total non-NHS trade invoices paid within target	161,977	1,230,509	129,831	1,141,760
% of non-NHS trade invoices paid within target	**73.4%**	**83.0%**	**64.8%**	**81.6%**
NHS Payables				
Total NHS trade invoices paid in the year	4,505	386,634	4,580	349,396
Total NHS trade invoices paid within target	2,282	357,944	2,221	314,285
% of NHS trade invoices paid within target	**50.7%**	**92.6%**	**48.5%**	**90.0%**

The Better Payment Practice Code requires the Trust to aim to pay 95% of valid invoices within 30 days of receipt, or by whatever alternative payment terms have been agreed with the supplier.

34 Losses and special payments

	2024-25		2023-24	
	Number	£000	Number	£000
Losses				
Cash losses (overpayment of salaries)	57	136	80	100
Fruitless payments	11	108	1	148
Bad debts and claims abandoned*	844	7,982	1,735	7,128
Stores losses and damage to property	1	5	1	159
Total losses	**913**	**8,231**	**1,817**	**7,535**
Special payments				
Extra-contractual payments	1	150	0	0
Ex-gratia payments	54	37	71	77
Special severance payments	0	0	3	29
Total special payments	**55**	**187**	**74**	**106**
Total losses and special payments	**968**	**8,418**	**1,891**	**7,641**

*In 2024-25 and 2023-24, a significant level of Overseas visitor historical debt was written off, and is included in these figures. The recovery of overseas visitor debt poses significant challenges, despite best endeavours and with diligent credit control processes in place. In 2024-25 two overseas visitor receivables, each with an individual value of more than £300k, and relating to deceased patients, were written off. The total value written off was £1,304k (nil in 2023-24).

35 Gifts

The disclosure of gifts is only required if the total value of gifts made exceeds £300,000.
No such gifts were received in 2024-25 (2023-24: nil)

36 Events after the reporting date

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

In May 2025, the government announced that NHS staff will receive pay awards in the 2025-26 financial year, to be backdated to the 1 April 2025. NHS Agenda for change staff will receive an increase of 3.6%; doctors and dentists a 4% increase plus an additional £750 for doctors and dentists in training; and 3.25% for Executive and Senior Managers and Very Senior Managers. The cost of the award is estimated to be in the region of £60m, and national guidance as to funding arrangements has not yet been issued, but the Trust anticipates that this will be fully funded as in previous years. This is a non-adjusting event, as the pay award relates to the 2025-26 financial year, and is disclosed in these 2024-25 accounts as the value is material.

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